Australian National University

Natalie Bryant
PhD Scholar
Centre for Indigenous Policy Research

natalie.bryant@anu.edu.au

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Prof. Michael Pervan
Chief Executive Officer
Independent Health and Aged Care Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Independent Health and Aged Care Pricing Authority (IHACPA) Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025-26

Dear Prof. Pervan,

Thank you for the opportunity to respond to the Independent Health and Aged Care Pricing Authority (IHACPA) Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025-26.

We write in our capacity as researchers at the Australian National University. Natalie Bryant is a Sir Roland Wilson Pat Turner PhD Scholar and a Yuin woman from the South Coast of New South Wales. Her doctoral research investigates Australian health system structures in the context of race and self-determination. Dr Francis Markham is a non-Indigenous scholar whose research and teaching focuses on a range of Indigenous public policy issues, including administrative and funding arrangements.

Our response to the Consultation Paper broadly addresses the importance of including First Nations perspectives in governance structures and reviewing aspects of the pricing approach to ensure that they do not further embed the inequities of health outcomes between First Nations and non-Indigenous peoples. The overarching recommendation is that IHACPA prevent the further marginalisation of Aboriginal and Torres Strait Islander Australians by ensuring that they have a role in the development and *implementation* of policies that affect them.

The importance of including Aboriginal and Torres Strait Islander Australians in governance structures and consultation

The importance of ensuring First Nations representations in the governance structures continues to be paramount. It is noted that IHACPA does not have any First Nations representatives on the Board, Clinical Advisory Committee nor in the Senior Leadership.

In response to the public consultation in 2024-25, we raised the lack of First Nations representation in the governance structures. The IHACPA response to this submission noted an intent to review its criteria for committee membership and specifically to review the Stakeholder Advisory Committee and consultation processes. We are not aware of any substantive change to the processes for public consultation or the membership of the Committees. As outlined in our submission from 2024-25, the lack of representation continues to embed the invisibility of First Nations people in key policy decisions regarding health care.

All governments in this country remain committed to "systemic and structural transformation of mainstream government organisations to improve accountability and respond to the needs of Aboriginal and Torres Strait Islander people" under the *National Agreement on Closing the Gap*. However, the recent Productivity Commission Report on the National Agreement on Closing the Gap stated that they were "yet to identify a government organisation that has articulated a clear vision for what transformation looks like, adopted a strategy achieve that vision" furthermore it goes on to say that "transformation can only be realised by drawing on the experiences and perspective of those who governments service – in this case, Aboriginal and Torres Strait Islander people – and working together with this knowledge to develop a strategy" (Productivity Commission, 2024, pp. 5–6).

IHACPA must articulate a clear vision for transformation and inclusion of Indigenous perspectives in the aspects of the policy environment for public hospital services over which it has influence. This process should be informed by First Nations people in order to ensure that the invisibility of First Nations peoples is not perpetuated any further. Including a representative of First Nations people in the governance of the authority would be a useful first step in this process.

Reviewing the Indigenous adjustment

Whilst the *National Health Reform Act 2011* and the IHACPA Pricing Guidelines require the development of an Indigenous adjustment, a cost adjustment may not be the best funding lever to address the poor health outcomes of First Nations peoples in the public hospital system. Whilst it is widely acknowledged that it costs more to treat Aboriginal and Torres Strait Islander patients due to

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the higher burden of disease and significantly poorer health outcomes,[1 2 3] a pricing adjustment based on historic cost does not address the significant under-servicing of the First Nations population in relation to hospital services. A study commissioned by the National Aboriginal Community Controlled Health Organisation (NACCHO) provides a crude estimate that this under-servicing is worth approximately $4.4 billion per year.[4] In order to address this, consideration should be given to replacing the cost-based adjustment with a needs-based adjustment.

In order to determine the factors that should be considered, IHACPA should engage directly with First Nations communities and organisations through representatives chosen by themselves in accordance with their own procedures. The National Agreement on Closing the Gap, agreed to by all Australian Governments and by the Coalition of Peaks[5] commits all Governments to a ‘full and genuine partnership’ when it comes ‘policy making that impacts on the lives of Aboriginal and Torres Strait Islander people’.[6] This pricing adjustment affects First Nations peoples and therefore it is incumbent on IHACPA to not just engage First Nations representatives in this process, but to attempt in good faith to come to an agreement on the best approach to this issue. Given the paucity of high-quality evidence on this topic, a considerable investment in research is likely to be necessary.

Disaggregated data in the National Benchmarking Portal

A significant enhancement that will support improvements in outcomes for First Nations peoples in public hospitals and policy-making would be ensuring access to data that can be filtered by Indigenous status. This would allow for public scrutiny of trends in relation to Hospital-Acquired Complications (HACs) and Avoidable Hospital Readmissions (AHRs) and how they affect First Nations people.

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[1] Australian Institute of Health and Welfare 2020. Aboriginal and Torres Strait Islander Health Performance Framework 2020 summary report. Cat. No. IHPF 2. Canberra: AIHW. https://www.indigenoushpf.gov.au/measures/3-14-access-services-compared-with-need

[2] Australian Institute of Health and Welfare 2018. Australia’s health 2018. Australia’s health series no. 16. AUS 221. Canberra: AIHW https://www.aihw.gov.au/getmedia/3a2cdfb0-ba14- 4b14-b6ac-039dcf35c5e3/aihw-aus-221-chapter-6-8.pdf.aspx

[3] Australian Institute of Health and Welfare 2020. Indigenous life expectancy and deaths. Canberra: AIHW. https://www.aihw.gov.au/reports/australias-health/indigenous-life- expectancy-and-deaths

[4] This estimate compares the ratio of estimated Indigenous-to-non-Indigenous healthcare expenditure to a ratio of Indigenous-to-non-Indigenous burden of disease, a comparison which is far from ideal. Nevertheless, it is the only comprehensive national study we are aware of. National Aboriginal Community Controlled Health Organisation, and Equity Economics. “Measuring the Gap in Health Expenditure: Aboriginal and Torres Strait Islander Australians,” May 2022, 3. https://www.naccho.org.au/app/uploads/2022/05/NACCHO-and-Equity-Economics-Report-Measuring-the-Gap-in-Health-Expenditure_FINAL.pdf

[5] An alliance comprised of over 80 Aboriginal and Torres Strait Islander community-controlled peak and member organisations across Australia. See https://coalitionofpeaks.org.au

[6] Australian Governments and the Coalition of Peaks (2020). National Agreement on Closing the Gap. Article 18.

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Reviewing the approach to pricing and funding for safety and quality

The reforms under the *National Health Reform Agreement – Addendum 2020-25* that focus on quality and safety are another example in which First Nations peoples are rendered invisible. The stated aims of the reforms do not include equity or reference First Nations people in any way. The development of the reforms was undertaken with minimal, if any, First Nations involvement. The Joint Working Party that informed this work did not appear to include any First Nations members. In the Literature Review that was undertaken as part of the development work, there is no mention of First Nations people and minimal references to equity. The final lists of Sentinel Events, Hospital Acquired Complications and Avoidable Hospital Readmissions and were all developed in consultation with the Joint Working Party.

The pricing approach includes a risk adjustment model that was also developed with minimal First Nations involvement. The lack of First Nations representatives on the IHACPA Clinical Advisory Committee and other working groups has previously been flagged. The apparent failure to include First Nations perspectives in this process may have resulted in safety and quality reforms that are at a minimum unconsciously biased and have the potential to further embed the inequities of health outcomes between First Nations and non-Indigenous peoples. The Sentinel Events, Hospital Acquired Complications and Avoidable Hospital Readmissions lists alongside the risk adjustment model should all be reviewed from a First Nations and equity lens. As outlined previously, IHACPA should engage directly with First Nations communities, organisations, and experts in undertaking such a review.

In concluding this submission, we note that the National Health Reform Agreement is currently been renegotiated and that all parties have committed to developing a First Nations Schedule. Whilst this process is ongoing and the outcome is unclear, IHACPA must acknowledge that the work of IHACPA deeply affects First Nations peoples and their needs and priorities need to be considered with the agency's work. In line with the *National Agreement on Closing the Gap*, IHACPA must act to prevent the further marginalisation of First Nations peoples by articulating a clear vision for transformation and inclusion of First Nations perspectives in all aspects of the policy environment for public hospital services.

Regards

Natalie Bryant and Francis Markham

Centre for Indigenous Policy Research
POLIS: The Centre for Social Policy Research
Copland Building #24
Australian National University
CANBERRA ACT 2601