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RACP submission to the Pricing Framework for Australian Public Hospital Services 2025-26

June 2024

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 30,000 medical specialists and trainee specialists across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients and the community.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Introduction

The Royal Australasian College of Physicians (RACP) appreciates the opportunity to submit feedback on the Independent Health and Aged Care Pricing Authority (IHACPA) Pricing Framework for Australian Public Hospital Services 2025-2026.

The RACP would like to thank IHACPA for its response to the RACP's 2023 feedback and its commitment to the considerations of:

- refinements in next iterations of the Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) and Australian Emergency Care Classification
- the ongoing development of the non-admitted care classification and
- incorporation of changes in healthcare trends related to the COVID-19 pandemic.

This submission addresses following key areas of the consultation:

- Updated classifications for pricing to better reflect complexity of care
- Accounting for and responding to the needs of the healthcare system
- Pricing and funding for safety and quality.

Updated classifications to pricing to better reflect complexity of care

Unaccounted costs in emergency, admitted and non-admitted care

The RACP believes that factors such as substance use, homelessness, mental health and physical and intellectual disability are additional significant cost drivers that should be considered in pricing hospital services. Complex needs, often presenting across the lifespan, require more intensive resourcing for appropriate hospital care, including higher staff-to-patient ratios, longer consultations, adjustments to facilitate support staff where applicable, appropriate safety for support workers on site, as well as additional discharge from hospital support.

To use one illustrative example, emergency department presentations and mental health inpatient services for patients who are NDIS participants need to cover any funding to support workers. This funding ensures the support worker can support the patient when accessing and participating in health care. Currently, some support funding may be already covered by the patients' NDIS plan but adults with intellectual or physical disability presenting with physical or mental illness often require more support than usual. Additional time, care and disability support for presentation to hospital/hospital admission need to be factored in the Pricing Framework and applicable funding models. As such, the omission of this and other mentioned cost drivers in the Pricing Framework underestimates the actual costs of delivering hospital services.

In refining classification for pricing emergency care and non-admitted care, it is important to consider additional resources (personnel, time, support, equipment) required to support or rehabilitate patients for the discharge from care process, or to support independent living in the community. Special consideration needs to be given in this context to rurality, regionality and associated operating costs and operational supply limitations. These additional resources are particularly critical in delivering emergency care and non-admitted care for older people, people with mental health conditions, people experiencing homelessness, people with a disability, or people with other complex needs.

With specific regard to emergency care, it is vital that the activities of all sub-specialties involved in the delivery of an emergency episode of care be captured for reporting and costing purposes, including sub-specialties that may not have a direct patient interfacing role, such as clinical pharmacology and toxicology.

Mental health care

The RACP reiterates that estimating the adequate level of future cost in rural, regional and remote areas may be challenging, particularly considering reported shortages of mental health services[1].

The RACP supports the proposal to transition community mental health from block funding to activity-based funding using Australian Mental Health Care Classification Version 1.1 and recommends special attention be given to the costing and funding implications of mental health care in these under-served rural, regional and remote areas.

Accounting for and responding to the needs of the healthcare system

IHACPA's commitment to assessing the ongoing impact of the COVID-19 pandemic on hospital activity and costs data for National Efficient Price Determination 2025-26 (NEP25) is welcomed.

COVID-19 costing adjustments have had an ongoing application to NEP25 as the disease and its long-term and flow on effects continue to impact working arrangements in hospital settings. The RACP continues to call for assessment of the impact of these factors on NEP25 costings.

Key additional factors that need to be accounted for when assessing the impact of the COVID-19 pandemic for NEP25 include:

- COVID-19 impact on emergency department presentations[2]
- Effect of COVID-19 on elective surgery admissions[3]
- Influenza cases[4,5]
- Implications of long COVID-19[6,7]
- Public health physician and other non-procedural subspecialty activity during and beyond COVID[8]

Pricing and funding for safety and quality

The RACP supports IHACPA's clear commitment to reducing sentinel events, hospital acquired complications and unplanned hospital admissions. To aim and fund for safety and quality, all players in the health system must:

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[1] Australian Institute of Health and Welfare [online]; Rural and remote health - Australian Institute of Health and Welfare (aihw.gov.au)[2] Australian Institute of Health and Welfare, Australia's hospitals at a glance, December 2022 [online];
[2] Australian Institute of Health and Welfare, Australia's hospitals at a glance, December 2022 [online]; Australia's hospitals at a glance , Impact of COVID–19 on hospital care - Australian Institute of Health and Welfare (aihw.gov.au)
[3] Australian Institute of Health and Welfare Elective surgery activity [online]; Elective surgery activity - Australian Institute of Health and Welfare (aihw.gov.au)
[4] Australian Influenza Surveillance Reports – 2023 | Australian Government Department of Health and Aged Care
[5] National Notifiable Diseases Surveillance System (NNDSS) fortnightly reports | Australian Government Department of Health and Aged Care
[6] World Health Organization [online] https://www.who.int/europe/news-room/fact-sheets/item/post-covid-19-condition
[7] Parliament of Australia, Sick and tired: Casting a long shadow, Inquiry into Long COVID and Repeated COVID Infections, House of Representatives, Standing Committee on Health, Aged Care and Sport, April 2023 [online]; https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/RB000006/toc_pdf/SickandtiredCastingalongshadow.pdf
[8] RACP, Public Health Physicians: Protecting, Promoting and Improving Health for the Whole Community November 2020 [online]; public-health-physicians-protecting-promoting-and-improving-health-for-the-whole-community.pdf (racp.edu.au)

- Promote ambulatory care programs in the community, including secondary prevention services post an acute episode.
- Incentivise clinician in-reach and outreach services, especially in rural and remote areas.
- Incentivise hospital-in-the-home programs.
- Incentivise innovative and integrated models of care incorporating technologies, particularly involving telephone, video and remote monitoring devices.

The RACP wishes to again stress that hospital reform is a component of the much broader national health system reform agenda. As such it must be closely aligned with and connected to the work on strengthening primary health care and improving integrated care between the primary, secondary and tertiary health care sectors. Such reforms have the greatest potential to keep people out of hospitals, improving patient outcomes and reducing the strain on the health care system.

The RACP thanks IHACPA for considering our submission and look forward to the opportunity to contribute to the work of IHACPA further. Please contact the Policy and Advocacy Unit via policy@racp.edu.au regarding any additional information.