The Royal Australasian
College of Physicians

RACP Submission (2015):
Pricing Framework for Australian Public Hospital Services 2016/17

Introduction

The Royal Australasian College of Physicians (RACP) welcomes this opportunity to provide feedback to the Independent Hospital Pricing Authority (IHPA) regarding its consultation paper on the Pricing Framework for Australian Public Hospital Services 2016-17.

This submission addresses the following issues identified in the consultation document:

- The importance of pricing guideline principles related to integrated care;
- Adjustments to the National Efficient Price to account for the higher costs associated with admitted patients with intellectual disability;
- Extending bundled pricing to a broader range of services;
- The potential benefits and risks of using best practice pricing to augment current average cost pricing of hospital services.

These matters are discussed in the following sections.

Pricing Guidelines

The RACP believes that the current pricing guidelines strike the right balance between the imperatives of efficiency, equity, and high quality patient care. We also welcome the fact that two of these principles, which can be found in the System Design Guidelines, recognise the importance of encouraging better integrated care. These principles are:

- **Fostering clinical innovation**: Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes and

- **Price harmonisation**: Pricing should facilitate best-practice provision of appropriate site of care.

These two principles will further support integrated care. The principle of 'fostering clinical innovation' recognises that new models of care need to be accommodated within the pricing system for public hospital services. Similarly, the principle of 'price harmonisation' is particularly important, as its implications are that pricing should not favour admitted over non-admitted care, or distort service providers' deciding between the two, as it is a decision that should be based on clinical outcomes.

Adjustments to the National Efficient Price for intellectual disability care

In response to the requests from stakeholders responding to its previous pricing framework consultation, the IHPA has analysed the average cost of care for patients with intellectual disability to determine if this cost was materially above the price currently paid for their care.

The consultation paper states that the IHPA was unable to find any material difference in costs, but at the same time acknowledged that the diagnosis codes it used to identify these patients may not have been sufficiently comprehensive. As raised in the consultation paper, the RACP is supportive of the IHPA exploring alternative approaches for identifying whether an upwards adjustment for patients with intellectual disability is required.

For this reason, the RACP calls on the IHPA to renew its investigative efforts, as we believe that the evidence points to the likelihood that patients with intellectual disability will have higher than average costs of care. In particular, we note that:

- Persons with an intellectual disability experience higher rates of many treatable health conditions compared to the mainstream population,[1] with one study estimating that they suffered from 5.4 conditions per person, half of which were unrecognised or poorly treated.[2]

- Even then, these findings may still underestimate the level of unmet health need in those with syndrome specific conditions, such as Down syndrome.[3] For instance, research has shown that adults with Down syndrome on average tend to have increased rates and longer periods of hospitalisation than the general community.[4]

- People with intellectual disability are more likely to face additional challenges that may lead to a greater health care administrative or management costs, such as;

    - difficulties with verbal communication;
    - reliance on formal and informal carers for meeting health care needs;
    - need for others to support decision making and provision of consent;
    - needs for assistance to participate in community access and leisure activities that might restrict healthy lifestyles;
    - limited literacy skills;
    - inability to recall personal health information, such as past major disease, operations, or health interventions

Healthcare for people with intellectual disabilities is very likely to involve multiple health professionals and multiple points of contact.[5] Indeed, for these very reasons, the healthcare of people with intellectual disabilities may be a good candidate for multidisciplinary models of care characterised by effective and sustained collaboration across sectors, health, disability, education and family and community services, and professionals.[6]

Classifications used by IHPA to describe public hospital services

The college supports the move towards the Australian Refined Diagnosis Related Groups version 8 (AR-DRG v.8) and the Australian National Subacute and Non-Acute Patient version 4 (AN-SNAP) in the hope that these will, as intended, better reflect the complexity, comorbidity, and principal diagnosis of presenting patients. However, we wish to emphasise that it is important that these changes are subject to an ongoing process of evaluation.

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[1] Lennox N, Bain C, Rey-Conde T, Purdie D, Bush R, Pandeya N. Effects of a comprehensive health assessment programme for Australian adults with intellectual disability: a cluster randomized trial. International Journal of Epidemiology. 2007;36(1):139-146; Lennox N, Bain C, Rey-Conde T, et al. Cluster Randomized-Controlled Trial of Interventions to Improve Health for Adults with Intellectual Disability Who Live in Private Dwellings. Journal of Applied Research in Intellectual Disabilities. Jul 2010;23(4):303-311; Lennox N, Ware R, Carrington S, et al. Ask: a health advocacy program for adolescents with an intellectual disability: a cluster randomised controlled trial. Bmc Public Health. Sep 7 2012;12

[2] Beange H, McElduff A, Baker W. Medical disorders of adults with mental retardation: a population study. Am J Ment Retard. May 1995;99(6):595-604.

[3] Leonard S, Bower C, Petterson B, Leonard H. Medical aspects of school-aged children with Down syndrome. Dev Med Child Neurol. Oct 1999;41(10):683-688; Pikora TJ, Bourke J, Bathgate K, Foley KR, Lennox N, Leonard H. Health Conditions and Their Impact among Adolescents and Young Adults with Down Syndrome. Plos One. May 12 2014;9(5).

[4] Tenenbaum A, Chavkin M, Wexler ID, Korem M, Merrick J. Morbidity and hospitalizations of adults with Down syndrome. Research in developmental disabilities. Mar-Apr 2012;33(2):435-441

[5] Australian Institute of Health and Welfare. The use of health services among Australians with disability. AIHW bulletin no. 91. Cat. no. AUS 140. Canberra: AIHW; 2011

[6] Royal College of General Practitioners. The Royal College of General Practitioners Curriculum 2010: 3.11 The Clinical Example on Care of People with Intellectual Disability. 2013; http://www.gmc-uk.org/3_11_Intellectual_disability_April_2013.pdf_52885340.pdf. Accessed Feb 12, 2014

The development of a model to support multidisciplinary case conference in the Tier 2 non-admitted patient services is also supported, as this is relevant to a number of aspects of geriatric, palliative and paediatric medicine, where multiple assessments by different health professionals may require discussion within a case conference setting.

The development of a funding model that recognises the role of teaching, training, and research within hospital settings is essential, and fully supported by the College. Given the role and requirements of accredited training organisations such as the RACP, should these services transition to the Activity Based Funding (ABF) framework, it is critical that further discussion occurs with relevant training organisations. The RACP reiterates that should ABF be considered feasible for teaching, training and particularly research activities, robust data collection will be necessary before meaningful pricing can occur. We look forward to the findings of the IHPA costing studies that have commenced into these matters.

Bundled pricing

The RACP reiterates its support, as raised in the previous submission to the IHPA 2015/16 pricing framework, for further work in the development of bundled pricing models. This includes support for IHPA's expanded policy intention for bundled pricing in future years. The RACP has a strong commitment to encouraging better integrated care, and bundled pricing can provide strong incentives for healthcare service providers to better coordinate and integrate care.

Hip fracture care is one such area where models of shared care are becoming increasingly common, and is likely to evolve over time to other surgical areas. However, at present, pricing in the acute hospital setting does not support such emerging models of shared care between surgeons and physicians. We therefore welcome IHPA's investigation, and hope that its findings will inform other concurrent government initiatives into bundled pricing, namely the Medicare Benefits Schedule Review Taskforce, the Primary Health Care Advisory Group, the Senate Health Standing Committee inquiry into Chronic Disease, and the reform of the federation white paper and associated COAG processes.

The evidence on the use of bundled pricing for facilitating integrated care is encouraging. A recent systematic review of price bundling studies between 1985 and 2011, which covered 58 studies, identified 20 different bundled payment interventions, and concluded that the introduction of bundled payment was associated with reductions in health care spending and utilization.[7] Similarly, a recent study looking at the introduction of bundled pricing for diabetes care, chronic obstructive pulmonary disease care, and vascular risk management in the Netherlands found that it improved the organization and coordination of care and led to better collaboration among health care providers and better adherence to care protocols.[8]

IHPA seeks advice on which services or patient episodes of care would most benefit from bundled care. Research has identified the following as characteristics of medical conditions which may be more amenable to bundled pricing treatment:[9]

- There is a clear clinical understanding of the beginning and end of the episode;
- Well-established clinical norms or guidelines exist;

[7] Bundled Payment: Effects on Health Care Spending and Quality: Closing the Quality Gap: Revisiting the State of the Science. August 2012. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/findings/evidence-based-reports/gapbundtp.html

[8] De Bakker et al, 'Early results from adoption of bundled payment for diabetes care in the Netherlands show improvement in care coordination', Health Aff (Millwood). 2012 Feb;31(2):426-33. doi: 10.1377/hlthaff.2011.0912.

[9] Appleby, J. et al 2012, 'Payment by Results: How can payment systems help to deliver better care?'.

- Well-understood service patterns are known;
- Reasonably predictable progression of condition or disease;
- Pre-existing integration of management of service-delivery for the condition; and
- Ease of attributing accountability to the providers involved

Research also suggests that a bundled pricing approach is easier to apply to acute care conditions because they are more practical to define with a clearer beginning and end.[10] Application of bundled pricing to the treatment of chronic conditions raises additional challenges due to their unclear onset period and lack of end point, need for multidisciplinary team approaches, and multiple transitions between care providers.

The RACP is supportive of bundled pricing policy options being further explored for particular chronic conditions. One relevant disease condition is stroke, even though there will be inherent variability in pricing options due to variability in stroke outcomes related to stroke severity. When designing bundled pricing options to improve efficiency, caution must be exercised that access to appropriate subacute care, mainly rehabilitation, is not compromised.

Pricing for Safety and Quality

In the health policy literature, best practice pricing involves identifying what constitutes best practice for a treatment for a particular condition, and then setting a price based on this best practice. In this respect it differs from the current approach of average cost pricing, which calculates the price of a particular procedure based on an average of the costs across all public hospitals. The intention of best practice pricing is to incentivise hospitals to adopt these best practice methods and achieve efficiencies. IHPA states that it sees best practice pricing as a means of augmenting the current approach based on the average cost of care.

The RACP recommends that the best practice pricing approach needs to be used with caution. Hospitals may differ in their underlying cost structures depending on legacy factors such as economies of scale and scope. Even if best practice pricing is based on solid data, caution must be exercised to ensure that hospitals are not made financially worse off from best practice pricing (due to being undercompensated for procedures).

Conclusion

As outlined throughout the submission, the RACP supports the exploration of innovative models of funding to provide for better integrated care. It is important the pricing mechanisms reflect, where possible, the complexities, comorbidities, and multidisciplinary care needs of patients.

The IHPA also has a responsibility to balance necessary revisions of the pricing framework with ensuring the provision of efficient and accessible public hospital services. The RACP is of the view that the IHPA Public Hospital Pricing Framework 2016-17 and subsequent amendments strike the right balance between the imperatives of efficiency, equity, and high quality patient care.

The RACP thanks the IHPA for the opportunity to provide a submission on this very important issue. We would be pleased to be involved in any future discussions on improving the pricing of public hospital services.

[10] Pham HH, Ginsberg PB, Lake TK, Maxfield MM (2010). Episode-based Payments: Charting a course for health care payment reform. Policy Analysis No 1. Washington DC: National Institute for Health Care Reform. Available at: www.nihcr.org/news_ episodebasedpayments.html (accessed on 20 September 2012.