1 April 2022

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority

By email to: submissions.ihpa@ihpa.gov.au

Dear Mr Downie

Re: Draft IHPA Work Program and Corporate Plan 2022–23

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide input into the public consultation on the draft Independent Hospital Pricing Authority (IHPA) Work Program and Corporate Plan 2022-23 (the draft Work Program).
The RANZCP is the principal organisation representing the medical speciality of psychiatry in Australia and New Zealand and is responsible for training, educating and representing psychiatrists on policy issues. The RANZCP represents more than 7400 qualified and trainee psychiatrists in Australia and New Zealand and is guided on policy matters by a range of expert committees.

The RANZCP acknowledges IHPA's work in developing and refining the national Activity Based Funding (ABF) system, with an aim to move the focus to paying for value and patient outcomes. Any changes to the funding model need to be based on robust costing studies undertaken across mental health sub-specialties, to ensure that differing complexities are incorporated into the pricing structure. As the move to ABF occurs, the RANZCP would like to highlight areas which IHPA should consider addressing in its work program.

Pricing needs to reflect the complexity of mental health service provision, and it also needs to reflect the difference in patient cohorts. The RANZCP is concerned that a generic 'one price' model will not be sufficiently specific and will not capture the level of care provision for patients presenting with complex mental health conditions. For example, in Child and Adolescent Mental Health Services (CAMHS), in addition to seeing patients face to face, there is a high level of liaison where support is provided to the child, their family, and community teams. Community CAMHS services see patients with complex conditions which require liaison with multiple agencies. Complex conditions will also need to be considered in other sub-specialities including aged care, neuropsychiatry, and dual diagnosis.

Costing studies would also address longstanding concerns in consultation-liaison psychiatry. While the RANZCP recognises that the multidisciplinary component of this role is funded within the ABF, development of management plans and specific patient therapeutic consultations provided by consultation-liaison psychiatrists outside multidisciplinary team settings remains unfunded.

Any inherent flaws introduced in the initial deployment of ABF for mental health care will lead to structural deficits in the funding model, which present financial risk to specialist mental health care providers. The RANZCP urges that while the proposed ABF is evaluated, a modified ABF system for services, or block funding is maintained.

309 La Trobe Street, Melbourne VIC 3000 Australia
T +61 3 9640 0646 F +61 3 9642 5652
ranzcp@ranzcp.org www.ranzcp.org
ABN 68 000 439 047

The RANZCP also suggests that the work program should consider how research and training should be included in funding calculations. The separate funding of research from training would enable training and education activities to be accounted for separately, which would ensure funding is utilised for its intended purpose.

The RANZCP would also like to raise the following points for consideration regarding more flexible and contemporary costing models in aged care, to cover episodes where:

- The inpatient unit is under the governance of psychiatric services or nonpsychiatric services.
- The episode is an acute, subacute or non-acute stay where the primary diagnosis for the acute and subacute stays is dementia or another Acquired Brain Injury (ABI) code (e.g., behavioural symptoms within Huntington Disease).
- For non-acute stays where the person is awaiting transfer to a residential aged care facility.

For example, in subacute and non-acute care (SNAP), dementia stays on medical inpatient units are covered by the Psychogeriatric Care Type. This costing relied on studies where length of stay for the dementia group was greater than 500 days. The pivotal 1990s MH-CASC studies used in the SNAP model included large numbers of people with dementia in long stay psychiatric hospital settings, who would now be in a residential aged care facility. In mental health inpatient units, access to SNAP type models is no longer accessible as Psychogeriatric Care Types are now unavailable.

With differences across service models in Australia, mental health inpatient units regularly provide acute and subacute services for assessment and treatment of behavioural presentations for patients with dementia/ABI. These inpatient units may also include numbers of non-acute patients awaiting aged care. With the ageing population, the numbers and care requirements of patients are rising, and this group needs to be costed properly both for medical and mental health settings.

The RANZCP also supports the recognition in the draft Work Program of the impacts of the COVID-19 pandemic on hospital pricing within the Work Program.

If you would like to discuss any of the items raised in this letter, please contact Rosie Forster, Executive Manager, Practice, Policy and Partnerships via rosie.forster@ranzcp.org or by phone on (03) 9601 4943.

Yours sincerely

Associate Professor Vinay Lakra
President

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