ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SUBMISSION TO THE INDEPENDENT HOSPITAL PRICING AUTHORITY

FEBRUARY 2012

RESPONSE TO THE DISCUSSION PAPER *ACTIVITY BASED FUNDING FOR AUSTRALIAN PUBLIC HOSPITALS: TOWARDS A PRICING FRAMEWORK*

Introduction

The Royal Australasian College of Surgeons, established in 1927, is a not-for-profit organisation training surgeons and maintaining surgical standards in Australia and New Zealand. Approximately 95 per cent of all surgeons practising in Australia and New Zealand are Fellows of the College (FRACS).

The College commits to ensuring the highest standard of safe and comprehensive surgical care for the community we serve through excellence in surgical education, training, professional development and support.

This commitment requires the College to take informed and principled positions on matters of public health.

The College appreciates the opportunity to make a submission in response to the discussion paper *Activity based funding for Australian public hospitals: Towards a Pricing Framework*.

The College believes it is imperative that the development and introduction of Activity Based Funding (ABF) does not result in an enormously complicated mechanism which gives rise to discrepancies and inequalities in funding, thereby exacerbating the very problem it was intended to resolve.

While the ultimate ABF model will necessarily involve the centralisation of funding, it is also imperative that its distance from the workface does not lead to unrealistic demands and unrealistic prices being imposed on our nation's public hospitals.

Avoiding Unintended Consequences

The move to activity based funding for Australian public hospitals constitutes a complex reform agenda and all interested parties must ensure that this complexity does not have unintended and adverse consequences.

The purpose of this exercise must be healthcare quality and it should be remembered that this has six components:

- Safety;
- Appropriateness;
- Access and timeliness;
- Patient centredness;
- Efficiency; and
- Effectiveness.

Pricing is just one factor in this reform agenda. Other factors include targets with regard to waiting times for elective surgery, and it is the interplay between these targets which could lead to unintended consequences.

The process of implementing ABF should be informed by evidence based medicine and surgery; it should not be driven by funding concerns alone.

Central to any pricing framework is the principle of comparative effectiveness. An understanding of comparative effectiveness casts light on which procedures and treatments work, which don't, and which are most cost-effective. It is about more than cost alone; other considerations must include the patient experience and other aspects of healthcare quality.

Transparency and Accountability

To avoid unintended problems, the new system must be founded on enhanced transparency and accountability.

For example, surgical teams have little exposure to the total cost of a patient's procedure. They might know the cost of a given prosthesis but they probably have limited experience in what constitutes the overall components of a procedure (eg the cost of a bed day, the cost of an investigation, the cost of one hour's use of an operating theatre). This is because hospital managements have never recognised the importance of informing surgical teams of these costs.

If clinicians are to play a part in determining the cost of a procedure, and perhaps play a part in achieving economies, they must be better informed. It is up to clinicians to seek this information but it is equally the responsibility of hospital managements to make this information readily available.

Transparency and accountability, and a requirement for rigorous record keeping in our hospitals, will also ensure that the state of service delivery in a given facility cannot be falsified by way of hidden waiting lists or the re-categorisation of patients.

Geography and Demographics

Factors arising from Australia's geography and demographics must be taken into consideration when determining a pricing framework for ABF. With its major capital cities located on its coastline, and a vast but sparsely populated interior, Australia is notable for the pronounced unevenness of its population distribution. Country patients have to travel considerable distances to receive medical treatment.

For example, the management of a facial fracture, and the delivery of post-operative care, in central Sydney could differ significantly from the management of the same fracture in the country.

We also have an ageing population, and this will have a bearing on ABF. The management of a skin cancer on the lower leg of an older patient involves different post-operative care from the management of a similar cancer on a younger patient, particularly in terms of mobilisation and hospitalisation (even without reference to possible comorbidities).

The needs of the Indigenous, the disadvantaged, the aged and the young need particular consideration, ensuring these groups are not adversely affected by ABF.

Hospital Acquired Conditions

The College would be strongly opposed to adopting the concept of the United States' Medicare list of Hospital Acquired Conditions (Box 7.1) as the basis on which to

preclude funding. This would be a punitive and unfair means of deducting payments from hospitals and could lead to patients who are predisposed to certain complications being excluded from some hospitals. Further, some high risk patients could potentially be denied proper access to inpatient treatment.

This is a good example of where a new policy might lead to unintended consequences. If a hospital is to be penalised every time a patient falls this could act as a disincentive for hospitals to admit elderly patients – an unintended and regrettable outcome.

Specialist Services

It should be noted that there are certain hospitals around Australia which focus on certain disease processes. A facility with a particular focus on breast cancer, undertaking increasingly complex reconstructions and aiming for ever improving outcomes, requires increased theatre time and post-operative care to achieve optimal results. Is such a facility to be prevented from or, worse, penalised for this pursuit of excellence?

With regard to prosthetics, breast reconstruction using prosthetic implants and tissue expanders needs to be addressed as part of this process.

Specialist Services for Children

Section 7.2.2 of the discussion paper addresses specialist services for children. It is noted that while specialist hospitals benefit from economies of scale they also treat a substantial number of patients with complex care requirements. And with regard to children's specialist care, it is calculated that the mean cost per weighted separation is about 20% more than the mean for all hospitals, as is the median.

This is unsurprising, given that children's hospitals and units attract additional costs associated with staffing requirements, particularly nursing staff.

The College endorses the conclusion that there are additional costs in specialist children's hospitals and units, and that this constitutes a case for loading.

Private Patients in Public Hospitals

The issue of managing private patients in public hospitals is complex and one that further complicates ABF. Any system that tries to make adjustments for private patients in public hospitals by deducting the costs of prostheses, pathology and diagnostic imaging will inevitably be complex and enormously bureaucratic. Arrangements will be further complicated by the fact that different states have different methods of managing private patients; in Queensland for example there is the intermediate system of care.

It would be simpler to fund all patients, both public and private, according to a national efficient price, but then make an adjustment for the number of private patients each hospital treats by way of some standard formula.

Block Funding

References to block funding in the paper are somewhat vague, the suggestion being this will be a fallback measure for those procedures, or whole areas of clinical care, to which activity based funding cannot be applied. It is to be hoped that greater clarity will develop around block funding as this process continues.

Block funding can and should be used, however, in cases where smaller or rural based hospitals are disadvantaged by the ABF mechanism.

Teaching, Training and Research

The Royal Australasian College of Surgeons, and the surgical Specialty Societies it serves, are gravely concerned that public hospitals' vital educational role will be subordinated to the goal of developing a "price list" of surgical procedures. We welcome therefore the discussion paper's recognition that: "Unless clinical education in public hospitals is explicitly funded, it runs the risk of being squeezed out" (9.5.4).

It appears likely that teaching and training will be initially managed by way of block funding, with a subsequent transition to ABF. Irrespective of how the educational role of public hospitals is funded, it is important that some sort of price loading reflect the fact that a given surgical procedure is costlier to perform in a teaching hospital. This is because the presence of Trainees entails costs associated with supervision, infrastructure and measurably diminished operating theatre productivity.

Moreover, it must be acknowledged that there are different tiers of teaching, with the standard of education being conducted in large teaching hospitals on an entirely different level from that which may occur in more provincial non-teaching hospitals. These differences in the scope and quality of teaching should be reflected in differential funding.

Rather than just a part of the provision of services, teaching, training and research must be recognised as a core function of hospitals and should be allocated a dedicated percentage of funding. Whether this is by way of block funding or the ABF pricing framework, this dedicated funding should be such that it guarantees the long term viability of Australia's health system.

An issue related to the important teaching role of public hospitals is the future of outpatient clinics at these facilities. In addition to providing an important clinical service, outpatient clinics have traditionally played a central role in teaching and training; it is here where young doctors learn the fundamental skill of diagnosis and treatment planning. The College considers the decision to downgrade or discontinue such services in some jurisdictions to have been a major step backwards in medical education.

Ideally, any new arrangements in hospital funding should allow for the expansion of outpatient services in Australian public hospitals. If this is not to be the case, funding of existing services should be such as to ensure their continuation. Any loss of public outpatients represents a threat to the comprehensive nature of medical training in Australia.

Conclusion

The College thanks the Independent Hospital Pricing Authority for this opportunity to comment on the discussion paper. The College is keen to work with all interested parties to ensure that Activity Based Funding represents not just an improvement in the funding arrangements of Australia's public hospitals, but a lasting improvement in the quality of healthcare.