SUBMISSION TO THE INDEPENDENT HOSPITAL PRICING AUTHORITY

ACTIVITY BASED FUNDING AND ABORIGINAL HEALTH

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Introduction

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles.

PHAA is a national organisation comprising around 1800 individual members and representing over 40 professional groups concerned with the promotion of health at a population level. This includes, but goes beyond the treatment of individuals to encompass health promotion, prevention of disease and disability, recovery and rehabilitation, and disability support. This framework, together with attention to the social, economic and environmental determinants of health, provides particular relevance to, and expertly informs the Association’s role.

Key roles of the organisation include capacity building, advocacy and the development of policy. Core to our work is an evidence base drawn from a wide range of members working in public health practice, research, administration and related fields who volunteer their time to inform policy, support advocacy and assist in capacity building within the sector. PHAA has been a key proponent of a preventive approach for better population health outcomes championing such policies and providing strong support for the Government and for the Preventative Health Taskforce and National Health and Medical Research Council (NHMRC) in their efforts to develop and strengthen research and actions in this area across Australia.

PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. The Branches work with the National Office in providing policy advice, in organising seminars and public events and in mentoring public health professionals. This work is based on the agreed policies of the PHAA. Our Special Interest Groups provide specific expertise, peer review and professionalism in assisting the National Organisation to respond to issues and challenges as well as a close involvement in the development of policies. In addition to these groups the Australian and New Zealand Journal of Public Health (ANZJPH) draws on individuals from within PHAA who provide editorial advice, and review and edit the Journal.

In recent years PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all levels of Government and agencies, and promoting key policies and advocacy goals through the media, public events and other means.

The PHAA has responded to a number of government and parliamentary inquiries and is pleased to have the opportunity to express an opinion to the Independent Hospital Pricing Authority (IHPA) on the relationship between Activity Based Funding (ABF) and Aboriginal and Torres Strait Islander health.
Background
The National Health Reform Agreement (NHRA) has a key objective to improve patient access to services and public hospital efficiency through the use of activity based funding (ABF) using a national efficient price (COAG, 2011).

The Agreement stipulates that in determining adjustments to the national efficient price, consideration must have regard to legitimate and unavoidable variations in inputs that affect the costs of service delivery, including Indigenous status (NHRA, section B13(c)).

The submission draws on evidence of existing approaches by Commonwealth, State and Territory governments, and international approaches to maintenance of equity issues in pricing policies.

Recommendation 1: Indigenous weighting

- IHPA adopt an Indigenous weighting under ABF. Unless there is better national costing data available to estimate these costs, an initial Indigenous weighting of 30% be applied for acute inpatients and emergency department patients across Australia, based on a fixed proportion of the casemix adjusted price.

- IHPA commission an independent national study and analysis of the costs of hospital care (admitted, emergency care and non-admitted care) for Aboriginal and Torres Strait Islander people including the impact of characteristics of patients (e.g. place of residence) and of hospitals (remote location) that contribute to higher costs. The study should include a ‘cost-based’ pricing approach, as well as a ‘best-practice’ or ‘normative pricing’ approach (IHPA, 2012) that should be developed in partnership with Aboriginal and Torres Strait Islander communities, peak bodies and providers of health services to Aboriginal and Torres Strait Islander people.

- IHPA consider an Indigenous weighting that reflects both the actual costs of care for Aboriginal and Torres Strait Islander people, plus additional incentive for improving access to services, equity in quality and safety of services provided, and improving the cultural competency of services delivered.

Rationale
One of the principal reasons for including an Indigenous weighting in ABF arrangements is to ensure funding provided under ABF is adequate to meet the costs of Aboriginal and Torres Strait Islander people treated. Without an appropriate weighting a pricing model may create a disincentive to treat Aboriginal and Torres Strait Islander patients especially if Aboriginal and Torres Strait Islander patients systematically cost more to provide equitable services.

Although there has been only limited analysis on the cost of providing services to Aboriginal and Torres Strait Islander people; published studies have suggested that Aboriginal and Torres Strait Islander patients have higher costs than non-Indigenous patients after adjustment for casemix (Fisher et al 1998; Russell-Weisz and Hindl 2000; AIHW 2009). More thorough analysis is needed that explores in detail the nature of additional costs. Research is needed into both the cost of
services as they are currently delivered, using a ‘cost-based’ approach, and importantly, research is needed into determining a pricing using a ‘best practice’ approach where the definition of ‘best practice’ is defined in partnership with Aboriginal and Torres Strait Islander communities, peak bodies representing Aboriginal and Torres Strait Islander health services, service providers and other relevant stakeholders.

Despite the limited information available on the additional costs of providing services to Aboriginal and Torres Strait Islander people, there is already a strong case for including an Indigenous weighting in ABF arrangements to ensure an adequate level of funding is provided to hospitals for treating Aboriginal and Torres Strait Islander people, and ensuring access to hospitals services, and the quality of services delivered to Aboriginal and Torres Strait Islander people is not adversely affected. This rationale applies equally to emergency department and non-admitted patient services.

In determining what an initial Indigenous weighting could be, the PHAA has based its recommendation on what Australian jurisdictions have applied as a proportion of the casemix weighted episode. It is understood that five jurisdictions have applied an Indigenous weighting, including NSW 10%, Victoria 30%, Queensland 30% excluding dialysis, South Australia 30%, and the Australian Capital Territory 30%. It appears that the rationale for applying weights has been to recognise additional costs and create incentives to improve the delivery of services to Aboriginal and Torres Strait Islander people, as well as improve the identification of Aboriginal and Torres Strait Islander people who access hospital services.

The PHAA therefore recommends that the initial Indigenous weighting be based on existing policies, at 30% of the casemix weighted episodes, and then refined as costing studies provide more accurate estimates of the additional costs of delivering health services to Aboriginal and Torres Strait Islander, according to a defined ‘best-practice’ approach.

**Recommendation 2: Indigenous weighting is linked to performance**

- IHPA consider developing and implementing a set of performance indicators linked to the Indigenous weighting that reflects best-practice in the delivery of accessible, culturally competent, and high quality services to Aboriginal and Torres Strait Islander people.

**Rationale**

A study conducted by the VicHealth Koori Health Research and Community Development Unit as part of the Aboriginal and Torres Strait Islander Hospital Accreditation Project (VicHealth, 2004) found that to drive improvements to the quality of care provided by hospitals to Aboriginal and Torres Strait Islander people, an Indigenous weighting or co-payment needs to be linked to standards for performance and accreditation, with guidance and support provided to hospitals in developing strategies to meet these standards. The PHAA therefore recommends that a performance framework with a concise set of indicators be implemented, with funding incentive to meet set benchmarks and targets.
Activity Based Funding and Aboriginal health - PHAA

The National Aboriginal and Torres Strait Islander Health Performance Framework identifies a number of indicators that represent the acceptability and quality of services from the perspective of Aboriginal and Torres Strait Islander people. These include whether Aboriginal and Torres Strait Islander people leave hospital before being treated, or before they have been discharged, and differential access to inpatient procedures (AHMAC, 2011).

For hospitals to be eligible to receive the Indigenous weighting, a performance framework could be implemented that sets targets and benchmarks on indicators of quality and safety. The weighting, or a proportion of the weighting could be conditional on hospitals meeting these benchmarks or targets, creating incentive to provide more culturally competent services. Indicators for consideration could include:

- Proportion of Aboriginal and Torres Strait Islander patients correctly identified (%) when attending a health service.
- Proportion of Aboriginal and Torres Strait Islander patients who leave emergency department at own risk, or do not wait.
- Proportion of Aboriginal and Torres Strait Islander patients who leave hospital against medical advice.

Indicators of access to services which will need to be developed in consultation with the National Aboriginal Community Controlled Health Organisation (NACCHO), NACCHO State and Territory affiliates, Commonwealth, State and Territory government agencies, and relevant committees including the AHMAC subcommittee the National Aboriginal and Torres Strait Islander Health Officers Network (NATSIHON). Indicators may include access to procedures such as cardiac procedures following acute myocardial infarction, elective surgery such as orthopaedic procedures and cataract procedures, and access to services such as cardiac and stroke rehabilitation services.

**Recommendation 3: Identification of Aboriginal and Torres Strait Islander people**

- In addition to the Indigenous weighting of 30%, an Indigenous co-payment per acute inpatient episode and per emergency department episode be considered for incorporating into ABF arrangements to create incentives to improve the identification of Aboriginal and Torres Strait Islander people in hospital data.

- IHPA consider implementing an ongoing system for monitoring and improving the quality of data in relation to the accurate identification of Aboriginal and Torres Strait Islander people attending health services.

**Rationale:**

The accurate identification of Aboriginal and Torres Strait Islander people is essential for ensuring clinicians’ diagnostic and treatment approaches are informed by the prevalence of specific health risks and chronic diseases in Aboriginal and Torres Strait Islander people. It also enables health services to measure the effectiveness of their interventions and assists planning and service delivery aimed at Aboriginal and Torres Strait Islander people (AIHW, 2010).
Despite improvements in recent years, the identification of Aboriginal and Torres Strait Islander people in key national health data sets needs to improve. This has been recognised nationally, and is a funded priority under The Council of Australian Governments (COAG) National Indigenous Reform Agreement, with a set timeline for all jurisdictions to complete implementation of the National best practice guidelines for collecting Indigenous status in health data sets (AIHW, 2010) by December 2012.

It is therefore recommended that an incentive be provided to hospitals that could be invested in strategies for improving the identification of Aboriginal and Torres Strait Islander people according to the national best-practice guidelines.

**Recommendation 4: Scope of services to be included in ABF relevant to Indigenous health**

- ABF funding arrangements initially be limited to mainstream acute inpatient, sub and non-acute inpatient, emergency department, outpatient and mental health services, hospital auspiced community health services.
- That national data collection for non-admitted care to include an Indigenous identifier, to allow for the possible inclusion of Indigenous weights for non-admitted care in the future.

**Rationale:**

Commonwealth funding for hospitals services under the NHRA will be on either an ABF basis or a block funding basis. The scope of public hospital services funded on an activity or block grant basis that are eligible for a Commonwealth funding contribution is to include:

a. all admitted services, including hospital in the home programs;
b. all emergency department services provided by a recognised emergency department service; and
c. other outpatient, mental health, subacute services and other services that could reasonably be considered a public hospital service

The scope of the definition of hospital auspiced community health services could over time be expanded to provide services with access to Commonwealth growth funding, however significant investment in community health data collection systems would be needed to improve the identification of Aboriginal and Torres Strait Islander people in community health data sets. There is currently no public reporting of community health services provided by public hospitals to Aboriginal and Torres Strait Islander people.

However, not all targeted Aboriginal and Torres Strait Islander programs will be suitable for ABF. Several of the targeted Aboriginal and Torres Strait Islander health programs in this setting may not be suitable for ABF (e.g. child and maternal services or chronic care programs where the aim is often to reduce hospitalisations). Finally, to gain access to new funding, activity will need to increase. There may be greater availability of funding through targeted Commonwealth funding for primary care services, rather than through ABF.
Conclusion

The PHAA is committed to working towards the best possible health outcomes for all Australians. With an understanding of the significance of the social determinants of health it is incumbent upon our association and our members to raise issues that we believe will support equitable and stronger health outcomes for communities, groups or individuals.

We are delighted to have had this opportunity provide input to this discussion by the Independent Hospitals Pricing Authority on ABF and to present our perspective with regard to the impact that it will have on Indigenous peoples.

Please do not hesitate to contact me if you require additional information with regard to this report.

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Terminology

The term ‘Indigenous’ in relation to the casemix weighting is used to refer to services provided to the Aboriginal and Torres Strait Islander peoples of Australia.

References


Independent Hospital Pricing Authority, Towards a Pricing Framework: Summary Report 2011


Victoria Health Department., Improving the patient experience for Aboriginal people in the emergency department. State of Victoria, Department of Health. 2010