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AMA response to the IHACPA Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025-26

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Thank you for the opportunity to comment on the Consultation Paper for the Pricing Framework for Australian Public Hospital Services 2025-26. The Australian Medical Association (AMA) is the peak professional body representing medical practitioners in Australia, focused on promoting and protecting the professional interests of doctors and the healthcare needs of patient communities.

As the frontline interface between medical professionals, patients and the public hospital system, AMA member feedback provides an invaluable insight into system design. The feedback, echoed by performance data analysed within our 2024 Public Hospital Report Card, points to a system in crisis. Doctors, along with the data, tell us that public hospitals are underfunded and over capacity, creating a feedback loop of staff burnout and poor patient outcomes in urgent need of redress.

The AMA is concerned the pricing framework is not being developed with sufficient attention to the growing needs and changing demographics of Australia's population. Of particular concern is the insufficient indexation of the NWAU(24), as funding increases are required to enable hospitals to provide more costly, but more efficient planned care in the future.

The state of Australia's public hospital system

The AMA's recently published 2024 Public Hospital Report Card highlights a concerning, long-term decline in performance of our public hospitals. The last reporting period saw worst on record performances at a national level for hospital capacity, planned surgery[1] waiting times, and ED performance. While Australia's health system remains one of the best in the world, these alarming trends point to a system in need of urgent attention.

[1] Due to the potential misunderstanding of the term "elective" in the broader public, the AMA uses the term "planned surgery" instead of "elective surgery" to highlight the medical necessity of the surgery that is required to improve the patient's health and wellbeing.

Long-term reductions in hospital performance have been occurring since the National Efficient Price (NEP) was first introduced. AMA analysis shows the percentage of emergency department visits completed in four hours or less has fallen from 73 per cent in 2013-14 to 56 per cent in 2022-23. The national proportion of emergency ED patients seen on time has fallen from 82 per cent to 63 per cent over the same period, while the proportion of urgent ED patients seen on time has fallen from 70 per cent to 58 per cent. The median waiting time for planned surgery has risen from 36 days to 49 days since the introduction of a NEP. All parties, including funding bodies, must reflect on how these trends can be reversed as soon as possible.

While COVID-19 clearly presented a serious challenge for Australia's public hospital system, performance trends have been falling since long before 2020. Patients, doctors and the broader public are rightly concerned by these trends. It is undeniable that funding is a pivotal factor influencing public hospital performance. Emphasis on efficient funding, although important, should not come at the cost of sufficient funding.

With a mid-term review of the National Health Reform Agreement soon to be completed, it is essential that funding priorities and cost determinations are in alignment to improve the outcomes of an increasingly worse-off patient population. The AMA's submission to the NHRA mid-term review highlighted that many of the agreement's objectives are not being met. In the submission, we contend that inadequate federal funding and cost-shifting between states and the Commonwealth Government are some of the key factors having a negative impact on the health of Australia's public hospital system.

Indexation rate of the National Weighted Average Unit (NWAU)

Setting a price that allows care to be delivered in a cost-effective and efficient manner is a central tenant of IHACPA. However, IHACPA's pricing guidelines also state that ABF and block grant funding must also be designed to facilitate timely quality care, a priority that has appeared to fall out of focus in previous years, particularly in the aftermath of COVID-19. Without appropriate measures to increase the National Efficient Cost and NEP along with the rising costs of delivering quality care, IHACPA risks placing too great a focus on efficiency rather than equity and outcome. In the longer term, the health costs paid by the public will only create greater inefficiencies for the public hospital system, and society overall.

In 2016-17, the Commonwealth Government paid roughly 45 per cent of per person expenditure into public hospital costs nationally, a figure in line with the volume adjustment multiplication mandated by the National Health Reform Agreement.[2] In the latest 2021-22 data published by the Australian Institute of Health and Welfare (AIHW), Commonwealth contribution to per-person public hospital expenditure has fallen to 41 per cent. While acknowledging the complexity of building an efficient funding model, the AMA continues to contest that indexation of the NEP has failed to rise at a sufficient rate.

An increase in 4.2 per cent to the NEP(24), represents an indexation rate that is lower than the current Reserve Bank of Australia's cash rate. While this is an imperfect rate for hospital costs, it

[2] https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/NHRA_2020-25_Addendum_consolidated.pdf (p19)

is also far below recent annual increases in public hospital expenditure. Analysis conducted by the AMA with publicly available expenditure data published by the AIHW demonstrates that overall public hospital expenditure has been rising at a much greater rate than the NEP.

Since the introduction of the NEP, there has been an average annual increase of 4.7 per cent in overall per-person expenditure on public hospitals, and an average annual increase of 3.7 per cent in cost per public hospital separation. Per person expenditure on salary and wages, the largest subsection of public hospital expenditure, has increased at 4.7 per cent per annum between 2014-15 and 2021-22. Meanwhile, there has only been an average annual increase of 1.4 per cent in the National Efficient Price over the same period.

The AMA acknowledges these figures do not count for inflation, nor take into account efficiency gains that have been driven by the NEP. Regardless, efficiency gains delivered so far are built into the current NEP, with diminishing returns expected in current and future years. We now have an efficient price based on activity hospitals can afford to deliver within their budget envelope. An ever-increasing share of that activity is unplanned. This makes delivering further long-term efficiency gains more difficult. The total funding envelope needs to increase to be able to encourage hospitals to provide planned elective surgeries to the same extent as past years to provide these at low-cost.

While the AMA acknowledges the complexity of setting price weights and adjustment of the national efficient price, the rate of NEP indexation has simply not kept up with the rate of inflation or public hospital expenditure increases. With Commonwealth contributions to public hospital expenditure remaining well below the target level of 45 per cent, the AMA is calling for a significant increase in the NEP's indexation to bring the price in line with broader inflation.

Community mental healthcare funding

The AMA remains concerned about the appropriateness of activity-based funding as a Commonwealth mechanism to resource community mental healthcare as proposed in the National Health Reform Agreement 2020-25. Mental healthcare is an essential part of the public health system, and strong community mental healthcare helps provide vulnerable Australians with the care they need before issues become more serious. Inadequate funding of grass roots mental health support will only exacerbate the burden placed on public hospitals if patients are forced to seek care in emergency departments that cannot be accessed in the community.

Mental health is an area where efficiency must be considered as a particularly nuanced objective. Transparent and complex pricing mechanisms may result in an upfront efficiency gain, but overemphasising expenditure efficiency for multifaceted areas such as mental healthcare may result in lower long-term efficiency if minor symptoms are allowed to grow into serious illness.

The AMA's 2023 Public Hospital Report Card – Mental Health edition found that the rate of ED mental health presentations per 10,000 Australians has risen from 69.2 in 2004-5 to 109 in 2021-22. Meanwhile, the percentage of ED mental health presentations ending in admission has risen from 31 per cent in 2013-14 to more than 36 per cent in 2021-22. If adequate block

funding is not provided to community mental healthcare services, Australia's hospitals risk being further inundated by vulnerable Australians in need of acute mental healthcare. For this reason, the AMA urges IHACPA to continue funding community mental healthcare through the block funding of the National Efficient Cost determination beyond 2024.

Teaching and training classification

As acknowledged by IHACPA's consultation paper, teaching and training funding continues to be provided through block funding rather than activity-based funding (ABF) due to inadequate volume and quality of data. AMA members continue to report that this arrangement fails to appropriately fund the essential teaching and training conducted in our public hospitals. Properly funding teaching and training is necessary for public hospitals to incentivise the process internally, and to ensure that patients are not worse off due to stretched internal resources.

The AMA endorses increased data sharing between organisations and jurisdictions to help drive improved pricing frameworks and will continue to work with all stakeholders towards more transparent and effective networks of data sharing. An essential step towards achieving ABF for teaching and training, as outlined in the IHPA Teaching, Training and Research Costing Study Project Report 2016, is achieving a range of uniform datasets between jurisdictions that do not currently exist. It is surprising that the data required to clearly identify "the number and type of trainee FTE employed (or placed) at a public hospital"[3] was not yet available, given this information plays such a key part not just in expenditure modelling, but workforce and training modelling more generally.

One outcome identified as necessary to implement a robust ongoing teaching, training and research data collection process was an "expanded roll out of electronic learning management systems to capture direct [teaching and training] activities".[4] To this end, the AMA is aware of an ongoing project being undertaken by the Health Workforce Taskforce in collaboration with the Australian Medical Council to develop and implement a National E-Portfolio that will support prevocational medical training for PGY1 and PGY2 doctors nationally. While this project is not designed to provide the quantitative data necessary to enable teaching and training to be funded through ABF, the cross-jurisdictional data collection may provide a useful platform for uniform data collection as a secondary benefit once the program is fully implemented.

Future funding models

The AMA is broadly supportive of the proactive undertaking of developing future funding models to incentive and support effective patient care. Promoting value-based care via innovative models will be essential to reverse the worrying trends being seen across Australia's public hospital system.

[3] https://www.ihacpa.gov.au/sites/default/files/2022-02/Teaching%20Training%20and%20Research%20Costing%20Study%20Final%20Project%20Report%20July%202016.pdf (p9)
[4] https://www.ihacpa.gov.au/sites/default/files/2022-02/Teaching%20Training%20and%20Research%20Costing%20Study%20Final%20Project%20Report%20July%202016.pdf (p9)

Virtual models of care, in particular, have the potential to greatly benefit health outcomes if enacted effectively. The AMA acknowledges the work being undertaken by IHACPA to address inconsistencies in definition and scope of virtual care across Australia to better price and fund digital care on a national level. We caution, however, that funding for digital models of care should be incentivised primarily in regional and rural areas where access to in-person healthcare is less accessible. The best form of healthcare remains in-person contact with a doctor, and it is imperative that virtual care delivery does not become the preferred model of care despite upfront efficiency gains.

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