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ACEM Response to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022-2023

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The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide feedback on the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022–23*. ACEM recognises the important role that Independent Hospital Pricing Authority (IHPA) plays in ensuring that the public hospital system is funded appropriately and efficiently.

As the peak body for emergency medicine, ACEM has a vital interest in ensuring the highest standards of emergency medical care for all patients. ACEM is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine (EM) in Australia and New Zealand.

1. General Feedback

1.1 Australian Emergency Care Classification

The introduction of the Australian Emergency Care Classification (AECC) in the National Efficient Price Determination 2021-22 (NEP21) is a significant change, and ACEM believes that this will better reflect the complexity of the work that occurs in Emergency Departments (EDs). We look forward to seeing further analysis of the impacts of the classification.

ACEM stands ready to support efforts to refine the AECC and supports further efforts to understand how 'diagnosis modifiers' impact on the complexity of care. An additional area of concern are changes regarding patients who present in emergency departments, and who are admitted to hospital but can't be sent to an inpatient ward due to access block. These patients receive the equivalent of inpatient care while in the ED (for anything from 8 hours to several days) and then are subsequently discharged from ED, however under the AECC, this will result in a significant reduction in cost calculation and funding allocations. This needs to be monitored closely to ensure the full scope of work is being captured within the system.

Activity-based funding must reflect the complexity of patient presentations, including the complex thought processes and investigations that may be required (whether the result is positive or negative for a condition), and the type of workforce that is required to safely conduct an accurate assessment. As such, final diagnosis does not always reflect complexity of the patient (or the steps required to get the diagnosis). In many circumstances, ED staff also provide significant support to families, who may be highly distressed.

IHPA should consider the need to collect and track the presenting problem and mapping terms across systems, as these drive a lot of the investigation costs rather than the ED final diagnoses which, for example, may end up being chest pain for a person who is investigated for an aortic aneurysm.

In the context of the ED, there is an important distinction between urgency and complexity. Many high urgency events have a high level of diagnostic certainty, while some lower urgency patients can require significant, complex assessment and interventions.

We note the proposal to recognise frailty as a cost driver for subacute care (section 5.3.1 – AN-SNAP Version 5.0). EDs see frequent transfers from residential aged care facilities (RACF), and in other presentations of older people from community. Frailty can add significant complexity to the work of the ED and further refinements of the AECC should incorporate this issue.

1.2 Access Block

Access block is the biggest issue facing EDs across Australia. Access block refers to the situation where patients who have been admitted and need a hospital bed are delayed from transferring to a ward or another appropriate health facility for more than eight hours because of a lack of inpatient bed capacity. Access blocked patients also include those who were planned for an admission but were discharged from the ED without reaching an inpatient bed, transferred to another hospital for admission, or who died in the ED while awaiting admission.

This creates situations where EDs are looking after patients for longer, which reduces the capacity of staff to meet the needs of other patients, due to lack of both time and available space. Access block is also the fundamental cause of ambulance ramping (the inability to offload patients from ambulances into appropriate bed spaces in ED).

IHPA should consider tracking the ED costs for prolonged length of stay and ensure that pricing adequately reflects activity for these patients, as well as tracking the total cost impact of such long stays on the system. Our research shows many ED staff can spend one third of their time looking after admitted patients who really should be on an inpatient ward.

It is essential that admitted patient care activities are funded sustainably so that hospitals have sufficient capacity to allow patients to be admitted to hospital or transferred to the next stage of their care within a reasonable timeframe. Patients that attend an ED experiencing access block have an 10% greater risk of dying within a week than patients that attend an ED without access block. Data from the Australian Institute of Health and Welfare indicates that between 2014-15 and 2018-19 the ratio of public hospital beds to population was stable at between 2.5 to 2.6 beds per 1000 population, while presentations to EDs requiring hospital admission increased by 3.2% on average per year.

2. Responses to Selected Consultation Questions

2.1 What feedback do you have on IHPA's proposed approach for using the 2019–20 cost and activity data to assess the short term activity and potential pricing impacts of COVID-19 on NEP22?

The consultation paper states that the NEP Determination 2022-23 (NEP22), will use 2019-20 costed data. The period with largest reduction in patient presentations at EDs occurred within that financial year – March to June 2020.

Prior to the COVID-19 pandemic, presentations at EDs had been at their highest levels ever, and subsequent to the initial national lockdown, they have quickly rebounded to the same, or higher levels.

While the number of presentations dropped in that period, many EDs remained extremely busy, acting as the front door for COVID patients and for COVID testing.

2.2 Are there any recommendations for how IHPA should account for COVID-19 in the coming years?

The length of the extended national lockdowns and the subsequent Victorian second wave are unlikely to be replicated. Given this, and the speed at which ED presentations rebounded, the period of March to June 2021 should not be used to project lower ED presentations in future years.

ACEM is also concerned that there will be further increases in ED presentations related to COVID. There are a range of public health and patient care factors that are likely to lead to increased ED presentations in coming years, including:

- the mental health impacts of the pandemic,
- increases in alcohol and other drug use during the pandemic, which may be sustained, and
- attempts to address the backlog in care for chronic conditions and elective surgery.

2.3 Do you support the proposal to establish standard development cycles for all classification systems?

ACEM supports the establishment of standard development cycles for all classification systems. We request that ACEM be formally invited to participate in the emergency care, and teaching and training classification cycles.

2.4 Is there a preferred timeframe for the length of the development cycle, noting the admitted acute care classifications have a three-year development cycle?

The proposed three-year cycles appear appropriate, and this can be reviewed after all of the classifications have gone through one cycle.

2.5 What are the potential consequences of transitioning block funded standalone hospitals that provide specialist mental health services to ABF?

The chronic shortage of mental health beds across the health care system is causing significant strain and poor outcomes for patients. Access block for patients with mental health conditions is particularly severe, and the ED is not the appropriate environment for ongoing therapeutic interventions for this group.

A transition of these hospitals from block funding to ABF must ensure that this does not reduce capacity within the system, but rather facilitates increased access to these essential services.

2.6 What other considerations should IHPA have in investigating innovative models of care and exploring trials of new and innovative funding approaches?

There are a number of innovative models of care relevant to the ED that the IHPA could investigate:

- outpatient and virtual care model funding for ED outreach,
- linked incentives to quality targets (eg. time to antibiotic, or time to thrombolysis), building on previous work IHPA has done on improving coding for sepsis,
- ED procedures to be collected separately - during the costing studies these were coded and compiled together though this is large cost that gets captured separately for other services,
- consider ED short stay units as a separate stream of funding rather than inpatient, which may have significant flow on effects on the understanding of ED funding and the Emergency Treatment Performance targets, as these are currently defined as admitted patients, and
- consider developing funding/ costing models for urgent care centres.

3. Contact Information

To discuss any of the issues raised in this submission, please contact James Gray, Manager, Policy and Advocacy, at james.gray@acem.org.au.