

Palliative Care Australia

**Submission to Draft Independent Hospital
Pricing Authority Work Program 2014-15**

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Palliative Care Australia (PCA) is the peak national organisation representing the interests and aspirations of all who share the ideal of quality care at the end of life. Our mission is to influence, foster and promote the delivery of quality care at the end of life through ongoing policy and advocacy, education, and developing collaborative relationships in Australia and internationally.

We believe that palliative care must be available regardless of location, age, income, diagnosis or prognosis, social and cultural background, to support Australians to live well at the end of life.

But we remain a very long way from achieving our goals. In 2011, nearly 147,000 Australians died. Of these 70% would have benefitted from access to palliative care services, yet only 30-50% did.

The National Palliative Care Strategy endorsed by the Australian Government in 2010 signalled the combined commitments of the Commonwealth, State and Territory Governments to the development and implementation of palliative care policies, strategies and services that are driven by standards and consistent across Australia. This sent a clear message that in order for Australians to live well at the end of life, its implementation is necessary if Australia is to continue to be a world leader in the provision of first class palliative care services.

PCA has been involved in formal stakeholder consultations conducted by the Independent Hospital Pricing Authority (IHPA) in developing the Activity Based Funding (ABF) classification system for subacute and non-acute care – Australian National Subacute and Non-Acute Patient Classification (AN-SNAP). PCA has through these formal processes identified issues for palliative care, in particular for community based palliative care, and the appropriateness of the current ABF framework to fund palliative care.

It is recognised that work has been undertaken by IHPA to refine the AN-SNAP framework that is reflective of clinical practice, and that from 1 July 2015 subacute services would be priced using only AN-SNAP grouped activity.

It is acknowledged that with the ceasing of the National Partnership Agreements, there is uncertainty about the future of ABF and the commitment of jurisdictions to implement a national model. The merging of different agencies to establish a single health productivity agency, of which IHPA will be a part, has also raised uncertainty about the future of IHPA's work program.

It is acknowledged that community based palliative care has been included as an in scope service for ABF, in consultation with the sector. However, PCA and its members would like to see the specific concerns relating to community based palliative care addressed by IHPA. In terms of comments on the IHPA Work Program 2014-15, this submission outlines the concerns for PCA and its member organisations which we would urge are taken into account in determining the work agenda for palliative care and ABF.

The pricing arrangements

The price weights for palliative care are being developed by IHPA based on limited information and data which represents problems for developing accurate costings. There are currently no data collections or mature costing approaches for subacute palliative care activity in Australia. There are considerable variances across jurisdictions in terms of who provides palliative care, with non-government and private providers having a significant role in some jurisdictions. While recognising that IHPA has limited involvement in the non-government and private sectors, this impacts on the data collected and the amount of recorded activity for the sector.

An issue of concern raised by a PCA member organisation is the different administrative arrangements between jurisdictions and the impact this has on comparing activity and attributing price-weights. The point has been raised that the price-weights established by IHPA should take into account the different administrative arrangements between jurisdictions, with a need for uniform administrative arrangements for comparable activity so that price-signals are fair and consistent. This is an issue that IHPA needs to clarify in terms of whether this is having an impact on pricing and if it can be addressed at IHPA's level.

The counting process

IHPA has determined that the counting unit for non-admitted palliative care is a 'service event', however the process for counting service events is not consistent with interdisciplinary, holistic, person and family centred care, which is integral to the philosophy and practice of palliative care. It is envisaged that the update of SNAP version 4 will recognise this, however, it is a general concern for palliative care.

A significant part of palliative care is providing support to the family and carer/s of the patient receiving palliative care, including bereavement services. An issue which has been raised previously with IHPA is capturing carers or family in costing and counting rules. Even where IHPA has looked at including service events where the patient isn't present, such as multidisciplinary case conferences (MDCC), it is still clinician and patient focused and does not consider how to include services which are a part of the care provided for carers or family.

Another concern with the counting method is that, an individual clinician or a team of clinicians seeing a patient at the same time or consequentially is being paid at the same rate. Such a process does not support the multidisciplinary approach of palliative care, which may involve joint home visits.

Group sessions as defined under ABF mean that group education sessions with carers to prepare them for their caring role would not be counted as service events, as they do not include therapeutic/clinical content for each patient. Given that the majority of home-based palliative care is provided by informal carers, providing them with the education needed to carry out this role is extremely important.

Tier 2 non-admitted patient classification

As is noted in the IHPA pricing framework consultation paper, the 2013 IHPA commissioned review of existing non-admitted patient care classifications for ABF found that the Tier 2 classification system was not ideal for the longer term. It also found that there were no classifications used internationally suitable for Australia and recommended developing a new Australian classification. It states that for National Efficient Price 2015-16 (NEP15) IHPA will continue to use the Tier 2 classification system for pricing non-admitted services and that only minor amendments were expected while work began on the new classification.

Palliative care does not fit appropriately into the current Tier 2 classification where a non-admitted service is categorised based on the nature of the service provided and the type of clinician providing the service. Palliative care can involve a range of categories, such as medical consultation and allied health or clinical nursing (based on existing major categories), and clinicians providing the care, as it encourages and is premised on interdisciplinary care.

The concern is that in the absence of an appropriate classification, as IHPA acknowledges, the existing Tier 2 classification will continue to be used even though this is not the best course of action for the long term. This presents problems for palliative care, again in particular community based palliative care, which does not fit the current Tier 2 system or classes for specialist clinics, and simplifies the nature of the clinical work, in a sector where interdisciplinary care is the basis of the care provided and encouraged.

It has been suggested by a PCA member organisation that a more appropriate classification system would be one based on client need characteristics, such as the five phases of care – stable, unstable, deteriorating, terminal, bereavement. This is used for inpatient palliative care. Benefits of such an approach would be it is:

- meaningful and relevant to clinical practice
- used by existing palliative care services participating in the Palliative Care Outcomes Collaborative (PCOC)
- already part of the AN-SNAP classification used for ABF for inpatient palliative care services.

Further concerns have been expressed that the application of the Tier 2 classification will create unhelpful silos for admitted and non-admitted activity, when palliative care patients need to move from one setting to the other based on their needs. Having diagnosis related groups classification as the basis of funding in the acute setting and the nature of service and clinician for non-admitted patients, may create barriers in the care provided.

The use of accurate and reliable data

Palliative care stands to be potentially negatively affected if there is not accurate data on activity in the sector and the cost for providing episodes of care, therefore there needs to be new efforts to cost community based palliative care. Palliative care is

delivered on the basis of interdisciplinary care and individual patient need, and therefore the framework that is developed nationally must be representative of the main models of palliative care and their cost profiles.

The draft IHPA Work Plan notes that IHPA is working closely with agencies such as the National Health Information Standards and Statistics Committee (NHISSC) and Australian Institute of Health and Welfare (AIHW) on non-admitted patient data collections and admitted sub-acute patients data sets.

We would urge the issues outlined above to be incorporated into this work and IHPA's *Three Year Data Plan*. This is in terms of examining, for example, in consultation with jurisdictions, if and what accurate data is available to progress developing appropriate classifications for community based palliative care, and whether implementing national pricing systems across jurisdictions is possible and will not result in adverse or unintended consequences for the provision of community palliative care services.

Palliative Care Consultation Activity in Hospitals

A further issue that has been raised with PCA is having a renewed effort to accurately classify and cost palliative care consultations in hospitals. The reasons for this are that in the majority of cases across Australia, the provision of palliative care starts in the acute hospital setting (before continuing into inpatient or ambulatory palliative care settings), and that the activity and costs are often invisible. There is work needed to classify and cost this activity.

Bereavement Activity

PCA wishes to raise the issue of bereavement activity, recognising that it involves bereavement support provided by the palliative care interdisciplinary team which is distinctly different from the bereavement counselling provided by trained health professionals in bereavement. PCA recognises that bereavement counselling is provided by health professionals who originate from different backgrounds (for example nursing, social workers and psychologists). IHPA should recognise that the Australian Health Practitioner Regulation Agency (AHPRA) and the National Association for Loss and Grief (NALAG) have not recognised this specific area of expertise.

PCA recognises some clients of bereavement services may never have had their loved ones referred to palliative care services and the number of bereavement clients arising from an individual patient will always vary depending on need. It is also recognised that clients may start their service event between 6 weeks to even years after a patient's death, and will not receive a set number of counselling sessions.

A key concern is that under the current ABF arrangements, bereavement services provided by palliative care services are not counted as an activity in their own right. While they may be included indirectly as part of the cost of service delivery, this runs the risk of creating disincentives to provide bereavement support.

Palliative care recommendations

The main areas of concern for palliative care relate to the development of an ABF national pricing and classification system and its applicability to community based palliative care. PCA and its member organisations would make the following recommendations for IHPA to consider as priorities for the 2014-15 Work Program:

- Prioritise the development of a new Australian non-admitted patient care classifications or the redevelopment or refinement of current SNAP classification, that is appropriate for community based palliative care and other non-admitted services.
- Facilitate consultation on and the development of a national community palliative care data collection to inform the development of an appropriate classification.
- Services provided to carers, including without a patient present, are explicitly included in the classification arrangements for palliative care and that those arrangements support multidisciplinary clinical care, including joint home visits.
- Bereavement support needs to be included and counted as an activity and costed.