

The Council of Ambulance Authorities Inc.



**The Council of Ambulance Authorities
Submission**

Response to:

Towards a Pricing Framework

Activity Based Funding for Australian Public Hospitals

Prepared for:

The Independent Hospital Pricing Authority

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The Council of Ambulance Authorities

Providing leadership for the provision of ambulance services

The Council of Ambulance Authorities (CAA) is the peak body established by its members to collaborate on ambulance matters of national, regional and international importance.

The CAA is governed by a Board, consisting of the Chief Executives of each member service, and supported by a Secretariat. There are 3 international committees whose collective knowledge and expertise combine to provide advice, explore opportunities for continuous improvement and innovation, advocate on behalf of the sector to lobby governments and key stakeholders.

The CAA exists to help advance ambulance services so that they are able to further develop superior pre-hospital care and ambulance services to communities across Australasia.

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- Ambulance Tasmania
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- Queensland Ambulance Service
- SA Ambulance Service
- St John Ambulance Australia NT Ambulance Service
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Activity based funding for Australian public hospitals: Towards a Pricing Framework¹

Introduction

The creation of the Independent Hospital Pricing Authority (IHPA) and the development of a system of activity based funding (ABF) for Australia's public hospitals represent a significant step in the reform of Australia's health system. It is an opportunity to ensure that appropriate financial incentives are put in place to encourage not only the best possible, efficient treatment of patients in hospitals but also greater effectiveness in the broader health system including optimal movements of patients into and out of hospitals and between hospitals and other care settings. As the overall health reform agenda makes clear, health care is about more than hospital care at the right price. The policy settings for our health system, including pricing, need to ensure that the 'right care' is delivered to the 'right patients' in the 'right settings' and at the 'right time'.

Conversely, we need to avoid setting prices for hospitals that optimise hospital services *at the expense of patients in other, vital components of our health system*.

As the Report states: 'Although the efficient price applies to hospitals, it needs to be set at a level which would be consistent with efficiency across the whole health system'².

From an ambulance service perspective we need to ensure that pricing frameworks facilitate the smooth and timely movement of patients into the appropriate hospital settings including: emergency departments, trauma centres, cardiac catheter labs, stroke units, mental health units and maternity suites. We need to ensure that current issues with the delayed handover of patients from ambulance services to hospitals are, at a minimum, not made worse by ABF and, more optimistically, can be avoided in the future.

The key requirement is to ensure that hospitals have sufficient capacity to accept new patients from ambulance services within twenty minutes of their arrival.

Background

Ambulance Services and Hospitals

Australia's ambulance services³ interact with hospitals in a variety of ways. These include: the initial treatment, delivery and handover of critically ill patients to hospital Emergency Departments – what many would regard as the traditional ambulance role; the initial treatment, delivery and handover of eg cardiac or stroke patients directly to specialist units such as catheter labs or stroke units within specific hospitals; the treatment at home (or on-site) of patients who do not need to be transported to hospital, a form of hospital avoidance or diversion (or 'urgent primary care'); and the transport of

¹ Referred to in this submission as the 'Report'

² Report p. 40

³ Australia has eight statutory ambulance services, one in each jurisdiction.

patients between hospitals and between hospitals and other care facilities (such as Aged Care Homes)⁴.

The potential for ambulance services to automatically transmit important, current and time saving data about incoming patients is significant and about to be realised in many parts of Australia. The CAA has some preliminary data which shows a high degree of correlation between the assessment of care needs by ambulance and subsequently by hospitals,⁵ raising a potential for streamlining in the future. Developments such as these reinforce the point that ambulance services and emergency departments make inter-related contributions to patient outcomes. From the patient's perspective, they can be seen to form part of a single episode of care.⁶

Hospital By-pass

Ambulance services are also involved in a form of work flow management in hospital systems in the form of hospital by-pass practices where patients are taken on to other hospitals when the closest appropriate one has capacity limitations and indicates that it can take no more patients for a period of time. This practice also needs to be minimised in the interests of patient well-being and the efficient use of ambulance services. Like excessive transfer times, ambulance by-pass is related to hospital resourcing levels.

Community Paramedicine

In some rural parts of Australia community paramedics work in hospitals, when no doctor is available, and help to maintain vital health services in these communities⁷. These arrangements need to be factored into the development of block funding arrangements for such hospitals.

These are some of the principal ways in which ambulance services provide part of, or support, episodes of care, considered from the patient's standpoint. They are not as separate from hospital services as it might at first appear.

Emergency Department Arrivals and Transfers – Data

Just under a quarter (23.5%, or 1.4 million 2009-10) of all patients arriving at Australia's Emergency Departments (EDs) do so by ambulance (road or air). Importantly, 85% of Triage Category 1 patients; 47.6% of Category 2 patients and 34% of Category 3 patients arrive at the ED by ambulance⁸. A significant proportion of a hospital's emergency and inpatient workload is delivered by ambulance⁹. The ambulance/Emergency Department interface is enormously significant for what goes on in this part of our health system.

There are problems with this vital interface currently. The data on ambulance to hospital transfer times¹⁰ around Australia¹¹ reveals considerable variation. In an analysis of 2009/10 data the

⁴ Some of this patient transport work is conducted by other suppliers rather than by ambulance services.

⁵ Unpublished data from a St John NZ project at Christchurch Hospital NZ

⁶ It is not suggested that it would be practical to fund them as such.

⁷ For example in parts of South Australia see *Australasian Ambulance Service: Rural and Remote Service Delivery Models* CAA 2009 (Unpublished)

⁸ Report on Government Services Table 9A 31

⁹ Patients arriving by ambulance accounted for 70% of bed days in the St John NZ Christchurch study

¹⁰ Various referred to as 'off stretcher time', 'hospital access block', 'ramping' etc.

proportion of patients transferred 'off stretcher' in 15 minutes or less ranged from a low of 17% to a high of 67% across four Australian jurisdictions¹². Patients transferred within 30 mins ranged from a low of 68% to a best performance of 90%. Average transfer times ranged from 15 to 28.5 minutes. Most jurisdictions reported that transfer times were increasing steadily (along with increases in patient volumes).

In some Australian jurisdictions hospitals pay the ambulance services for the additional costs of extended transfer times, for example the overtime cost incurred. Such transactions nicely illustrate the link between hospital funding and the smooth flow of patients into hospitals. A lack of capacity to meet peak workloads in the hospital imposes a cost on other parts of the health system, in this case the ambulance service. It is appropriate that this cost be reimbursed but it would be better if it were avoided.

Issues

Transfer Time

Transfer time is the CAA's central concern with the introduction of ABF across all Australian Hospitals. **If the (total) price paid for hospital services does not include an amount to ensure that capacity is provided to meet peak incoming workloads, then hospital transfer times will blow out.**

This would be contrary to the principles articulated for ABF specifically:

Timely-quality care: ABF should support timely access to quality health services¹³

Similarly, 'a hospital operating at the national efficient price will...minimise negative consequences that fall on patients ... or on other parts of the service system.'¹⁴

To avoid a blow out in transfer times it will be necessary to ensure that resources are available in Emergency Departments (and in the form of in-patient beds), not just for the existing volume of patients at a point in time, but also for the next ones to arrive. A degree of redundancy is needed to ensure a timely response.

This could be achieved by including a component for readiness in the ED prices, or by adjusting the volume of services planned for, or some combination of such measures. To achieve the necessary ability to respond in Emergency Departments it may well be necessary to address issues further along the hospital 'chain' such as sufficient capacity to admit patients *from* the Emergency Department.

A new study by Griffith University suggests that both price and volume issues are relevant¹⁵. Insufficient in-patient beds and the number and skill mix of ED (and in-patient) staff were both found to contribute to delayed handovers. This latter issue would seem to relate fairly directly to the price

¹¹ Data on hospital transfer times is not currently collected on a uniform basis around Australia but this situation is improving as ambulance services move to electronic patient data systems. Some states publish this data.

¹² CAA unpublished data

¹³ Report p. 6.

¹⁴ Report p. 7

¹⁵ <http://www.griffith.edu.au/health/research-centre-clinical-community-practice-innovation/research/acute-critical-care/emergency-services> Other factors, not as directly related to resourcing, are also cited.

of ED activity. However, if the findings of this study hold true elsewhere, attention to price alone without looking at the volume of in-patient bed days available would not result in a complete solution. Recent media reports of hospital performance under the '4 Hour Rule' in Western Australia also suggest that attention to patient flows in hospitals significantly reduces transfer delays for ambulance patients.¹⁶

This may be one area where 'ABF design should recognise the complementary responsibilities of each level of government in funding health services'¹⁷ but, regardless of this consideration, some action is essential.

It is true that "Pricing is only one mechanism that can be used to influence policy objectives such as improved patient access"¹⁸ and that 'other health reform initiatives such as the Performance and Accountability Framework are also (potentially in this case) available'. The performance of health systems in terms of achieving a smooth inflow of patients into hospitals should be measured and perhaps be monitored by the new National Healthcare Performance Authority. The Expert Panel reporting on elective surgery and emergency access targets under the National Partnership Agreement on Improving Public Hospital Services¹⁹ recommended that 'Ambulance access to emergency departments' be included in the suite of ED performance measures as a matter of priority²⁰.

Transparent monitoring of performance at this critical interface is essential but, at its core, the problem of excessive transfer times cannot be separated from resourcing levels.

The required resources could be applied directly to ambulance services, so that additional ambulances and crews are available to cover for the ones parked on hospital driveways or to hospital emergency departments (and inpatient beds) so that inordinate delays do not occur in the first place. Either way, inattention to this issue is likely to produce adverse outcomes for patients, for both hospitals and ambulance services and adverse publicity – not least since rows of ambulances outside hospitals – parked on their 'ramps' - are already something of a media stock-in-trade in several states.

Scope of Public Hospital Services

The Report asks specifically for input on the question of the scope of hospital services that should be eligible for Commonwealth funding under the public hospital funding reforms²¹. There are two specific areas from an ambulance sector standpoint which should be considered under this question: i) patient transport and ii) services provided by paramedics in some rural hospitals.

Currently ambulance services are specifically excluded from the National Hospitals and Healthcare Network Agreement²². That *may* be appropriate for emergency ambulance services and for most of

¹⁶ ABC News 16 February 2012 reports a 28% reduction despite a 10% increase in numbers.

¹⁷ Report p. 6

¹⁸ Report p. 10

¹⁹ Chaired by Professor Christopher Baggoley

²⁰ Expert Panel *Supplementary Annexure* accessed through health.gov.au

²¹ Report p. 8

²² But are not defined in that context

the community paramedicine work carried out by ambulance service staff but clarification or confirmation is required in the two areas listed above.

Transfers between public hospitals are paid for by the hospital. This is logical; if a patient admitted to one hospital is transferred to another one because it has more suitable facilities, or if a patient is transferred from one setting to another during an acute episode of care – such as in a hospital in the home scenario, then the transport component falls within the acute care of that patient²³. The Report notes²⁴ that higher patient transport costs in rural hospitals was one of two factors that were recognised as generating additional costs in rural Victorian hospitals when DRG funding was introduced in that State. Inter-hospital patient transfers should continue to be in scope as hospital services. In many cases such services will be delivered by the jurisdictions’s ambulance service²⁵ but paid for by the hospital.

Similarly if a paramedic employed by an ambulance service is providing services in a rural hospital that would be provided by hospital staff if they were available, then this would seem to plausibly be a hospital service. However the distribution and nature of both of these types of service is far from uniform around Australia and the IHPA may need to take care that it does not penalise any jurisdiction for innovative methods of service delivery ...’it is important that desirable developments in care are not stymied by ABF product-definition incentives’²⁶. The examples cited here indicate that this is not a purely *clinical* matter, questions of broader service design may also be invoked.

It is likely that many of the hospitals where this is relevant may be candidates for block funding under the proposed Pricing Framework. Community paramedicine itself does not have the technical attributes (uniformity of services/precision of definition or cost data) that would enable it to be funded on an activity basis, in the short to medium term at least.

Conclusion

The ambulance sector would be pleased to contribute to the further exploration and resolution of the issues raised in this brief submission through further discussion. Ambulance services have good data on service volumes and patterns in demand which could assist in resolving the transfer time issue.

Recommendations:

1. Hospitals must have sufficient capacity to accept new patients from ambulance services within twenty minutes of their arrival.
2. Performance at the ambulance/hospital interface should be regularly monitored.
3. Inter-hospital transfers should continue to be considered as hospital services.
4. Community paramedicine services provided in (eg.) rural hospitals should be regarded as a hospital service.

²³ Transfers to private hospitals may be billed to the patient.

²⁴ Report p. 55

²⁵ This is the current practice in most jurisdictions.

²⁶ Report p. 48