NORTHERN TERRITORY GOVERNMENT

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Our Ref: EDOC2016/34043
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Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
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Dear Mr ~~Downie~~ James

RE: PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITALS 2017-18

Thank you for the opportunity to comment on the 2017-18 Australian Public Hospitals Pricing Framework. Please find attached the Northern Territory feedback which highlights those areas within the consultation paper with potential to impact both funding of the NT services and the implementation of the Pricing Framework by the Northern Territory Department of Health.

If you require any further information, please contact Mr Ian Pollock, Director Activity Based Funding on 08 8999 2429.

Yours sincerely

J. M. Anderson

Janet Anderson PSM
31 October 2016

Northern Territory Department of Health
Response to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2017/18

Consultation question
Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2017-18?

The Northern Territory (NT) supports the use of the non-admitted cost data collection from the National Hospital Cost Data Collection (NHCDC) to price non-admitted services, noting the significant improvements in the reporting and accuracy of non-admitted costs in the NHCDC. The NHCDC results best reflect the actual costs in the NT when compared to the original non-admitted services costing study.

Consultation questions
Should IHPA further restrict year-on-year changes in price weights?

The NT supports maintaining the existing mechanisms used to determine the National Efficient Price (NEP), noting the improvements in the stability of the non-admitted pricing.

Consultation questions
What are the priority areas for IHPA to consider when evaluating adjustments to NEP17?

While the impact of changing the methodology for determining remoteness from the use of post codes to 'Statistical Area 2' (SA2) is not known, the NT supports in principle the use of a patient's SA2 and recognises that appropriate geography such as SA2 level is central to appropriate funding.

The Northern Territory has proposed that costs relating to emergency medical inter-hospital transfers to interstate hospitals constitute a legitimate and unavoidable cost variation and could be better recognised through amending the current adjustments to the NEP. IHPA have noted that these interstate transfers to other hospitals may be required where a jurisdiction lacks the facilities to treat a complex patient due to economies of scale or other factors relating to remoteness.

For NEP17, IHPA proposes that all high cost outlier episodes be included in the calculation of the Patient Remoteness Area Adjustment (the Adjustment). When the unavoidable costs incurred by the NT for interstate hospital transfers are included in the total national costs used to determine the Adjustment the result is a marginal increase in the size of the adjustment. This has, at best, a minimal impact on addressing the ongoing unavoidable cost incurred by the NT in transferring patients interstate when compared to adjusting the pricing for the NT where the unavoidable costs have been recognised.

Consultation question
Should IHPA phase out the private patient correction factor in 2018-19 if it is feasible to do so?

The difficulty in the collection of private patient medical expenses in the NHCDC is acknowledged and the NT supports the phasing out of the correction factor in 2018-19 if a consistent methodology to replace the correction factor prior to phasing it out can be agreed to by all jurisdictions.

Consultation question
Do you support IHPA's intention to introduce a bundled price for maternity care in future years?

The NT does not support the Bundled Pricing of Maternity Care in the current structure based on the following concerns:

- There are currently (NEP16) two Tier 2 Clinics for an Antenatal occasion of service - 20.53 Obstetrics – Management of Complex pregnancy (which includes Indigenous women) and 20.40 Obstetrics Management of Pregnancy without complications. The weighting for 20.53(0.0803) is significantly higher than that for the 20.40(0.0484). Approximately 39% of all births in the NT are Indigenous and without adjustment for complexity in the bundled pricing model consistent with the variation in the Tier 2 clinics, the NT will be disadvantaged.
- In the existing Pricing Framework, indigeneity and remoteness are adjusted for in the admitted and indigeneity in the non-admitted setting. These existing adjustments need to be incorporated in the bundled pricing model to ensure services with high proportions of patients with these characteristics are not disadvantaged.
- The consultation paper does not adequately address the proposed treatment of Admitted Antenatal episodes. Potentially high rates of antenatal admissions related to high rates of conditions such as Gestational Diabetes need to be addressed prior to the implementation of bundled pricing (as supported in the Consultation Paper - Bundled Pricing at Item 9.3.2 Patient Cohort.).

Consultation question
What stages of maternity care and patient groups should be included in the bundled price?

The NT supports the inclusion of Antenatal & Postnatal care (excluding Antenatal admissions, Delivery admissions and Maternity readmissions) and acknowledges the benefits it may bring to innovation in services but the support is conditional on patient demographic and complexity issues raised above being adequately addressed.

Consultation question
Should IHPA include postnatal care provided to the newborn in the bundled price?

Without adequate differentiation between qualified and unqualified newborns NT does not support their inclusion in the model.

Consultation question
Is there support for pricing and funding models for safety and quality to be applied broadly across all types of public hospitals, all services, all patients and all care settings?

The NT provides in principle support for the inclusion of pricing and funding for safety and quality to be applied in the public hospital setting where there is significantly robust data to support the development. Given the responsibility of the jurisdictions, as system managers, to maintain safety and quality standards, the NT does not support the loss of funding at the jurisdictional level and proposes that any reduction in payments should stay within jurisdictions to fund change initiatives.

Consultation question
What are the advantages and disadvantages of Option 1 which reduces funding for some acute admitted episodes with a HAC?
Do you agree with IHPA's assessment of this option?

The NT agrees with IHPA's assessment of Option 1 and it is the NT's preferred option of the three provided in the consultation paper. While it is retrospective in its operation, it is transparent and most importantly will be relatively straightforward to implement at the jurisdictional level. The NT does however have reservations about the lack of risk adjustment in this option and if it proceeds to implementation, the NT recommends that this issue be the focus of refinement in the shadow-pricing year.

The NT also has an interest in the alternative option proposed by NSW.

Back casting will be required to ensure that any reductions for safety and quality are applied to the base year level of NWAUs as well as the growth year level of NWAUs so that growth in NWAUs is largely unaffected.

The impact of the National Health Reform Agreement (NHRA) Activity Based Funding initiative on data quality has been significant across all jurisdictions. This is best demonstrated through the decline in the National Efficient Price over the past three years. What is not evident is the equivalent improvement in HAC reporting at the episode level. Running a full year of shadow pricing similar to the first year of the NHRA and using this year as the evidence base for the back casting would address this issue and also provide jurisdictions with an opportunity to address known data quality issues in HAC reporting.

Consultation question
What are the advantages and disadvantages of Option 2 that adjusts funding to hospitals on the basis of differences in their HAC rates?
Do you agree with IHPA's assessment of this option?

The NT does not agree with IHPA's assessment of option 2 and does not support it as the preferred option in the consultation paper. It is overly dependent on the risk adjustment model and the introduction of a relative ranking ensures that regardless of how well hospitals perform, the lowest ranking hospital will be penalised, even if it meets national standards. Any ranking should be absolute rather than relative, so that any hospital below a given benchmark would be penalised. The penalty need

not be financial to stimulate practice improvement. The publication of national league tables would probably suffice.

Further, the complexity of the model and the impost on jurisdictions when implementing it will add another administrative overhead to small jurisdictions required to manage an increasingly complex pricing and funding model.

Consultation question
What are the advantages and disadvantages of Option 3 that combines funding incentives and penalties? Do you agree with IHPA's assessment of this option?

The NT agrees with IHPA's assessment of Option 3 and while it does not have the inherent complexity of Option 2, it is not the preferred Option. It does not discriminate between hospitals on the basis of their performance, instead allowing a central pool of discretionary funds for redistribution. There is nothing to prevent the jurisdictions implementing this under the current funding arrangements, so it adds little or no value.

HACs are correlated with risk, particularly for age, and are difficult to avoid. Hospitals with low HAC rates are already likely to face lower costs of care and have a financial advantage. In the NT's case this model exacerbates the existing challenges of providing care within a national efficient price for any high risk patient cohort.

Consultation question
Do you support the proposal to not fund episodes that include a sentinel event? If not, what are the alternatives and how could they be applied consistently?

The NT supports the proposal to not fund episodes that include a sentinel event. As these events are considered "never" events, hospitals should strive to never have a sentinel event in their health service. As numbers are low nationally the sentinel event in itself will not act as a disincentive but the fact that these events are to be identified as 'not funded' episodes sends an important signal to hospitals about the importance of the quality & safety of health care delivery. It also serves to highlight them in the jurisdictional data.

Consultation question
Do you support the proposal to include a sentinel events flag to improve the timeliness and consistency of data that is used for funding purposes?

The NT supports the proposal to include a sentinel events flag to improve the timeliness and consistency of data if it is implemented as a practical solution given how rare sentinel events are.

Consultation question
How should IHPA treat hospitals with poor quality Condition Onset Flag (COF) reporting?

Removing the COF from the DRG assignment will lead to a reduction in erroneous COF reporting. For example, removing the COF from the DRG of a post-operative infection acquired in the hospital where surgery was originally performed with a COF of "present on admission" will provide a strong incentive for hospitals to audit their COF before data submission and improve the quality of COF reporting.

One of the difficulties of monitoring poor quality COF in the NT where there is a relatively high proportion of patients presenting with chronic diseases is that there is a premise that all of the HACs listed in the Consultation Paper are preventable and avoidable. Is a HAC of heart failure in a patient with underlying cardiomyopathy or rheumatic heart disease (who is in hospital for an acute condition) necessarily a HAC? It is possible the patient already has an element of undiagnosed heart failure. The NT advocates for the HAC implemented in 2017/18 with consideration given to reducing some of the conditions listed in Table 2 e.g. Heart failure & pulmonary oedema, Respiratory failure and Delirium , In the NT there are a large number of dialysis dependent patients who are at times noncompliant with treatment, creating a higher likelihood of acquiring a diagnosis of Acute Pulmonary Oedema.

Consultation questions
What approach is supported for setting timeframes within which avoidable hospital readmissions are measured?

The readmission methodology of matching the HAC from one admission with the principal diagnosis of the subsequent admission is considered robust, and could be applied with variable timeframes for different HACs. For example, the US model detailed in the consultation paper of seeking clinical review on the readmission windows acknowledges that not all conditions are likely to have the same readmission timeframes. This seems a clinically coherent method to use when setting readmission timeframes. However, measuring timeframes for avoidable readmission that have a distinct subset of conditions, as outlined in Point 2 at 11.7.2 of the Paper would seem to be a good starting point.

In the NT the single patient master index makes measuring the HAC feasible.

Consultation question
Is there support for pricing and funding models to be based on avoidable hospital readmissions within the same LHN?

Contrary to information in the Consultation Paper, the NT does have a unique patient identifier and given the distances between the two NT Local Hospital Networks the consultation question of whether to apply pricing and funding at the LHN or hospital is irrelevant. However, given the NT's high ratio of patients with chronic medical conditions, e.g. Chronic Kidney disease, Diabetes, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure and the level of non-compliance of some patients, models based on avoidable readmission rates for medical patients is likely to disadvantage the NT where current readmission rates for certain procedures are the highest in the country in all but one (hysterectomy) of the selected procedures. *(Australian Hospital Statistics – 14/15)*

Without adequate recognition and adjustment for the unique challenges related to this cohort of patients, the NT does not support the development of pricing and funding models based on avoidable hospital readmissions.

Consultation questions
What do you think are the most important considerations for implementation of pricing and funding approaches for safety and quality?

The most important consideration is that "best practice evidence based" care is incentivised and poor quality care and misadventures are dis-incentivised without penalising hospitals which treat a proportionately greater volume of high risk patients (including indigenous and those with long term chronic conditions) who already have a higher likelihood of acquiring a complication. Any model for pricing and funding also needs to consider the existing incentive inherent in the cost of treating episodes with HAC's which are substantially higher than non-HAC episodes.

Consultation questions
Do you agree that IHPA would need to back-cast the impact of introducing new measures for safety and quality into the pricing and funding models?

The NT agrees that IHPA would need to back-cast but in order to do so accurately this would need to occur after at least a one year period of shadow funding and pricing to provide jurisdictions the opportunity to improve the quality of the data that is used to backcast.