Government of South Australia
SA Health

Finance and Corporate Services
Citi Centre Building
11 Hindmarsh Square
Adelaide SA 5000

PO Box 287, Rundle Mall
Adelaide SA 5000
DX 243
Tel 08 8226 6082

ABN 97 643 356 590
www.health.sa.gov.au

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eA982606

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Dear Mr Downie

RE: PUBLIC CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2018-19

Thank you for the opportunity to provide input as part of the *Pricing Framework for Australian Public Hospital Services 2018-19* Consultation Process.

SA Health is still committed to work constructively with the Independent Hospital Pricing Authority (IHPA) and other jurisdictions and stakeholders to ensure that the national Activity Based Funding (ABF) system reflects best practice in health care and is as robust as possible. In this spirit, I am pleased to provide the following comments, outlined in the attachment. Once there is further elaboration or specific options put forward on the changes to the National Efficient Price by the IHPA, SA Health will engage further on the matter through the appropriate advisory groups.

Should you require any further information, please feel free for you or your officers to contact Mr Alberto Logozzo, Assistant Director, Budgeting and Funding on 08 7425 3633 in the first instance.

Yours sincerely

JAMIN WOOLCOCK
Chief Finance Officer
21 / 08 / 2017

Att: SA Health Response To The Independent Hospital Pricing Authority Public Consultation Paper On The Pricing Framework For Australian Public Hospital Services 2018-19

SA HEALTH RESPONSE TO THE INDEPENDENT HOSPITAL PRICING AUTHORITY PUBLIC *CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2018-19*

What additional areas should IHPA consider in developing Version 10 of the Australian Refined Diagnosis Related Groups classification system? (pg11)

At present South Australia does not wish to put forward any areas for consideration but requests that previous changes to DRGs are monitored going forward for relevance. For example the removal of the Mental Health Legal Status flag for grouping of schizophrenia has seen a change in DRG complexity distribution. South Australia is monitoring this particular care however a review from a national perspective of all changes would be useful to ensure the proposed changes are acting as expected, especially from a funding perspective.

Do you support the phasing out of older versions of the Australian Refined Diagnosis Related Groups classification system?
What time frame would be sufficient for the health care sector to transition to the more recent versions of the classification? (pg 11)

South Australia maintains at least three versions of AR-DRGs at any one time which are typically the current and previous two versions. We also support some of the private sector in their DRG analysis and they typically require earlier versions. Maintaing multiple versions provides flexibility in terms of indicator sets, analysis of changes in previous years and explanations of activity anomalies arising from DRG changes. SA always moves to the three most recent versions of DRG, in line with the IHPA timeframes, so this proposal to phasing out older versions should not have a significant impact on our work. As for the timing of the phasing out of the earlier versions of DRGs we are not wedded to a particular timeline at this point.

Do you support the proposal to shadow price non-admitted multidisciplinary case conferences where the patient is not present for NEP18? (pg13)

South Australia's position on this new clinic type remains the same in that we do not believe that it is necessary at the national level to provide improved allocative efficiency between jurisdictions. We do understand that this activity is undertaken in hospitals and is a very important part of patient care however it has always been costed, through overheads and believe that this is satisfactory. We believe it would be more beneficial to focus on improving the patient level data quality so that it can be a fully-fledged national minimum dataset before any further changes are implemented. Focussing on new data items will mean that resources are diverted to this project rather than on enhancements to the existing data set.

Given this data is yet to be collected nationally, SA would like to better understand how the IHPA plans to determine the "shadow" price weights given there is no robust costing of this activity to our knowledge.

Do you support investigation of the creation of multiple classes in the classification for home ventilation? (pg13)

South Australia supports the investigation of the need to split Tier 2 clinic 10.19 (Home Ventilation) into multiple clinics. Depending on the type of ventilation required, ie overnight only or constant, the cost associated with this clinic can vary and a review of the clinic structure is supported. As with any change to the funding model and the associated classifications any change must be supported by empirical evidence.

What other issues should be considered in the development of Version 2 of the Australian Mental Health Care Classification? (pg 15)

South Australia is currently satisfied with the work already underway via the Mental Health Working Group. This works includes the phase of care refinement project, however this project must ensure that the scope is broad enough to capture all care settings, ie residential, and engages with clinicians from all jurisdictions.

Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2018-19? (pg 17)

What are the priority areas for IHPA to consider when evaluating adjustments to NEP18?

What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available. (pg 19)

South Australia does not believe there are any technical improvements required to the model at the moment. The work on the Australian Mental Health Care Classification is continuing and that should be where the main focus is.

At present SA would like to see further stability in the model to enable comparisons to be made between years without any major changes or contention. The work that has been undertaken by the IHPA and also the NHFB on the changes between years highlights that a year or two of relative stability would enable all jurisdictions to understand the growth in the system without being hidden or enhanced by model changes.

Should IHPA ensure that there is no financial penalty due to the transfer of public hospital services from ABF hospitals to block funded hospitals?

If so, how should this be carried out? (pg 24)

The IHPA should always ensure there are no (financial) penalties in transitioning from one model to another, including new classifications implementation. Given the work that has had to be undertaken by the IHPA, NHFB and all jurisdictions in trying to explain the year on year changes a consistent methodology for changes would be beneficial. Any change should have at least one year's worth of data in both methods to enable a smooth transition. This would enable growth funding to be accurately calculated so that there can be no question as to what is real. In this example of ABF to block there will be activity (and potentially some cost data) that would enable the hospital to be classified under the NEC in previous years, this would ensure growth is substantiated and cannot be disputed.

Do you support IHPA's proposal to continue to block fund residential mental health care in future years? (pg 25)

Yes, South Australia still supports the proposal to continue to block fund residential mental health services. This is expected to be an interim method while development work is continued on the Australian Mental Health Care Classification (AMHCC) in the area of residential services. We hope that these services will be able to be funded under the AMHCC in future years once enough data has been captured to adequately classify and price these services.

Do you support the proposed bundled pricing model for maternity care? (pg 31)

In principle, we recognise that commissioning services across a bundled continuum of care can provide flexibility to a range of health providers to develop cost-effective clinical services. As demonstrated with the maternity case-study, however, we recognise there will be many complexities (including ability to capture the requisite data and clinician support) to explore and resolve, prior to widespread acceptance of this pricing and funding approach.

Do you agree with IHPA's assessment of the preconditions to bundled pricing? (pg 31)

Yes, South Australia does agree with the preconditions to bundled pricing. All four of the conditions are necessary to ensure any future implementation is done so successfully. We are particularly pleased to see an emphasis placed on demonstrating a benefit to patients.

Do you support investigation of whether the Individual Healthcare Identifier or another unique patient identifier could be included in IHPA's national data sets? (pg 31)

An individual healthcare identifier for every patient is a consideration that goes wider than the use of bundled maternity services. SA considers this type of identifier is best developed by the Australian Institute of Health and Welfare, as it is beyond the remit of IHPA. Further, until such time as all jurisdictions have the ability to model patient movements across various sites and care settings then the implementation of bundled pricing cannot be fully considered.

What issues should IHPA consider when examining innovative funding model proposals from jurisdictions? (pg 35)

South Australia has no issues with the IHPA investigating new innovative funding model proposals however it should be recognised that the outcomes of this evaluation is non-binding on states and that it should not place additional cost pressure on states for their development/maintenance.

Should IHPA consider new models of value-based care, and what foundations are needed to facilitate this? (pg 35)

South Australia has never raised objections to new methods of funding care providing there is sufficient evidence to warrant the change, there is clinician support and it doesn't significantly disadvantage any jurisdiction. There is support on a number of levels to review and potentially limit the use of what is considered "inefficient technology" and determine ways to move to more appropriate technology. This would however need to be considered in conjunction with the introduction of new health technologies.

Do you support the proposed risk adjustment model for HACs? Are there other factors that IHPA should assess for inclusion in the model? (pg 43)

South Australia supports the current risk adjusted model as a reasonable starting position for the implementation of adjustments for hospital acquired complications. Once we have access to the model and are able to analyse our own data we may have additional adjustments for consideration. SA will work with the IHPA during this shadow funding year to ensure implementation of this aspect of the model runs smoothly.

Do you agree that HACs third and fourth degree perineal lacerations during delivery and neonatal birth trauma be excluded from any funding adjustment? (pg 43)

South Australia has no objections to this.

What pricing and funding models should be considered by IHPA for avoidable hospital readmissions? (pg 44)

South Australia supports a simple/practical model that is clear and unambiguous and should consider peer adjustments rather than a flat national tolerance. In addition to this there is a requirement that any methodology can be replicated by all jurisdictions, this includes access to all pertinent data sets, ie Medicare. While the most appropriate solution is to wait for an individual healthcare identifier to be implemented, if the decision is not to wait then any linked data used by the IHPA and NHFB must be available to all jurisdictions.

Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing and funding adjustments for avoidable hospital readmissions? Are there any other criteria that should be considered? (pg 45)

While South Australia would need to see the proposed model to make an informed comment on the adjustments to avoidable hospital readmissions the criteria listed is acceptable. We will note though that any model that is proposed by the IHPA to adjust for avoidable readmissions must be reproducible by all jurisdictions, therefore any data used by the IHPA must be available to jurisdictions as well.