

# Department of Health and Human Services

PLANNING PURCHASING AND PERFORMANCE

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

Dear Mr Downie

**Subject: Consultation Paper for the Pricing Framework for Australian Public Hospital Services 2018-19**

Thank you for the invitation, as part of the public consultation process, to provide comment on the Independent Hospital Pricing Authority's (IHPA) '*Consultation Paper for the Pricing Framework for Australian Public Hospital Services 2018-19*'.

Please find attached the Tasmanian Department of Health and Human Services submission.

Thank you for the opportunity to provide comment.

Yours sincerely

A handwritten signature in black ink, appearing to read "Ross Smith".

Ross Smith  
Deputy Secretary, Planning Purchasing and Performance

16 August 2017

Attachment 1. Tasmanian DHHS Submission

## Responses to the Consultation Questions - IHPA Consultation Paper on the Pricing Framework for Public Hospital Services 2018-19

### Classifications used by IHPA to describe public hospital services

#### Section 4.3 Australian Refined Diagnosis Related Groups classification

##### Consultation question

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

Unless there is a significant change to the classes structure or the grouping logic, Tasmania does not believe there should be a need to create a new point version or number version, to allow some continuity.

##### Consultation questions

- 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?

##### Supported

The current level of support provided to older versions of AR-DRG and the industry's ability to accept older versions of the classification system does not support the requirement to update to the newer versions.

On the basis that the current timeframes for the development of new versions of the AR-DRG and editions of the ICD-10-AM occur every two years, support should be withdrawn for the DRG version two years after the implementation of the next version. For example AR-DRG version 6.0x was implemented for the fiscal year 2011–12 and used in 2012–13, AR-DRG version 7.0 was implemented in 2013-14 and used in 2014-15 and DRG Versions 8.0 was implemented in 2015-16. On this basis the support for 6.0X should have been withdrawn in 2015-16 when DRG Versions 8.0 was implemented.

#### Section 4.5.1 Multidisciplinary case conferences where the patient is not present

##### Consultation question

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

##### Not Supported

The concept of non admitted multidisciplinary case conferences where the patient is not present is considered part of good clinical practice. As Tasmanian hospitals information systems do not currently report and collect these data items, a significant administrative and cost burden would be imposed in collecting these data. Tasmania would prefer investment of resources to be directed towards the development of a new non admitted classification system rather than an ongoing process of amendments to the Tier 2 classification.

Tasmania supports continuing work to be undertaken with jurisdictions to price non-admitted multidisciplinary case conferences where the patient is not present, to enable the development of a more robust non admitted classification system. For these reasons Tasmania does not support the shadow pricing of this service for NEP18.

## Section 4.5.2 Home ventilation

### Consultation question

- Do you support investigation of the creation of multiple classes in the classification for home ventilation?

### Supported

Tasmania supports IHPA investigating multiple classes within the classification for home ventilation to clearly define cost differences in the type of home ventilation care being provided. It would also be useful to undertake analysis of the NWAU of services such as this, as they migrate to the National Disability Insurance Scheme (NDIS).

Of major concern for Tasmania is the data and information system burden that the collection of multiple classes in the classification for home ventilation will require.

As previously stated, the investment in the ongoing refinement of the Tier 2 Classification which is provider setting centric is questionable. Tasmania believes that resources would be better directed at the development and transition to the new non admitted classification system.

## Section 4.8 Australian Mental Health Care Classification (AMHCC)

### Consultation question

- What other issues should be considered in the development of Version 2 of the Australian Mental Health Care Classification?

The implementation of AMHCC Version 1.0 in Tasmanian hospitals is in the early implementation phase. For this reason, it is premature for Tasmania to provide comment on possible enhancements to Version 2.0.

## Setting the National Efficient Price for activity based funded public hospitals

### Section 6.1.

### Consultation question

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

In Tasmania, the public sector is the only provider of a range of highly specialised services including, cardio-thoracic surgery, neo-natal intensive care, neurosurgery and burns. The sustainability of these services is challenging in a small population where there are no economies of scale.

As highlighted in previous submissions the cost of providing health services in Tasmania is affected primarily by three factors which generally have compounding effects in their interaction:

- Small scale due to small population
- The most decentralised population pattern in the nation (with Hobart being the only capital city with below 50 per cent of a state or territory population) and
- Regionality, in terms of both intrastate characteristics (as indicated by the decentralised population spread) and interstate characteristics, due to its small population size and isolation from the mainland.

These comments remain valid.

## Section 6.3 Stability of the national pricing model

### Consultation questions

- 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.

Tasmania would support IHPA undertaking further work to investigate the application of a Paediatric adjustment to be applied to the Acute admitted event for patients outside of Specialised Children's Hospitals. The proposed Paediatric adjustment would only apply to the Acute admitted events in major referral centres or principal referral centres as identified by the Australian Institute of Health and Welfare (AIHW) peer grouping. Similarly Tasmania would support consideration by IHPA for the application of a Paediatric adjustment for Emergency Department service events. The inclusion in the model of these adjustments would assist Tasmania in sustaining the provision of highly specialised services in the public sector.

## Section 8 Treatment of other Commonwealth programs

### IHPA's decision

IHPA will maintain the existing approach of removing blood costs and Commonwealth pharmaceutical program payments from the National Hospital Cost Data Collection prior to determining NEP18

While IHPA does not intend to change the treatment of programs funded by the Commonwealth for NEP18, it is noted that an ongoing funding gap continues to exist in the funding of these programs. Tasmania agrees that hospitals should not be funded twice for items covered by Commonwealth programs; however, consideration should be given towards a reconciliation process between the expenditure in the reported Public Hospital expenditure and the amount identified by the Commonwealth for these programs.

## Setting the National Efficient Cost

### Section 9.1.1 Transferring services from ABF hospitals to block funded hospitals

#### Consultation questions

- 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?

One of the initial objectives of the National Health Reform Agreement (NHRA) was to support the community service obligation that Jurisdictions encounter at the LHN level and the expectation of communities to have services provided in their communities. Tasmania supports the concept of funding flexibility in service delivery for NEC model funded facilities.

For these reasons there should be no financial penalty for the transfer of public hospital services from ABF to block funding. Tasmania would support a fixed and variable component in the funding model to ensure that there is no financial penalty due to the transfer of public hospital services from ABF hospitals to block

funded hospitals. The fixed component would cover both direct and indirect costs until a activity and costs threshold is reached and from that point a variable component based on activity would enable funding levels to driven by the in scope activity above the pre-determined levels.

### Section 9.3.1 Residential mental health care services

#### Consultation question

- Do you support IHPA's proposal to continue to block fund residential mental health care in future years?

#### Supported

With current limitation in the DRG Classification system in explaining the cost profiles of residential mental health care patients and the immaturity of the Australian Mental Health Care Classification in this area of the current block funding arrangements should continue.

## Bundled Pricing for maternity care

### Section 10.7 Next steps

#### Consultation questions

- Do you support the proposed bundled pricing model for maternity care?
- Do you agree with IHPA's assessment of the preconditions to bundled pricing?
- Do you support investigation of whether the Individual Healthcare Identifier or another unique patient identifier could be included in IHPA's national data sets?

#### Supported

Tasmania is on record as supporting the bundling of both antenatal and postnatal care for maternity services, on the proviso that IHPA develop a methodology of differentiating the various modes of delivery of maternity products provided across both the public and private sectors.

Tasmania notes that IHPA has identified a range of barriers in the process of the development of a bundled pricing model which will need to be overcome prior to the introduction of this approach.

Tasmania supports the range of preconditions to be used as an initial test prior to the development of the potential bundled pricing approach for maternity care as identified by the IHPA Bundled Pricing Advisory Working Group.

Tasmania supports IHPA investigating whether the Individual Healthcare Identifier or another unique patient identifier can be established in the IHPA's national data sets. However, while Tasmanian has a unique patient identifier for the public healthcare sector, most jurisdictions still have multiple unique patient identifiers across LHNs. It is important for IHPA to ensure that the administrative and data burden imposed on jurisdictions in establishing these processes does not outweigh the benefits to the new funding approach.

## Innovative funding models

### Section 11.4 Value-based healthcare

#### Consultation questions

- What issues should IHPA consider when examining innovative funding model proposals from jurisdictions?
- Should IHPA consider new models of value-based care, and what foundations are needed to facilitate this?

The growing 'demand' for services is being driven by increasing complexity, not increasing acuity. The current funding model is acuity based and founded on single disease episodes. Tasmania supports the proposed concept of a funding model for patients with chronic disease that allow for complexity of care and integrated care across the full continuum of care.

Tasmania would support IHPA undertaking work to develop a more flexible funding environment for providers to alter models of care and configure services based on complexity.

## Pricing and Funding for Safety and Quality

### Section 12.1. The Rationale for pricing and funding for safety and quality

It is recommended that the rationale include an additional statement on how safe services are efficient services, as this is not clearly defined in this section.

### Section 12.4 Sentinel Events

It should be made clear in the definition of adverse event in this section, that this is a definition as determined by the Productivity Commission. It would be useful to include in this section that states and territories will have the opportunity to cross-reference self-reported events that are captured by incident reporting systems and hospital administrative system data sets, as not all jurisdictions directly electronically capture sentinel events on their hospital administrative systems.

### Section 12.5.1 Risk adjustment model

#### Consultation questions

- Do you support the proposed risk adjustment model for HACs? Are there other factors that IHPA should assess for inclusion in the model?
- Do you agree that HACs third and fourth degree perineal lacerations during delivery and neonatal birth trauma be excluded from any funding adjustment?

#### Supported

Tasmania cautiously supports the proposed risk adjustment model but believes that the risk adjustment in the model needs another 12 months in the shadowing phase to enable all levels of the health service to review the risk adjustment factors, including the robustness of the Charlson score, and provide real time appraisal, before being implemented into the main stream funding model.

It is not clear from the information provided on the treatment of a subsequent HAC, i.e. a patient with delirium (1st HAC), is at increased risk of sustaining a fall (2nd HAC). It is unclear if there is a funding adjustment for having a HAC and then a further funding adjustment for having a subsequent HAC. It is recommended that this is clearly defined in this section.

Tasmania agrees that HACs third and fourth degree perineal lacerations during delivery and neo-natal birth trauma be excluded from any funding adjustment, as the small cohort of patients in this category constrains the application of the pricing model.

### **Section 12.6.1 Policy context of pricing and funding models to reduce avoidable hospital readmissions**

#### **Section 12.6**

It would be useful to include in this section what we mean by avoidable readmissions. The Commission used “readmission to hospital for a condition or conditions arising from complications of the management of the condition for which the patient was originally admitted”.

##### **Consultation question**

- What pricing and funding models should be considered by IHPA for avoidable hospital readmissions?

In particular it is important that the model does not trigger perverse incentives such as keeping people longer than required in order to avoid a potential readmission. It will also need to consider how the funding is funnelled back into the safety and quality space of the health care system so that poor performing areas do not become even worse because they lose funding that could have been used to make improvements.

In addition there are issues with private sector patients returning to the public sector with an avoidable admission. These patients put stress on the public system that otherwise would not eventuate. This issue is not necessarily under consideration, since any model is designed to pick up hospital readmissions to the hospital where the person was admitted for their primary event and then later readmitted to the same site. Tasmania would support further investigation of this issue within the scope of the development of the pricing and funding model.

### **Section 12.6.3 Criteria for assessing pricing and funding options**

##### **Consultation question**

- 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?

Tasmania believes that the assessment criteria should include that the condition is clearly related to the reason for the original admission. It should also include that the conditions should be measureable through data generated from the patient medical records (this is alluded to in Point 5 of Section 12.6.3).