DEPARTMENT OF
HEALTH

Northern Territory submission

Pricing Framework for Australian Public Hospital Services 2020-21

The Northern Territory (NT) has a unique demographic unlike all other states and territories, where we have a growing young Aboriginal population with a slowing birth rate and an ageing non Aboriginal population. The NT population mainly reside in remote areas and poverty remains a consistent public health challenge, where homelessness influences service delivery.

The Northern Territory, Department of Health (NT Health) delivers services to a population with multiple, complex and varied health needs and it is essential that these needs are addressed appropriately in the national model to continue to provide quality health care. This submission highlights those areas within the consultation paper with potential to impact both funding of NT Health services and the development and refinement of the NT Health system.

The Pricing Guidelines

Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?

NT Health considers the Pricing Guidelines to be relevant, however, NT Health recommends that IHPA expand Fairness, Stability and Administrative Ease as specified below. NT Health considers that these Pricing Guidelines should apply to all advice that relates to pricing and not just in determining the National Efficient Price.

Fairness

The current Overarching Guideline articulates the policy intent behind fairness and provides clarification around providers of services, however, it should be expanded to provide clarification around social inclusion and reducing disadvantage (especially for Indigenous Australians) and equity of access (including those living in regional and remote areas).

Social inclusion and reducing disadvantage

NT Health recommends that IHPA expand Fairness to ensure that pricing arrangements enable a collaborative approach with Aboriginal communities to design and deliver health services for Aboriginal people, to ensure access to effective, culturally responsive health services and programs to achieve equitable health outcomes. Recognising the centrality of culture to health and respecting Aboriginal people and cultures is necessary to enhance service access, equity and effectiveness. Cultural security is fundamental to closing the gap in health outcomes for Aboriginal Territorians.

Example

The Indigenous adjustment aims to account for the additional cost of services provided to Indigenous Australians, however, the NT consider this adjustment *only maintains* the status quo but does not adequately *promote* social inclusion and *reduce* disadvantage of Indigenous Australians to closing the gap. The indigenous adjustment only account for legitimate and unavoidable costs, that are reflected in the data much after the services are delivered and the current model needs to be adjusted to ensure that hospitals are priced to prospectively fund more culturally responsive services that contribute to closing the gap.

Equity of access

NT Health recommends IHPA expand Fairness to ensure that pricing arrangements ensure equitable access to services regardless of their geographic location. NT Health recognises that the remoteness adjustment aims to account for the additional cost of providing access to services for those who live in regional and remote areas, however it is unknown whether this adjustment is sufficient to ensure all Australians have equitable access to high quality care.

Example

The NT has a high prevalence of patients with chronic disease who live in rural and remote areas, and as such, these health needs are being addressed through outreach services and integrated care. This provides the opportunity to access various health services at the same time, particularly given distance from health providers. The pricing and funding models currently limit access by deeming some integrated care models as out-of-scope for funding or inadequately reflecting outreach costs. Pricing should enable equal opportunity to access health care and not discriminate given logistic and clinical requirements for provision of care.

Stability

Predictability and financial sustainability

The current Process Guideline guides the implementation of ABF with regards to stability by stating that payment relativities should be consistent over time. NT Health recommends that IHPA expand Stability to provide clarification that processes should support predictability and consider the potential to adversely impact financial sustainability. Any decision, including provision of advice, should be subject to consideration around whether such decisions may undermine the predictability of the payments and consequently the financial sustainability of the public hospital system.

Example

In 2016-17 hospitals provided services and received Commonwealth payments based on IHPA's National Efficient Price for that year, which was used to pay doctors, nurses and suppliers. However, in 2018-19, IHPA undertook analysis and provided advice that resulted in a retrospective reduction of entitlements, which undermined predictability and Heath departments were required to pay back money which adversely impacted the financial sustainability of the public hospital system. Expansion of the pricing guideline relating to stability would provide assurance that IHPA will consider this in issuing future pricing advice and determinations.

Administrative Ease

Practicability

The current Process Guideline guides the implementation of ABF with regards to administrative ease by stating that funding arrangements should not unduly increase the administrative burden on hospitals and system managers. NT Health recommend that Administrative Ease be expanded to consider practicability noting the differing levels of maturity of ABF processes, particularly for smaller jurisdictions such as the NT.

Example

In 2018, IHPA amended its Data Compliance Policy, which now considers jurisdictions non-compliant if they do not submit the Mental Health Care National Best Endeavours Data Sets. NT Health had advised IHPA of the significant resourcing required to engage and train clinicians. This change in policy did not appropriately consider practicability, particularly given the infancy of ABF processes in the NT and the additional administrative requirements to engage and educate clinicians regarding a classification that IHPA was still refining.

Classifications

Admitted acute care

What should IHPA prioritise when developing AR-DRG Version 11.0 and ICD-10-AM / ACHI / ACS Twelfth Edition?

NT Health recommends that IHPA prioritise a review of comorbid patients and seizure classification.

Review of comorbid patients

NT Health delivers services to a population with multiple, complex and varied health needs and it is essential that patients who present with comorbidities are addressed appropriately in the national model to reflect the complexity and reason for remaining in the hospital. NT Health acknowledge that the Episode Clinical Complexity Model was introduced to recognise cost variation within Adjacent Diagnosis Related Groups (ADRGs) however there continues to remain a heavy reliance on principal diagnosis in Diagnosis Related Group (DRG) allocation, which should be assessed to consider appropriateness for patients with comorbidities.

Review of seizure classification

NT Health requests that the classification of seizures be improved in ICD-10-AM Twelfth Edition, particularly as further distinction is required between epilepsy and seizures induced by external factors.

Seizures and epilepsy are not the same. A seizure is an event – a disruption of the normal electrochemical activity of the brain – and epilepsy is a disease of the brain characterised by the tendency to have recurrent seizures. There are many different types of 'epilepsies' and people's experiences differ greatly. Under certain circumstances, anyone can have a seizure and not all seizures are diagnosed as epilepsy.[1]

Example

If a patient is documented as having a complex partial seizure, or a tonic-clonic seizure without any documentation of epilepsy, the seizure is coded as R56.8. Clinical Coders should be able to code the type of seizure when there is no documentation of "epilepsy" or "epileptic".

[1] Epilepsy Action Australia: https://www.epilepsy.org.au/about-epilepsy/understanding-epilepsy/

Are there other priorities that should be included as part of the comprehensive review of the admitted acute care classification development process?

NT Health recommends that IHPA prioritise the review of the eleventh revision of the International Classification of Diseases (ICD-11) and the consideration of transitional arrangements.

Review of ICD 11

The World Health Organisation (WHO) released ICD-11 which is a far more granular classification than ICD-10, and possibly an improvement over ICD-10-AM with multiple concepts being included in single codes. ICT-11 is expected to be implemented in all countries for reporting by 2022 and given this timing, NT Health recommend that IHPA initiate review of ICD-11 as a change for diagnosis coding for AR-DRG allocation. Additionally, WHO will no longer review and update ICD-10 and some other classifications have diagnoses no longer relevant in ICD-10 (e.g. DSM-V used by mental health services).

Consideration of transitional arrangements

IHPA should consideration of transitional arrangements in understanding stakeholder needs regarding development. In particular, IHPA should have regard for the implementation requirements around funding implications, system modification and staff training.

Emergency care

Are there any impediments to implementing pricing using the Australian Emergency Care Classification (AECC) Version 1.0 for emergency departments from 1 July 2020?

NT Health considers the implementation of pricing using the AECC Version 1.0 to be a significant change to the ABF classification system and therefore should be implemented with a transitional arrangement, in line with the requirements of clause A40 of the National Health Reform Agreement. NT Health considers a shadow implementation period over the financial year 2020-21 to be a reasonable transitional arrangement that would provide the lead time to assess the funding impact, implement system changes as well as mitigate any unintended consequences. This would allow the classification to create the right incentives for improvements in clinical practice.

Funding impact

NT Health acknowledges that the AECC Version 1.0 recognises some complexity and cost drivers, however NT Health considers that it ignores other cost drivers such as social, location and capacity (including overcrowding and underutilisation).

A shadow implementation period would provide useful funding information to drive improvements in the system as well as ensure that the legitimate and unavoidable cost drivers that were not adequately addressed in AECC Version 1.0 are identified and appropriately priced to ensure equitable funding.

System changes

NT Health is currently testing the grouper, which will need to be incorporated into systems to ensure appropriate reporting. A shadow implementation period would allow for appropriate system changes to be implemented to ensure that the new classification may be used in a way that is clinically meaningful and drive improvements as intended.

Unintended consequences

NT Health acknowledges that IHPA cannot anticipate all potential changes that may occur on implementation and a shadow implementation period is sensible as it would enable any unintended consequences to be identified, such as changes to coding practices, which may then be addressed prior to having funding implications

Mental health care

Are there any impediments to implementing pricing for mental health services using AMHCC Version 1.0 from 1 July 2020?

NT Health considers the implementation of pricing using the AMHCC Version 1.0 to be a significant change to the ABF classification system and therefore should be implemented with a transitional arrangement, in line with the requirements of clause A40 of the National Health Reform Agreement, similar to the recommendation related to the AECC above. NT Health considers a shadow implementation period over the financial year 2020-21 to be a reasonable transitional arrangement that would provide the lead time to assess the funding impact, implement system changes as well as mitigate any unintended consequences. This would allow the classification to create the right incentives for improvements in clinical practice.

NT is a small jurisdiction and requires additional time to implement major changes to classifications to be able to capture the data and as such NT was not in a position to submit all data required for AMHCC implementation, particularly the mental health phase of care, given this represents a significant change in practice and intense training as it is a clinician rated data element.

NT Health advises that any price based on available data would not appropriately represent the nation, particularly Indigenous Australians and/or those living in remote areas, as data excludes NT due to our unavoidable inability to implement changes as quickly as metropolitan areas. Any funding implications has potential to disadvantage Indigenous Australians and/or those living in remote areas, given that these Australians are largely represented in the NT.

National Efficient Price

Technical improvements

Are there adjustments for legitimate and unavoidable cost variations that IHPA should consider for NEP20?

NT Health recommends that IHPA incorporate a medical evacuation adjustment. NT Health is heavily reliant on medical evacuations given the relatively small size of its hospitals with no alternative other than referral and transfer to specialty facilities. Therefore medical evacuations are an essential service which facilitate equitable access to high quality health care for those living in regional and remote areas.

These services have a significantly high cost due to the isolation of NT hospitals and these costs have had to be absorbed by the hospital thereby disadvantaging its patients as the current funding model does not appropriately reimburse these services on an activity basis.

Example

A 15-year-old Indigenous patient with lymphoma and non-acute leukaemia required a medical evaluation as specialist clinical care for this type of aggressive paediatric cancer is not available at the Royal Darwin Hospital.

The cost incurred for the medical evaluation was over $130,000. The current adjustments in the model calculated the hospital funding for this patient as approximately $6,500 for providing this patient access to the required health care.

Is there any objection to IHPA phasing out the private patient correction factor for NEP20?

NT recommends that IHPA consider a shadow implementation period to phase out the private patient correction factor, where IHPA undertake an impact assessment to determine whether the application of the Australian Hospital Patient Costing Standards Version 4 adequately addresses the issue relating to missing private patient costs. Additionally, this change should be back-cast to understand effect of removing the private patient correction factor.

Shadow implementation periods

IHPA will develop criteria for the parameters around when shadow pricing should be applied based on stakeholder feedback with the intention to implement the criteria from July 2019.
[Pricing Framework 2019-20]

IHPA stated in its Pricing Framework 2019-20 that it will work with stakeholders to develop criteria that provide the parameters around whether to apply and when not to apply a shadow implementation period and for how long the shadow period should apply, with a view of implementation from July 2019.

NT Health notes that IHPA has yet to develop the criteria for shadow pricing and NT requests that this work continue, particularly given IHPA's intention to introduce new classifications for mental health and emergency.

NT Health reiterates is position that IHPA apply a shadow implementation period to all changes to the ABF classification systems and National Pricing Model, unless otherwise agreed by States and Territories, where criteria is developed to provide the parameters around when it is appropriate to consider **not** applying a shadow implementation period.

Data collection

Access to public hospital data

Do you support IHPA making the National Benchmarking Portal (NBP) publicly available, with appropriate safeguards in place to protect patient privacy?

NT agrees that greater publication of analysis using IHPA data would assist in the development and evaluation of health policy and programs, however, NT recognises that data access has been restricted to protect patient privacy, in accordance with legislative requirements.

NT supports broadening access to the National Benchmarking Portal only to those who are appropriately educated around its fitness for purpose, provided that IHPA assures that patient privacy is protected. This should include at a minimum obtaining legal advice to ensure compliance with all state and territory laws, implementing rigorous safeguards (as agreed by all jurisdictions) and consulting with the human research ethics committees across all jurisdictions.

NT Health recommends that IHPA work together with the Australian Institute of Health and Welfare to consult with human research ethics committees across all jurisdictions to consider whether public consumption of the data available in the NBP is appropriate. NT Health has concerns that the public may misinterpret the data, where a potential unintended consequence is that the public may use cost as a proxy for quality or clinical capability. The primary purpose of the data was not performance assessment and as such, consumers may be misguided in making decisions about their healthcare providers.

Unique patient identifier

What are the estimated costs of collecting the (Individual Health Care Identifier) IHI in your state or territory?	NT Health may provide cost information regarding IHI collection and validation subject to clarification of scope and requirements, including clarification on the agreed mechanism to assist in covering the costs (refer consultation question below). NT Health recommends that IHPA carefully consider the following issues in addition to costs in collecting and validating the IHI, which are not necessarily unique to the NT: - Aboriginal and Torres Strait Islander peoples data is prone to inaccuracy (e.g. use of multiple names due to cultural reasons, date of birth varied due to lack of verified birth information and language difficulties relating to ascertaining these details); - People living in rural and remote areas have limited access to services to update details.
Would you support the introduction of an incentive payment or other mechanism to assist in covering these costs for a limited time period?	NT Health does not support the proposed adjustment whereby funding is reduced for episode records without a valid IHI and increased for records reported to IHPA with a valid IHI. This arrangement is inappropriate as IHPA should only apply adjustments to reflect legitimate and unavoidable variations in the costs of delivering health care services, where similar costs have previously been rejected by IHPA. Additionally, if such costs are included as an adjustment, this would in effect redistribute growth funding and NT Health do not consider it appropriate for such incentive payments to be considered a contributor to efficient growth.

Example

IHPA has not supported jurisdictional submissions under the legitimate and unavoidable cost framework relating to ongoing expenses with the implementation of electronic medical records. IHPA did not support this request given that electronic medical records will be implemented across all hospitals nationally and considered there to be no unavoidable cost difference for patient or provider groups.

NT Health recommends that IHPA consider entering contractual arrangements with jurisdictions for provision of data services. This process would ensure that the processes for data acceptance are in line with appropriate standards and will build capacity within public hospitals to improve their data quality frameworks. This is in line with the process for collecting cost data from private hospitals, where private hospital groups are incentivised to provide data given its importance in developing future pricing and funding models.

Example

In 2017-18, IHPA engaged Australia's largest private hospital operator, Ramsay Health Care Investments, to provide data services for the National Hospital Cost Data Collection, as published on AusTender. IHPA may consider supporting public hospitals to provide data services, in line with this arrangement.

Patient Reported Outcome Measures (PROMs)

What initiatives are currently underway to collect PROMs and how are they being collated?	NT Health does not currently collect PROMs but has initiated a project to collect PROMs using an online patient experience survey based on the survey developed by the Australian Commission on Safety and Quality in Health Care (the Commission). NT Health has a unique demographic unlike all other states and territories and as such NT Health has translated the patient experience survey into six Aboriginal languages as well as nine international languages. The data will be collected using a staged approach which will initially be trialled across acute care later in the 2020-21 financial year using iPads distributed across the NT (including provision of single use earphones to hear translations). Depending on the outcomes of this trial, the collection is intended to be rolled out to primary care, noting that it will take some time until it can be integrated in routine practice.
Should a national PROMs collection be considered as part of national data sets?	NT Health recommends that IHPA work closely with the Commission to better understand the appropriate use of PROMs in informing policy and change initiatives. NT Health consider it too early to comment on the value of collecting the PROMs as part of national data sets as we expect further refinement in our internal collection and use particularly as we note the high risk of experiencing difficulties collecting PROMs from our transient and nomadic Indigenous population. NT Health advise there is a key requirement to culturally validate the collection to ensure translation is appropriate and results are valuable.

Example

The patient experience survey translated in one language may not be an exact match for another language, such as the word "sometimes" which may not exactly translate into "sometimes" in the other language, and the question and responses may be open to interpretation. Therefore cultural validation is required.

Alternate funding models

Bundled payments

IHPA proposes investigating bundled payments for stroke and joint pain, in particular knee and hip replacements. Should any other conditions be considered?	NT Health supports consideration of bundled payments, subject to adequate stakeholder consultation, particularly to ensure clinical pathways are appropriately reflected across and within jurisdictions. NT Health recommends that IHPA carefully consider indigeneity and remoteness in determining whether bundled payments are an appropriate funding model, particularly given the service variability for very remote areas. NT Health considers consistency in service provision to be a key parameter in bundling services, where nationally driven loading factors may not adequately address the differences in the patient cohort across jurisdictions.

Pricing and funding for safety and quality

Hospital acquired complications

Is IHPA's funding approach to HACs improving safety and quality, for example through changing clinician behaviour and providing opportunities for effective benchmarking?	NT Health advises that IHPA's HAC penalty has not provided an opportunity for effective benchmarking but rather has increased difficultly in explaining and engaging with stakeholders regarding what was already a complex pricing model. The NT is comparatively in its infancy in terms of its maturity of ABF processes, which decreases the practicality of effectively implementing IHPA's funding approach to HACs. NT Health has attempted to deliver this arrangement with no net increase in bureaucracy in line with the requirements of clause 17 of the National Health Reform Agreement, however the increased complexity has made this difficult as the NT already operates with limited resources. IHPA stated in its Pricing Framework 2019-20 that it was progressing the development of the evaluation framework and NT recommends IHPA continue to progress the evaluation framework to undertake a systematic approach to determining the answer to the consultation question posed.

Avoidable hospital readmissions

IHPA will commence analysis of three funding options from 1 July 2019 for a 24-month period.	IHPA stated in its Pricing Framework 2019-20 that it would provide opportunity for further stakeholder input in the Consultation Paper for 2020-21. NT Health would like to take this opportunity to reiterate its position that IHPA should broaden its approach beyond funding penalties to also implement positive funding incentives. NT recommends that funding approaches for safety and quality introduce incentives to improve care rather than solely through penalty. Funding incentives are required to facilitate systematic improvement in safety and quality particularly for small and isolated hospitals, as they already operate with limited resources.
What should IHPA consider to configure software for the Australian context that can identify potentially avoidable hospital readmissions?	NT Health recommend that IHPA consider whether the current separation mode data element in the National Minimum Data Sets are granular enough to describe separation modes that may impact hospital re-admission. **Example** A patient from a remote community may be discharged to a hostel in town for ongoing treatment or may be discharged back to their remote community where there are less clinical facilities available. The current Separation Mode may not adequately describe the conditions some of our patients are discharged to, which will impact their risk of readmission.