Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021-22

Northern Territory Submission

NORTHERN TERRITORY GOVERNMENT

1. Introduction

The Northern Territory faces unique challenges in delivering health care services. This includes significant geographical and cultural barriers, as well as high rates of social disadvantage, chronic conditions, and premature death. These challenges make it costly to ensure equity of access to high quality health services.

This submission provides feedback on issues highlighted in IHPA's *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021-22,* particularly where there may be potential impacts to equity of access to hospital services or the financial stability of the Northern Territory public hospital system.

2. Impact of COVID-19

Consultation question/s

- What changes have occurred to service delivery, activity levels and models of care as a result of COVID-19?
- How will these changes affect the costs of these services in the short and long term?
- What aspects of the national pricing model will IHPA need to consider adapting to reflect changes in service delivery and models of care?

Surgical and ward capacity

The NT public hospital system has implemented a number of safety and preparedness protocols to prevent spread of COVID-19 and protect vulnerable cohorts, particularly those living in remote regions. These changes have resulted in an effective reduction in overall surgical and ward capacity.

To manage reductions in surgical capacity, elective surgeries have been deferred or cancelled. A consequence of this has been a need to carry out more emergency surgeries as the condition of some patients has deteriorated because elective surgery could not be accessed. These surgeries are more complex and have higher resource requirements. However, these higher costs may not be fully recompensed through movements in complexity partitions in the AR-DRG classification, particularly due to overtime and shift-work loadings. Accounting for these costs could be achieved through an urgency of admission price adjustment.

Alongside impacts to surgical capacity, reductions in acute and mental health ward capacity have been required to maintain physical distancing and set aside beds for potential COVID-19 patients. In turn, this has created a need for patient loads to be more widely distributed across hospitals. This has resulted in an increase in staffing costs per patient and NT Health therefore anticipates an overall increase in the costs for admitted acute and admitted mental health services. These cost impacts could be mitigated by applying a prospective adjustment to the National Efficient Price for these services.

Example

Surgical capacity

To better prevent the spread of COVID-19, one operating theatre at Royal Darwin Hospital (the NT's principal referral hospital) has been converted to a negative pressure room and set aside to be used exclusively for potential COVID patients. While some low-complexity procedures have been able to be diverted to other facilities, this change has resulted in an overall reduction in surgical capacity.

Admitted acute ward capacity

Preventing the potential spread of COVID-19 at NT public hospitals has included a general reduction in bed capacity. This has been in order to set aside some capacity for COVID-19 exclusion but also to reduce the number of patients across all wards at any given time for general physical distancing purposes.

Admitted mental health ward capacity

Admitted mental health wards in the NT have needed to separately reduce capacity in order to set aside beds for potential COVID-19 patients. This is because there are seclusion requirements for these patients, which means that they cannot not be accommodated in general COVID-19 exclusion wards.

Deployment of additional resources to remote hospitals

To minimise patient movement between communities, NT Health has stationed additional clinical staff (such as anaesthetists, surgeons and theatre nurses) at remote hospitals. This is despite these facilities typically not experiencing the levels of patient volume to necessitate such resources. This policy, implemented to safeguard community health, has led to an increase in the average cost of activity at remote hospitals. NT Health recommends that IHPA consider a prospective increase to remoteness loadings to account for this cost increase.

Emergency department average length of stay

Homeless and other vulnerable patients with respiratory symptoms or who have travelled interstate are retained at NT public hospitals emergency departments are retained within the department until a COVID-19 test returns negative. This requires a portion of emergency department to be set aside, reducing the speed at which patients can be treated. This practice has resulted in a general increase in emergency department length of stay and average episode cost, particularly as NT's continues to have high rates social disadvantage and homeless. To mitigate this cost increase, IHPA should investigate options for a prospective emergency department price loading.

Example

As a precautionary measure to prevent the potential spread of COVID-19, all patients who attend emergency departments at NT public hospitals with respiratory symptoms, interstate travel and/or contact history are assumed to have COVID-19 until a test shows otherwise. While awaiting test results to return, some patients can be discharged home to self-isolate. However, many NT patients are not able to properly self-isolate because they are homeless or live in over-crowded conditions. Therefore, these patients must be kept at the hospital until test results return. These patients generally cannot be moved to an inpatient ward for this period as there are insufficient isolation bed spaces. As a result, these patients must be kept in the emergency department.

3. The Pricing Guidelines

Consultation question/s

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

NT Health considers that the Pricing Guidelines have an important role in providing stakeholders with transparency on how IHPA undertakes its functions. NT Health recommends that IHPA expand the existing process guideline of "Stability" to also reflect the new requirements in the Addendum around shadow pricing for changes to classification systems or costing methodologies and the circumstances when retrospective adjustments can be made to the national funding model.

Stability, Certainty and Predictability
The current process guideline of "Stability" provides that ABF payment relativities should be consistent over time. NT Health recommends that IHPA expand this guideline to clarify that IHPA's work, including any decision or advice, should support funding predictability and consider the potential for adverse impacts to financial sustainability. This is important when planning budgets and service agreements.

This amended guideline should read as follows: *Stability, Certainty and Predictability - Pricing and funding arrangements, including ABF payment relativities, will support certainty and predictability for hospitals and system managers.*

4. Classifications used to describe and price public hospital services

4.1. Admitted acute care

4.1.1. Enhancing education material and other support for implementation

ICD-10-AM/ACHI/ACS and AR-DRG Education

Consultation question/s

- What should be included in online education for new editions of ICD-10-AM/ACHI/ACS?
- How should AR-DRG education be delivered and what should it include?

Educational materials produced to-date to accompany changes to the ICD-10-AM/ACHI/ACS classifications have been useful for expert users such as Health Information Managers and clinical coders. However, NT Health notes that these materials could be further supplemented by practical case studies and workshops. Furthermore, non-expert users (such as clinicians) have expressed interest in having access to educational materials that provide context on how clinical diagnoses can impact AR-DRG assignment.

Electronic Code Lists

Consultation question/s

- What improvements to the content and format of the electronic code lists could be made to enhance their utility?

NT Health notes that electronic code lists are used to enable interface between ICD/ACHI and software systems. Noting that the users of these code lists are predominantly information technology specialists and not clinical coders, there could be scope to enhance the use of plain English terminologies to improve integration, understanding and usage amongst clinicians and health administrators.

Hard Copy Definitions Manuals

Consultation question/s

- Is there support to replace the hard copies of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS with electronic versions?

NT Health supports retaining hard copy versions of ICD-10-AM/ACHI/ACS as clinical coders use these for teaching and annotation. However, NT Health supports phasing out hard copy support for the AR-DRG Definitions Manual in favour of a suitable electronic substitute.

4.1.2. Release of ICD-11

Consultation question/s

- Are there other suggestions for approaches or measures to assess impact and readiness of ICD-11 for use in the classifications used in admitted care, or more widely?

NT Health recommends that IHPA's work to assess impact and readiness of ICD-11 should also include consideration of how the new classification will impact local information systems and coding workforces, particularly the training and system adaptations that will be required prior to implementation. Consideration should also be given to how ICD-11 will impact the financial stability of the health system under the NHRA and what transitionary arrangements should apply.

4.2. Emergency care

Consultation question/s

- What has been the impact on emergency department data since IHPA commenced shadow pricing using the AECC Version 1.0?
- Are there any barriers to implementing pricing using the AECC Version 1.0 for emergency departments for NEP21?

NT Health acknowledges that the AECC Version 1.0 recognises some complexity and cost drivers. However, NT Health considers that the AECC inadequately accounts for other cost drivers such socioeconomic status (including homelessness), location, and capacity (including overcrowding and underutilisation). Furthermore, the cost impact of homelessness and overcrowding on NT emergency departments has been exacerbated by COVID-19. This is due to the need to retain these patients in the emergency department when they are suspected of having COVID-19 because they cannot be safely discharged to self-isolate.

IHPA has previously noted these issues and indicated that it would work to ensure any barriers to pricing emergency department activities using the AECC would be addressed for NEP21. As such, NT Health recommends that IHPA demonstrate the effectiveness of AECC Version 1.0 in accounting for these cost drivers over the 2020-21 shadow period and assess the need for any refinements to the classification before pricing for NEP21.

4.3. Mental Health Care

Community Mental Health Services

Consultation question/s

- How can IHPA further support development of pricing for community mental health services using AMHCC Version 1.0 to transition to shadow pricing?

NT Health notes that there has been an increase in community mental health cost data submitted for 2018-19. However, NT Health considers that no consultation or analysis has occurred to enable an assessment as to whether the quality and stability of this data is appropriate to commence formal shadow pricing. NT Health therefore recommends that further consultation should take place before a decision is made to commence shadow pricing for community mental health services as a transitionary arrangement to pricing and funding these services. This may include development of indicative price weights that do not contribute to the two-year shadow period required by Clause A42 of the Addendum.

NT Health also recommend that IHPA do not shadow-price community mental health services under the AMHCC until after refinements to the MHPoC are implemented. These changes have a high potential for variability in price weights and shadow pricing community mental health services before refinements are implemented would not be an effective transitionary arrangement to assess financial and counting impacts.

Admitted Mental Health Services

Consultation question/s

- Are there any impediments to pricing admitted mental health care using AMHCC Version 1.0 for NEP21?

NT Health notes that one third of admitted mental health patient records submitted nationally for 2018-19 have an unknown Mental Health Phase of Care (MHPoC) value. Furthermore, NT Health notes that IHPA is in the process of refining the MHPoC to address inter-rater reliability amongst clinicians and the ability of the MHPoC to reflect resourcing requirements. On this basis, NT Health considers that it would be appropriate for IHPA to continue to shadow-pricing admitted mental health services under the AMHCC Version 1.0 until after these issues are rectified. Before transitioning to pricing, IHPA should also provide assurance that the classification is both clinically relevant and is able to consistently account for the costs of providing mental health care services across jurisdictions and regions. This will ensure that states and territories are not exposed to unnecessary financial risk or instability.

5. Setting the national efficient price for activity based funded public hospitals

5.1. Adjustments to the NEP

Consultation question/s

- Do you support the adjustment IHPA has proposed for NEP21?
- What evidence can be provided to support any additional adjustments that IHPA should consider for NEP21?

NT Health supports IHPA's proposed adjustment to account for legitimate and unavoidable costs for patient transport in rural areas, including medical transfers and other inter-service transports. NT Health recommends that this proposed adjustment include regional areas and also extend to include aeromedical emergency evacuations more broadly, rather than being limited to transfers between hospitals. Furthermore, if IHPA determines that an NEP-based adjustment is not technically feasible in the near term, it should introduce block funding arrangements for patient travel as an interim measure.

Inter-hospital transfers

NT hospitals, especially those in remote areas but also those in regional areas, do not have the same level of specialist capability as hospitals in major cities. Given the NT's relatively small population, some specialist services are not clinically or financially feasible. This means that it is sometimes necessary to transfer patients from regional and remote hospitals to other facilities, including in other jurisdictions, to receive critical or specialist care services that are not available locally.

NT Health recommends that IHPA extend the patient travel adjustment for remote areas to also include inter-hospital transfers that occur from outer regional areas. This is because all NT hospitals must at times transfer patients thousands of kilometres, from both regional and remote areas, to facilitate equitable access to high quality health care, regardless of geographic location.

Example

An Indigenous patient with an intraspinal abscess was transferred by air from Royal Darwin Hospital to receive specialist care at Royal Adelaide Hospital. The cost of travel for this patient was $112,000. Under the current national pricing model, it was calculated that the total cost of care for this patient (inclusive of adjustments) should not have exceeded $5,500.

Aeromedical emergency evacuations

In addition to inter-hospital transfers, NT Health also incurs substantial costs associated with medically evacuating patients by air from communities and points of incident (e.g. trauma) to the nearest appropriate hospital in order to receive critical care. Aeromedical emergency evacuation/retrievals are essential services to facilitate equitable access to high quality health care for those living in regional and remote areas and these costs are in-scope under the NHRA. This is as the Addendum, under Clause 1 (g) reaffirms high-level service delivery principles provided by the National Healthcare Agreement and Clause 24 (h) of this Agreement provides that "emergency responses", which includes "support for emergency air retrieval", are to be jointly funded by the Commonwealth and states/territories.

Aeromedical emergency evacuation/retrieval services carry a high cost due to the isolation of NT hospitals. For instance, in 2018-19, NT Health incurred costs totalling approximately $17.2 million, across 2,643 occasions of

service. These costs have had to be absorbed by hospitals, disadvantaging its patients because the current funding model does not appropriately reimburse these services on an activity basis.

NT Health did not submit these costs as part of the Round 23 NHCDC and will instead submit these as part of Round 24. NT Health understands that states and territories submit aeromedical evacuation costs inconsistently and may not be properly reflected in national costing data. NT Health therefore recommend that IHPA review and confirm how these costs have been accounted for at a national level.

Example

A patient was trampled at a remote cattle station and required urgent medical attention. This patient was collected by helicopter and transported to Royal Darwin Hospital. The cost of this emergency aeromedical evacuation was $85,000.

5.2. Harmonising price weights across care settings

Consultation question/s

- Are there any obstacles to implementing the proposed harmonisation of prices for dialysis and chemotherapy for NEP21?

NT Health does not support harmonising prices if it results in a financial penalty for hospitals that admit patients for clinical reasons. For instance, chemotherapy patients in the NT are admitted when they require intravenous delivery of medications and additional monitoring by clinical staff. These patients therefore have a higher cost profile compared to the non-admitted setting, which is used for low-complexity oral delivery of chemotherapy medications. NT Health recommends that IHPA take these clinical differences into account when considering harmonising price weights.

5.3. Costing private patients in public hospitals and the patient correction factor

Consultation question/s

- Is there any objection to IHPA phasing out the private patient correction factor for NEP21?

NT Health recommends that IHPA undertake a shadow implementation period to phase out the private patient correction factor, including back-casting. As part of the shadow process, IHPA should 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. Furthermore, phasing out the private patient correction factor should not proceed until assurance on costing standard compliance can be provided through the NHCDC's Independent Financial Review process.

6. Alternate funding models

Consultation question/s

- What comments do stakeholders have regarding the innovative funding models being considered by IHPA?
- What other strategic areas should IHPA consider in developing a framework for future funding models?
- Apart from the IHI, what other critical success factors are required to support the implementation of innovative funding models?

NT Health supports IHPA's efforts to trial alternate funding models and develop a strategic framework to guide work on investigating the feasibility of these models. NT Health recommends that, as a core guiding principle of this work, IHPA gives consideration to accounting for the different clinical pathways that may exist across and within jurisdictions. In particular, IHPA's framework for future funding models should carefully consider the feasibility of such models in the context of remote and regional areas.

7. Avoidable Hospital Readmissions

Consultation question/s

- Do you support IHPA's proposed pricing model for avoidable hospital readmissions, under funding option one at a jurisdiction scope level?
- What additional aspects does IHPA need to consider when implementing a funding adjustment for avoidable hospital readmissions?

NT Health agrees that funding option one is less complex than funding option three and is similar to the approach used for pricing hospital-acquired complications by applying penalties at the patient level. However, NT Health notes that, as part of the development of the readmissions model, IHPA's Clinical Advisory Committee favoured the system-focussed view of funding option three. NT Health also supports system-focussed approaches as penalising individuals may lead to inadvertent consequences, particularly for vulnerable patient cohorts. NT Health therefore recommends that IHPA adopt funding option three for avoidable hospital readmissions.

NT Health notes that funding option one has a more stable impact than funding option three when applied to small hospitals in remote and regional areas. NT Health considers that this issue could be addressed by continuing to refine the risk adjustment model and exclusion rules, including for hospital transfers, to eliminate disproportionate funding impacts between funding options.