Government of **Western Australia**
Department of **Health**

Our Ref: F-AA-72056-2
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Dear Mr Downie James

CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR PUBLIC HOSPITAL SERVICES 2021-22 – WA SUBMISSION

Thank you for the opportunity to provide a submission to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021-22.*

Western Australia's consolidated feedback is provided in Attachment A.

The State's response to the COVID-19 pandemic has resulted in substantial changes to service delivery, models of care and activity levels across all areas of the Western Australia (WA) health system. These changes have significant implications on the costing and pricing of public hospital services.

It is recommended that shadow pricing of admitted mental health services using the Australian Mental Health Care Classification (AMHCC) continue in 2021-22 to allow for further refinement of costing episodes at phase levels, while monitoring funding implications. Shadow pricing of community mental health services using the AMHCC should be deferred until sufficient quality data is available for costing and pricing purposes.

WA suggests that further work is required on price harmonisation for chemotherapy and dialysis across care settings in particular for paediatric patients.

WA is supportive of IHPA's plans regarding funding model enhancements and continued investigations of alternative funding models. WA would welcome an incentive-based approach to avoidable hospital readmissions and will continue working with IHPA on improving patient safety and quality outcomes.

Please note that further comments will be provided during the statutory 45-day Ministerial consultation period when the Draft Pricing Framework 2021-22 is released.

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Yours sincerely

Dr D J Russell-Weisz
DIRECTOR GENERAL

8 October 2020

Attachment A: WA submission

ATTACHMENT A

WESTERN AUSTRALIA'S SUBMISSION TO THE CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2021-22

Introduction

Western Australian (WA) welcomes the opportunity to provide feedback to the Independent Hospital Pricing Authority (IHPA) on the Consultation Paper for the *Pricing Framework for Australian Public Hospital Services 2021-22.*

Addendum to the National Health Reform Agreement (NHRA) 2020-2025

High cost therapies

The Addendum contains specific arrangements for new high cost, highly specialised therapies recommended for delivery in public hospitals by the Medical Services Advisory Committee (MSAC). It is noted that IHPA and the National Health Funding Body have a process for funding of chimeric antigen receptor (CAR-T cell) therapy which could be used for other new highly specialised therapies. The NHRA however makes no provision for what happens to the Commonwealth funding after the two initial years. As it often takes more than two years to accrue actual cost data, this is an area of concern. Collaborative work on CAR-T, as one of the first high cost therapies in Australia, highlighted a number of challenges and gaps in the process such as cost impacts beyond the 2 years and incorporation of jurisdictional views into the MSAC's considerations. Allocation into the Pharmaceutical Benefits Advisory Committee (PBAC) versus MSAC category also remains unresolved. Currently this rests with the Chairs of PBAC and MSAC, and the Commonwealth. Legislation limits what PBAC can review (drugs), but several new treatments coming out are neither Medical Services nor Pharmaceuticals. The Commonwealth determining which pathway it goes down could be open to scepticism as funding implications are uncertain. WA will continue to work with IHPA on addressing these challenges and refining future processes.

Impact of COVID-19

Consultation Question - What changes have occurred to service delivery, activity levels and models of care as a result of COVID-19?

Changes to activity levels

During April 2020, WA experienced a large upturn in non-admitted telehealth service events. For the same period, there was a rapid reduction in Emergency Department (ED) presentations which is still recovering to pre COVID-19 levels as at September 2020. There has also been an increase in pathology screening related to COVID testing. So far, there has essentially been no observable 'flu season' in ED, which was consistently evident in the past few financial years.

Following the National Cabinet decision to suspend all non-urgent elective surgeries, Local Health Networks scaled back reportable and non-reportable elective surgeries during March 2020. From 28 April 2020, 25% of elective surgeries were reinstated, and subsequently had been further reinstated such that as of 15 June 2020, the system was capable of delivering 100% of elective surgeries. Further analysis on the impact of rescheduled activity will be determined in future months.

As of September 2020, admissions are now exceeding pre COVID-19 highs as WA has embarked on an elective surgery blitz to address the increase in over boundary patients on the elective surgery waitlist. Additional funds have been provided to support the system in performing additional surgeries in the period July to December 2020.

Early analysis of mental health data for the early response period, indicates reduced in-person attendances at many sites offering mental health services. This reduction has been partly, but not completely, offset by an increase in the service contacts undertaken electronically or over the phone where patients are presenting with higher levels of acuity caused by reluctance to attend hospital and not taking prescribed medications.

Changes to models of care and service delivery

Training and use of Personal Protective Equipment (PPE), and infectious disease protocols have impacted/changed service delivery across the whole system, including public health, GP networks etc. Even with changes in government policy and easing of restrictions to workplaces and the public places, there is a continued change in the model of care/service delivery, particularly in relation to surgery, which will inherently increase cost and reduce efficiency of the hospital system. Increase in resource surveillance and temporary cessation of teaching and training activities in some areas were noted.

There was an increase in the use of telehealth as substitute for face to face service delivery particularly in non-admitted services. In rural areas, a Telehealth Inpatient Physician Service has been established to support Physician consultations for patients under the care of General Practitioners at district sites to support reduced patient movement/transfers. This outreach consultation support has cost implications for the delivery site. There is interest in a similar model of outreach consultation support into Aged Care Homes to prevent patients needing to come to an acute facility. There would be costs including the employment of Physicians and Nurse Practitioners to support this model.

The Hospital in the Home service has been increased slightly and there is potential to incorporate a broader scope of patients in this service and extend it to incorporate home monitoring technologies.

The models of care for respiratory patients and those with infectious diseases were adjusted to eliminate the risk of contracting COVID-19. This includes segregation of respiratory patients presenting to the ED and designated wards/areas to care for

patients presenting with COVID-19 symptoms. This resulted in displacement of some specialties to other wards/contracted service.

The models of care for non-admitted services were modified to include COVID-19 screening questions and essential use of PPE resources. Where possible, telehealth appointments were offered in place of face to face contact and identification of patient's capability for telehealth was established. There was an increase in non-admitted pop-up COVID-19 clinics. For some health service providers, outpatient services were moved off site and into the community or patients' homes. This introduces costs in terms of leasing facilities, vehicle expenses and clinicians spending time travelling.

There are ongoing challenges in managing the normal volume of patients and maintaining separation of potential COVID-19 patients to minimize risks of cross infection. Additionally, there is an increased burden on the system with pre-admission/ pre-presentation screening requirements.

Increase use of contracted services for specialties such as maternity to offer delivery in a safer environment was observed in rural areas.

How will these changes affect the costs of these services in the short and long term?

In preparation for COVID-19, staffing levels were substantially increased, which is expected to have flow on affects to hospital efficiency levels for Quarter 4 2019-20. At this point in time and whilst further analysis is yet to be undertaken, it is expected that patient and staff profile changes at the hospital level will impact costs negatively in the short and longer term, particularly whilst Australia remains in a pandemic state.

Whilst there has been a decrease in activity in some areas such as ED presentations and changes related to waitlist surgery, costs of these services in the short term are expected to be higher than pre-covid due to a higher fixed cost per service/patient, increased staffing levels, changes in PPE usage and changes related to infectious disease protocols. This applies across all hospital service areas. The specific areas and magnitude of change in the cost profile in relation to hospital services is yet to be fully analysed.

In the context of ongoing national discussions on funding options of PPEs, considerations should be given to the possibility that relative PPE expenditure may never return to pre-pandemic levels due to general increases in hygienic vigilance and behaviour, and changes in hospital policy and practice around usage of PPE. It is unclear when, or if, a return to pre-pandemic prices for PPE in the global market will occur; it is unlikely that the usage or consumption levels will return. Further work is required to assess the ongoing changes to PPE usage in a post-pandemic environment and the impact on the NEP, including the possible need to reflect an increase in baseline usage.

In the short term, LHN's expect that the cost of hospital Services will increase. There is already a noted increase in the staffing cost per Weighted Activity Unit, and in

productive FTE - the former because 'normal' operations and clinical activity were not fully substituted by pandemic activity, and the latter because of staff continuing to defer taking leave. Other increases in expenditure relate to consumables (hand sanitisers, PPE), pharmaceuticals and additional minor capital expenditure on equipment such as respirators.

Due to the comparative low level of COVID-19 cases in WA, costs were incurred in preparation for activity that did not eventuate. Significant planning and preparation occurred with no opportunity to identify resulting activity, which means that associated costs will not be funded through ABF.

Activity and expenditure impacts will vary between states both in size, time and areas affected. Consequently, there should be a period where the pre-COVID-19 data is indexed rather than trying to apply COVID-19 period data to any post-COVID-19 years.

What aspects of the national pricing model will IHPA need to consider adapting to reflect changes in service delivery and models of care?

WA suggest the IHPA will need to consider jurisdictional differences as COVID-19 has affected each state differently in terms of staffing, PPE usage, cost profiles, activity levels, overall COVID-19 preparedness, levels/amount of COVID-19 testing, and may need to consider other aspects related to security/hotel and quarantine and the impact of infectious disease protocols on surgery and the wider hospital services. How will IHPA adjust its methodology to account for these differences?

Backcasting and year on year growth calculations will be impacted by the changes in activity levels. How will IHPA's model take into account specific COVID-19 costs in service delivery and the flow-on impacts to the price weights?

Furthermore, will IHPA consider possible changes/review to the National Pricing Model Stability Policy and how it will be applied in the event of significant changes in price weights related to the impact of COVID? Will IHPA consider trimming/excluding COVID activity from the model development and/or will consideration be given to COVID specific adjustments?

<u>Cost of telehealth</u>

There is often an assumption that telehealth is good and cheaper however this needs to be validated. Telehealth generates additional expense on ICT infrastructure. It needs to ensure documentation processes are in place and also notes that it marginalises some groups (such as the elderly and adolescents who may not have access). It impacts on patients' privacy and confidentiality in doing this from home vs attending a clinic appointment that they may not have told others about. There should be safeguards to ensure a funding model does not favour one practice and creates a preference for something that does not work for clinicians or patients.

While telehealth is currently priced based on Tier 2 clinic price weights, there is additional resourcing required in supporting clients using this technology/receiving services in this way that needs to be factored in.

In rural areas, consideration should be given to funding mechanisms for hospitals taking on a role supporting smaller block funded hospitals, as well as hospitals supporting Aged Care facilities.

Incentivise funding for value-based services delivering healthcare in settings that support out of hospital care and collaborative programs that have a technology focus in particular Mental Health, Alcohol and Other Drug services.

Pricing guidelines

Consultation Question – Are the Pricing Guidelines (PG) still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?

WA is generally supportive of the current Pricing Guidelines with particular regard for the patient-centred focus. It has been noted there is scope for improved agility in response to rapidly changing care environments. WA would also welcome increased cognizance of the wide diversity of service delivery models across Australia.

Does the change to the public-private neutrality pricing guideline accurately reflect the intent of the Addendum?

WA is supportive of IHPA's proposal to change the public-private neutrality guideline to reflect the requirements of the Addendum noting the revised guideline is less focused on the patient and more on funding the neutrality for the provider.

WA notes that while the change reflects the new intent of the Addendum, it could have significant impacts on the WA health system and how WA handles private patients. To a degree there is ambiguity in the Addendum in relation to what 'funding neutrality for the service provider' means.

WA will continue to work with jurisdictions and IHPA to implement the intent of the Addendum.

Classifications used to describe & price public hospital services

WA supports the ongoing classification development and refinement for ABF purposes and will continue to participate in this work through its representation on the IHPA working groups and advisory committees. The IHPA should ensure that jurisdictions are provided with adequate time to implement any new classification systems before introducing pricing based on that new or revised classification.

Admitted acute care

Consultation Question – What should be included in online education for new editions of ICD-10-AM/ACHI/ACS?

WA is supportive of the online delivery of the education for new editions of ICD-10-AM/ACHI/ACS and notes the following points for IHPA's consideration:

- Online courses could be promoted more widely, and content could be better tailored to a wider audience including all health service staff who work with and

need to understand ICD10 instead of coders only. LHNs reported interest from clinical and administrative staff seeking better understanding of ICD-10.

- There may also be benefits in providing a summary of "Z" DRGs that have been expanded into one of the families of an AR-DRG or vice versa and highlighting where AR-DRGs have been developed as a direct result of the implementation of a new clinical innovation. Greater detail on which ICD-10 principally drives the AR-DRG assignment may also enhance understanding of the classifications.
- Electronic versions of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS would also be a positive step forward from the current hard copy editions.
- Online education would ideally be interactive and provide opportunity for Question and Answer.
- A module-based approach has been suggested to allow focus on relevant areas of interest.
- Materials should avoid simple reiteration of the coding standards and include case studies and examples of the interpretation using common scenarios including comparison to prior editions for enhanced clarity and justification for changes.
- As it is not in IHPA's remit to deliver education, train the trainer style education to jurisdictional/health service representatives should be considered. Jurisdictional/health service representatives could then deliver face to face education to the state, as well as provide coders with a permanent expert point of contact.

How should AR-DRG education be delivered and what should it include?

AR-DRG education should be delivered via webinars covering explanations of the version changes. These webinars should be tailored to the audience and include specific examples of how assigned codes will vary when using previous compared to current versions. The content should be easily understood by clinicians and managers and not just health information/ coding staff.

The webinar should also provide explanations and examples of the exclusion principles, conditional and unconditional exclusions, and workings of a DRG version including complexity scores.

The education needs to cover/reiterate the grouping process as well as:

- Overarching aims of the changes to the DRG classification.
- Any reasons for the proposed changes.
- Changes to DRGs and demonstrate how this change impacts the look of the activity data through examples.
- Changes to complexity scores and impact on the look of activity.
- Some information on the associated NEP for the implementation year.

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

It has been suggested that adding Episode Clinical Complexity Score thresholds for the AR-DRG Admitted acute price weights would be beneficial.

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

WA is supportive of electronic versions for both the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS. WA envisions that these will improve access for all users, improve communication of upcoming version updates and enhance timeliness of access through downloading rather than waiting on mail delivery. A hard copy to supplement the ICD-10-AM/ACHI/ACS electronic version will also mitigate issues arising when there are unexpected down times or system crashes.

On occasions where the versions for ICD-10-AM and DRG change in the same year, consideration could be given to combining them.

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?

Though mapping back to ICD-10-AM has been mentioned in the paper, there are other significant issues related to readiness:

- ICD-11 has been designed to be incorporated into Electronic Medical Records (EMR). This is not being flagged with the many jurisdictions working towards an EMR. IHPA needs to assess any impact of this development on AR-DRG development and the Australian Coding Standards. The WA Digital Health Strategy outlines the vision for a digitally-enabled public health system for 2020-30. Working in a hybrid online environment may provide a challenge.
- Readiness assessments will need to be conducted by each jurisdiction of their data collection applications and feeder systems and reporting dashboards.
- Third Party Agencies readiness will require extended timeframes for implementation with consequent increase in implementation costs.
- Comparability of longitudinal data collections will be an issue and will require mapping tables in order to make comparison possible.
- The suitability of ICD-11 for other classification systems e.g. ED and outpatients may require phasing in via dual classification systems or not implementing ICD-11 for these areas.
- Clinical Classification workforce review – with an aging workforce, many coders won't stay for this significant change. Training of those who remain will require allocation of time and resources.
- Overarching education needs to be offered as part of any readiness assessment.

Suggested approach: at the first instance, participants may be surveyed to identify knowledge and skill gaps so that the training topics could be prioritised. The actual and perceived impact to infrastructure requirements and staffing should also be surveyed to ensure business continuity. IHPA can also clarify with participants

regarding the mode of training delivery and avenues for technical support to ensure that they can understand the impact of the changes in ICD-11.

Non-Admitted Care

Consultation Questions - Are there any other factors that should be considered for the addition of pain management and exercise physiology classes in the clinic nurse specialist/allied health led services of classes in the Tier 2 Non-Admitted Services Classification?

When recording pain management or exercise physiology using the Tier 2 classification, consideration of the patient diagnosis or presenting complaint is necessary to distinguish which Tier 2 classification provides the best reflection of healthcare provided.

How would activity that falls under these proposed new classes previously have been classified?

In general, the following classes under which this activity may have previously fallen have been identified as:

- 10.14 Procedure Classes – Pain Management Interventions.
- 20.03 Medical Consultation Classes – Pain Management.
- 20.47 Medical Consultation Classes – Rehabilitation.
- 40.09 Allied Health / Clinical Nurse Specialist – Physiotherapy.
- 40.12 Allied Health / Clinical Nurse Specialist – Rehabilitation.

However, it has been noted that in practice, depending on specific patient circumstances, other classes could have been used. For example, a patient is recently discharged from hospital following an acute cardiac event and is referred to Exercise Physiology for ongoing care. This may include assessment of cardiac function, education and prescription of exercises and self-management training to monitor their condition. The clinician may have recorded this activity as Clinical Measurement 30.08 (to undertake specialised cardiac stress tests), Hospital Avoidance Program 40.58 or Post-Acute Care 40.59.

Additional comments for Non-Admitted Care

Genetic Counselling

Clarification is sought as to the appropriate Tier 2 outpatient code for use for genetic counselling delivered by a genetic counsellor as part of a specialist medical consultation clinic for genetics, which occurs in WA primarily at Genetic Services of WA (GSWA). All genetic counsellors are supervised by a clinical geneticist and all cases are discussed with at least one clinical geneticist. As such, a clinical geneticist is ultimately responsible for every case.

Historically, WA has used code 20.08 "Genetics" for activity generated by clinical geneticists, whereas code 40.53 "General Medicine" has been used for activity generated by genetic counsellors at the same specialist clinics at GSWA. However, as code 40.53 is for "general medical conditions" and when "patients are not required to attend a specialist medical consultation clinic or such clinics do not exist", the code

does not seem suitable for genetic counsellors delivering genetic counselling to individuals who have a "genetic condition" or are at risk of having a genetic condition, and who are seen as part of specialist medical consultation clinic.

It is noted that the 20.08 code is mentioned as "genetic counselling" in the Tier 2 Non-Admitted Services 2019-21 document when listed as an exclusion for items 40.33 (general counselling) and 30.05 (pathology (microbiology, haematology, biochemistry)). Therefore, is 20.08 code the one to be used for a service event delivered by a genetic counsellor when part of a specialist medical consultation clinic for genetics?

Molecular Tumour Boards

The increasing clinical utility of genomic testing in cancer, combined with the evolving improvements of the associated technology has meant that Molecular Tumour Boards (MTB) are becoming more important to appropriately discuss and interpret a cancer patient's extensive genomic results. MTB are a specialist form of multidisciplinary team meeting where the genomic results of cancer patients are discussed to inform a molecular diagnostic report. The types of professions participating in MTB include pathologists, oncologists, medical scientists, bioinformaticians, surgeons, radiologists and researchers. During these multidisciplinary meetings the participants discuss the results of next generation (massively parallel) sequencing investigating somatic and/or germline variations. Following a systematic and comprehensive analysis of the genomic variations, they are collectively evaluated by the MTB for their anticipated effects on tumour pathophysiology. Participants assess prognosis, treatment options, possible participation in clinical trials, as well as consider risk, possible interventions and familial implications for germline variations. Could IHPA investigate the possibility for introducing a Tier 2 Non-Admitted Services code for MTB, as the existing codes for multidisciplinary teams (e.g. 20.56, Multidisciplinary case conference patient not present) does not appear to be suitable?

Emergency care

Consultation Questions – What has been the impact on emergency department data since IHPA commenced shadow pricing using the AECC Version 1.0?

WA has been closely monitoring ED data since IHPA commenced shadow pricing using the Australian Emergency Care Classification (AECC) v1.0. There has been no noticeable impact on ED practice that WA is aware of at this point in time. WA will continue to monitor the data.

Are there any barriers to implementing pricing using the AECC Version 1.0 for emergency departments for NEP21?

WA welcomes IHPA's intention to review the shadow year for AECC Version 1.0 and assessing the impacts of the shadow pricing period and the merits of the shadow process.

In terms of barriers to implementing pricing using the AECC V1.0, WA notes concerns regarding data quality of the diagnosis field, particularly when comparing to historical

data. The diagnosis field, although available in WA, has never been robustly collected and validated. Historically, all presentations received a price weight, however under the AECC where the diagnosis code cannot be mapped or is missing, these presentations will now have funding implications.

There is currently no UDG like fall back when the AECC field returns an error code which may present as a barrier for implementation at the Local Health Network level.

Mental health care

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

WA does not currently cost community mental health services therefore additional time could assist WA in implementing systems and processes to address the gaps. IHPA can further support development in this area by assisting with the standardisation of jurisdictional processes to ensure data quality, consistency and comparability.

WA recommends that shadow pricing of community mental health services using the AMHCC should be deferred until sufficient data is available for costing and pricing purposes.

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

WA is currently working towards costing mental health services at the phase of care level with the intent to provide phase level mental health inpatient costs for 2019-20.

WA notes that a key impediment to pricing using AMHCC v1.0 for NEP21 would be the quality of data being collected along with the ability for each jurisdiction to cost at the phase level. Variability in costs in each phase and across each jurisdiction could have unintended incentives for services not being appropriately priced. WA therefore is supportive of continued shadow pricing for 2021-22 to allow for further refinement of costing while monitoring funding implications.

Additional comments for Mental Health Care – Mother and Baby Units (MBUs)

WA welcomes IHPA's decision to further investigate MBUs' potential cost differences and assess how they could be addressed as part of the future refinement of the AMHCC. WA notes the following:

- While these units are small in size the costs of care for mother and baby while being managed in the unit is significantly greater than managing an adult only in an adult inpatient unit.
- The accurate identification of activity data specifically for MBUs is difficult. A specific costing study of MBU care, which would be feasible in WA may be a more efficient pathway to obtaining data on the true cost of MBU care and identifying the gap with adult mental health inpatient care.

- These units are small and the total cost as such is small, however the viability of offering this model of care across Australia is reliant on appropriate pricing and as such this has a potential impact on future accessibility and viability of MBU care across Australia.

Setting the National Efficient Price (NEP) for activity based funded public hospital services

As noted in previous years' Pricing Framework submissions, WA is strongly opposed to any change in the calculation of the NEP that has the potential to reduce the Commonwealth contribution to jurisdictions under ABF going forward.

Adjustments to the NEP

Consultation Question – Do you support the adjustment IHPA has proposed for NEP21?

WA supports the adjustment for patient transport in rural areas, including medical transfers and other interservice transports in rural areas proposed for NEP21.

What evidence can be provided to support any additional adjustments that IHPA should consider for NEP21?

WA supports valid, evidence-based adjustments to the pricing model and encourages the IHPA to further explore the possibility of implementing financial incentives as opposed to disincentives (i.e. financial penalties) to promote better, efficient healthcare and to avoid unintended consequences.

At the August 2019 TAC meeting, IHPA shared an article which found that financial disincentives for hospital readmissions may have caused an increase in 30-day heart failure mortality rates. Additionally, the article recommends using a progressive program that improves patient care as opposed to a regressive financial penalty. Examples of financial incentives/pay-for-performance schemes include, but are not limited to:

- United Kingdom's National Health Service Best Practice Tariffs; and
- Queensland Health's Clinical Practice Improvement Payment.

Price harmonisation

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

In principle WA supports the initiative of reducing financial incentive for hospitals to admit patients that could be treated on a non-admitted basis noting concerns that current cost variations are partly due to the diversity of patients' clinical risks.

WA encourages IHPA to further consult with the jurisdictions and to provide more detailed analysis around the proposed harmonisation of dialysis and chemotherapy, noting comments from IHPA's Clinical Advisory Committee and discussions at Jurisdictional and Technical Advisory Committees.

A few issues had been identified as potential obstacles to implementing the proposed harmonisation:

1. Higher comorbidity risk profile of inpatients and associated cost variation. Although similar service is being delivered in both settings, costs might differ in relation to comorbidity risk profile. Patient care might be detrimentally affected if different services are expected to be provided at the same level of funding.

2. Paediatric specific factors (oncology):
   - In paediatrics, procedures like lumbar puncture and intrathecal chemotherapy administration are performed under general anaesthesia (GA) compared to under local anaesthesia or sedation in the adults. This is a very common procedure, for example, at Perth Children's Hospital there is an Oncology GA list 3 times a week with around 3-6 patients requiring this procedure on each list. Patients spend 4-6 hours in the unit which requires significant nursing and medical care.
   - Nearly all paediatric patients have a central venous line to facilitate chemotherapy administration. Sometimes accessing these devices is tricky due to patient anxiety. Staff routinely use occupational therapy support and sedation in such cases which also prolongs the duration of hospital visit with significantly higher burden of care.
   - Harmonising chemotherapy price in paediatric setting could result in funding that does not correlate with the intensity of care given to children with cancer and would not reflect the Overarching Pricing Guideline of Fairness.

Are there other clinical areas where introducing price harmonisation should be considered?

It has been suggested that treatment of anaemia with blood transfusions and infusions of blood products such as gamma globulin, platelets and other serum transfusions could be investigated for potential price harmonisation.

Additional comments - Treatment of other Commonwealth programs

It is noted that the PBS, Highly Specialised Drugs and Efficient Funding of Chemotherapy medicines programs are excluded. The state administers these programs for free and recoups the costs of the items themselves. The agreements for the program are out of date and no longer reflect the cost of providing the programs. It is arguable that the (clinical) services provided as part of supply are not adequately captured in the price calculations. Last year the Commonwealth reduced the wholesale mark-up (unilaterally) on these items. The Commonwealth confirmed that there would be a corresponding correction via NHR funding, that the reduced alternative Commonwealth revenue would eventually flow into the NEP calculations and the NEP would adjust based on 2019 data in three years' time. However, due to the funding formula, this correction would only account for part of the reduced funding.

Setting the NEP for private patients in public hospitals

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

WA would be supportive of removing the private patient correction factor provided it can be demonstrated that all material missing costs are now included in the NHCDC. Given the correction factor is 1.4%, this suggests there may still be material cost exclusions.

Setting the National Efficient Cost

Consultation Question - Are there refinements to the 'fixed-plus-variable' model that IHPA should consider?

There are no refinements to the 'fixed-plus-variable' model that WA believes IHPA should consider at this point in time. However, WA recommends continued monitoring and refinement of the way remoteness costs are being captured in the model to ensure it reflects the true cost of service delivery in rural and remote areas.

Alternate funding models

Consultation Question - What comments do stakeholders have regarding the innovative funding models being considered by IHPA?

WA encourages IHPA to continue to explore innovative funding models and welcomes discussion on these, particularly those that improve health outcomes and promote/increase hospital service avoidance.

Further, WA encourages IHPA to explore the incorporation of incentives that will promote better, efficient healthcare as opposed to financial penalties such as those applied for Hospital Acquired Complications and Avoidable Hospital Readmissions. Under the current model, the health system is incentivised via penalties for safety and quality, which may not have the intended consequences. Has IHPA considered a reward-based incentive for better safety and quality outcomes (i.e. rewards to reduce HACs and/or readmissions).

IHPA's future work on innovative funding models needs to support States and Territories to test and trial the models of care they want to implement to improve patient experience and health outcomes. IHPA needs to set proportionate data submission requirements for States. Western Australia accepts the need to provide data to the IHPA in support of their work in this area, but the IHPA's requirements need to be streamlined to incentivise States to pursue innovative funding models. IHPA's remit in setting incentives that encourage better health outcomes and patient experience needs to be established within its current legislated scope.

What innovative funding models are states and territories intending to trial through bilateral agreements under the Addendum?

WA continues to investigate the low value care in conjunction with Curtin University and at the right opportunity will report back on progress and findings.

Are there other factors that IHPA should consider in its analysis to determine which patient cohorts or ADRGs are amenable to certain funding models?

External environmental and/or geospatial factors have been suggested as worth considering. For example, living close to industrial/commercial/high traffic areas, area population density, location/access/density of primary or other healthcare services including the ratio of GP and nurse practitioners to a local demographic, public transport access, education level and health literacy. Additionally, IHPA could investigate public health factors with correlation to patient cohorts. For example, BMI, blood pressure, diet, exercise and recreational drug use.

What other strategic areas should IHPA consider in developing a framework for future funding models?

A strategic area that IHPA should consider is a funding model that integrates primary healthcare which could assist with reducing the divide between primary and tertiary care. Consideration for initiatives that demonstrate investment in evidence-based research and primary health care partnerships will ensure the sustainability and relevance of future funding models.

Where clinical care standards are available, it would be interesting to look at funding the bundle of care instead of individual procedures. The CAR-T example is a case in point where the therapeutic agent is one (costly) component, but not the only cost driver and there is often a lot of un-costed in kind support if patients who were screened but not eligible, are included. In addition, the pre and post-operative care components which would improve outcomes and recovery times, are important cost drivers.

Consultation Question - Apart from the IHI, what other critical success factors are required to support the implementation of innovative funding models?

WA supports the discussion of valid evidence-based innovative funding models which have shown to improve patient health outcomes and/or improve health system efficiencies. WA would hope that any innovative funding model would lead to a reduction in the financial burden to tax payers and/or improvement in understanding of cost per service/s.

Pricing and Funding for Safety and Quality

Avoidable Hospital Readmissions

Consultation Question – Do you support IHPA's proposed pricing model for avoidable hospital readmissions, under funding option one at a jurisdiction scope level?

On a fundamental level, WA agrees that decreasing avoidable hospital readmissions will lead to better patient health outcomes. However, there are concerns that avoidable hospital readmissions are targeting the same/overlapping conditions with hospital acquired complications. Local Health Networks and other relevant stakeholders may have the unintended perception of an IHPA double-setback for the same condition/s.

The cross over is understood to be minimal however it has been suggested that other options should be explored such as allowing for positive incentives (such as a financial reward) as opposed to a negative financial penalisation.

WA would welcome an evidence-based approach in light of the article presented at the IHPA Advisory Committees in 2019 re: *Hospital Readmissions Reduction Program, New England Journal of Medicine* where it is understood that financial disincentives for hospital readmissions could cause unintended consequences. Additionally, the article recommends using a progressive program that improves patient care as opposed to a regressive financial penalty. Given the context of this article, what further considerations have IHPA taken into account for Avoidable Hospital Readmissions? Whilst WA notes the practicality of implementing Option 1 (deduct the cost of the readmission episode from the index episode), LHNs have indicated a preference for Option 3 (adjust funding at hospital level where actual rates of avoidable readmissions exceed expected rates of avoidable readmissions).

Are there any refinements to the risk adjustment model and risk factors that IHPA should consider?

WA considers the risk factors to be comprehensive however would like to suggest consideration of the following:

- What is avoidable in metropolitan Perth or Sydney is different to what is avoidable in rural and remote areas because it is also a reflection of what community or hospital in the home programs are available.
- Sociodemographic factors - refinements could potentially look at consideration of the accommodation status of the patient and whether there is a home or stable environment on their release from hospital. Other sociodemographic risk factors include patients from Culturally and Linguistically Diverse Background including refugees. Hospitals with a high proportion of patients in these cohorts who could be predicted to be at higher risk of re-admission, may be unfairly disadvantaged.

- Additional clinical factors
    - Advanced neoplastic disease should feature as a risk factor e.g. terminal cancer results in quickly developing pressure injuries.
    - Oesophageal cancers may contribute to aspiration pneumonia.

- Paediatric specific factors

  It should be noted that there is a range of factors specific to paediatric patients which should be recognised in the risk adjustment model. Whilst age group is considered as a risk factor in the readmission categories, it is not clear how this will impact the risk adjustment model. It has been suggested that the use of Rhee score instead of Charlson score would account for the paediatric factors and therefore be a preferred risk factor ranking. Additionally, congenital paediatric conditions while

appearing similarly in DRGs to adult conditions often have a significant difference in treatment, outcomes and complications that are not related to quality of care.

Some examples of these variations between adult and paediatric cohort are provided below:

- Surgical Site infections – 30 days post appendectomy wound infection rates

  Wound infection rates are higher in patients with perforated appendicitis. Children have a higher perforated appendicitis rates than young adults. This is due to pre-hospital reasons. Penalising paediatric hospitals for this condition which is beyond their control is not in line with the outcomes endeavoured to achieve with this model.

- Pain Following Surgery – 14 days

  Pain in the paediatric age group has complex underlying aetiologies. Part of the contributing factors to pain is separation anxiety and fear of new environments. This has led to clinically driven decreased Length of Stay. Sometimes the analgesic regimes fail, and patients require readmission. Parental anxiety in managing pain is a known factor in readmission, parents are encouraged to represent with pain management concerns with children under 5 years old and hence a family's inability to cope in this situation should not negatively impact on hospital funding.

- Readmission Following Neonatal admission

  The most common reason for neonates to be readmitted to hospital after discharge is for repair of inguinal hernia. If these are identified in hospital, then repair is done immediately before discharge. Presentation with hernia's after discharge is not related to clinical care but is a normal pathological condition.

- Thoracotomy in Neonatal patients

  Neonatal patients having thoracotomy need to be handled multiple times per day and by necessity are prone to more wound infections or wound dehiscence.

- Other surgical complications – 28 days tonsil readmission

  Paediatric patients post tonsillectomy and their parents are encouraged as part of discharge planning to represent with any pain, failure to eat and drink and any level of bleeding that causes parental concern. Readmission is often observed in case of families with complex social histories and complex comorbidities. As such readmission is not related to post-surgical bleeding requiring surgical arrest but due to family's inability to manage the pain relief regimes for their young child. There is a risk that by not funding readmissions for tonsillectomy, organisations will be incentivised not to admit children who could go on to have a catastrophic tonsillar bleed and result in preventable mortality.

What additional aspects does IHPA need to consider when implementing a funding adjustment for avoidable hospital readmissions?

WA has identified the following issues for consideration:

- The proposed use of the Medicare PIN for data linkage has been identified as a potential risk, as Medicare numbers are not always available or recorded for categories of patients including overseas, on reciprocal health care agreements, or compensable patients.
- A process to reverse the funding adjustment should be incorporated into the model in case a hospital readmission is found not to be avoidable.
- As mentioned earlier, readmission rates will be impacted by social disadvantage, poor health literacy, multiple morbidities, socioeconomic status, housing or accommodation and chronic disease. These issues which are rarely within the hospital's ability to control and are primarily impacted by the quality of care provided in primary care sector, are not in scope.