# Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022-23

## Northern Territory Submission

NORTHERN TERRITORY GOVERNMENT

# 1. Foreword

This submission provides feedback on issues highlighted in IHPA's *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022-23*, 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.

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.

# 2. Impact of COVID-19

**Consultation question/s or issue**

- What feedback do you have on IHPA's proposed approach for using 2019-20 cost and activity data to assess the short term activity and potential pricing impacts of COVID-19 on NEP22?
- Are there any recommendations for how IHPA should account for COVID-19 in the coming years?

NT Health notes that future pricing periods (commencing from NEP22) may be impacted as costing data from the COVID period is reported and included in the pricing model. As with all jurisdictions, NT has experienced a significant impact to service delivery costs associated with the pandemic. This includes reductions in hospital capacity to ensure safe distancing from suspect COVID patients as well as maintain readiness in case of an outbreak. This has led to a general increase in average episode cost across admitted and emergency settings. NT Health notes that some cost impacts due to ongoing service redesign may not be evident in 2019-20 cost data as they became prominent in 2020-21. These impacts are expected to continue in the near term.

NT Health supports IHPA's intended review of the short and long term impact of COVID-19 on patient complexity and costs. NT Health recommends IHPA prioritise addressing under-pricing in previous and current periods to ensure appropriate funding and use learnings to determine corrective measures for future periods. Hospital services are likely to be currently under-priced as they do not account for COVID-related cost pressures which were not reflected in data that informed previous NEP Determinations. NT Health recommends that IHPA work with jurisdictions to determine mechanisms to retrospectively account for price variations as required under clause 37(d) of the National Partnership on COVID-19 Response.

# 3. The Pricing Guidelines

**Consultation question/s or issue**

- IHPA has reviewed the Pricing Guidelines again in 2021 and considers that further amendments are not required.

NT Health recommends that IHPA introduce the following system design guideline:

> ***Promoting equitable access:*** *Pricing should support funding solutions that facilitate equitable access to healthcare.*

NT Health notes that existing adjustments in the national pricing model are designed to reflect the legitimate and unavoidable additional cost of treating particular population such as Indigenous people and those that live in remote areas. NT Health recommends IHPA review its system design guidelines to ensure that current and future funding models address inequities in health status that exist for disadvantaged population groups by promoting and incentivising improved access to healthcare.

For instance, NT Health notes that Indigenous people face significant barriers to accessing effective healthcare services, including a lack of cultural safety, and communication and language barriers between staff and the patient. NT Health note that introducing this system design guideline would facilitate equitable access to healthcare by enabling pricing mechanisms to reduce these barriers, e.g. identifying appropriate pricing to support tailored service delivery that responds the health needs important to Indigenous people.

# 4. Classifications used to describe and price public hospital services

## 4.1. Standard development cycles for all classifications

**Consultation question/s or issue**

- Do you support the proposal to establish standard development cycles for all classification systems?
- Is there a preferred timeframe for the length of the development cycle, noting the admitted acute care classifications have a three-year development cycle?
- Do you have any feedback on what measures should be standard as part of the review and development of an updated version of an established classification?

NT Health recommends that IHPA not only consider timeframe for classification development cycles, but also include the following standard review and development measures/considerations:

- **Undertake materiality and impact assessments to determine whether to proceed with a new version:** This will ensure development work balances the clinical relevance of the classification with stability and potential for unintended consequences. Materiality assessments should include consideration of the extent to which new classification versions address shortcomings including the ability to account for chronic illness.

- **Stagger development across classification types**: Subject matter experts are generally the same across care types, particularly in small jurisdictions such as the NT. Staggering will ensure stakeholders can comprehensively engage with issues.

- **Communicate early and provide education.** IHPA's classification working groups engage only a small number of stakeholders at the early stage of development. While public consultation provides opportunity for wider input, this occurs at a late stage of development when draft decisions have already been made. Consulting earlier with accompanying education will ensure a wide range of stakeholders can provide input on key issues.

- **Review the impact of changes to the Australian Coding Standards and National Coding Rules**: IHPA should ensure it evaluates how changes in coding practices impact the data used as the basis for classification updates. This is given data used may not always reflect current coding standards

and rules. For instance, datasets used to test AR-DRG Version 11.0 and AN-SNAP Version 5.0 do not reflect coding practice changes following 2019-20 revisions to Australian Coding Standard (ACS) 0002 Additional Diagnoses, which incorporated more stringent requirements for recording additional diagnoses.

## 4.2. Admitted acute care

**Consultation question/s or issue**

- It is anticipated that AR-DRG Version 11.0 will be used to price admitted acute patient services for the NEP Determination 2023-24

**Using AR-DRG Version 11.0 to price for NEP23**

NT Health notes that IHPA will provide a statement of impact as required under the National Health Reform Agreement. NT recommends that IHPA's statement of impact include the funding impact at the jurisdictional level to identify any potential funding impacts as a result of introducing AR-DRG Version 11.0 without shadow pricing.

**Technical issues**

NT Health notes that IHPA undertook a review of codes that contribute to episode complexity as part of developing AR-DRG Version 11.0. NT Health notes that IHPA proposes to exclude diagnosis code *M62.50 Muscle wasting and atrophy* from the AR-DRG complexity model on the basis that this code is manifested through diseases classifiable elsewhere.

NT Health does not support exclusion of the diagnosis code *M62.50 Muscle wasting and atrophy* as this code is associated with various additional resourcing requirements such as physiotherapy and dietetics. NT Health notes that this code is associated with clinical status "deconditioning", which is not always manifested through other conditions.

## 4.3. Subacute and non-acute care

**Consultation question/s or issue**

- Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP22?

**Using AN-SNAP Version 5.0 to price for NEP22**

NT Health does not support pricing admitted subacute and non-acute services using AN-SNAP Version 5.0 for NEP22. NT Health recommends that IHPA shadow price AN-SNAP Version 5.0 for NEP22.

NT Health considers that the introduction of a frailty risk score to determine episode complexity in AN-SNAP Version 5.0 represents a major structural change to the classification. Consistent with IHPA's *Alterations to the National Pricing Model Framework*, a shadow pricing period should be used to ensure that changes do not result in any unintended financial consequences.

In particular, NT Health considers that there is a risk that the updated classification may incorrectly assign complexity. This is noting that conditions tested as informing frailty may now be coded far less frequently because they no longer meet coding requirements following revisions to ACS 0002 Additional Diagnoses. NT Health recommends that IHPA analyse 2019-20 datasets to assess the impact of these coding standard revisions on the Frailty Risk Score methodology during the shadow pricing period.

## 4.4. Non-admitted care

**Consultation question/s or issue**

- How can IHPA support state and territory readiness for recommencing the non-admitted care costing study?

NT Health has limited resources available due to increasing competition to attract and retain a skilled workforce and as such would appreciate any additional support for our participating sites to ensure limited disruption to service delivery. Such support may include financial support or provision of resources to undertake data capture and submission requirements of the costing study.

NT Health also notes that there may be short term and ongoing changes to service delivery particularly in the non-admitted setting due to the COVID-19 pandemic. NT Health request that IHPA first undertake an analysis to determine key priority areas for development to ensure that the classification captures services required for pricing.

## 4.5. Mental Health Care

**Consultation question/s or issue**

- Are there any impediments to pricing admitted and community mental health care using AMHCC Version 1.0 for NEP22?

**Admitted Mental Health Services**

NT Health does not agree to proceed from shadow pricing to pricing of admitted mental health care using AMHCC Version 1.0.

NT Health has identified the following impediments during the shadow pricing period:

- **Potential to unfairly penalise regional and remote areas:** IHPA's cost ratio analysis has shown that regional and remote areas are under-priced under the AMHCC, even after incorporating adjustments[1]. This results in NT and other jurisdictions with significant remote populations being substantially penalised under the AMHCC compared to the current AR-DRG model. Further analysis is required to ensure that ABF payments are fair and equitable, and properly reflect legitimate and unavoidable costs of service delivery in line with the Pricing Guidelines.

- **Potentially inaccurate pricing:** NT Health considers that the AMHCC shadow prices may not be sufficiently accurate given year on year changes in shadow price weights show significant volatility. NT Health notes this could potentially be driven by inadequate coverage of the patient service category, given one-third of national admitted mental health records had an unknown Mental Health Phase of Care reported in 2018-19. Further analysis is required to understand how current data reporting represents jurisdictions and how this might impact price accuracy.

NT recommends that IHPA continue to shadow price AMHCC Version 1.0, noting that further analysis and review is required to ensure stability and accuracy of pricing. This includes data quality assessment, activity monitoring and funding impact analysis.

[1] IHPA 2020. 'Update on pricing mental health care for 2021-22', *Technical Advisory Committee, 7 October*

**Community Mental Health Services**

NT Health does not agree to shorten the shadow pricing period for community mental health care using the AMHCC Version 1.0. NT Health notes that above concerns relating to admitted mental health also apply to community mental health. NT Health therefore recommends that IHPA continue shadow pricing the classification for NEP22. IHPA should not shorten the shadow pricing period if it does not obtain agreement from a majority of states and territories, as required by Clause A42 of the NHRA Addendum.

# 5. Setting the national efficient price

## 5.1. Adjustments to the NEP

### 5.1.1. Patient travel

**Consultation question/s or issue**

- What costs associated with patient transport in rural areas are not adequately captured by existing adjustments within the national pricing model?

NT Health notes that IHPA's analysis of patient travel costs as part of the development of NEP21 found that existing remoteness adjustments in the national pricing model do not adequately capture the cost of patients transferred between hospitals in the NT.

NT Health notes that there is significant variation in costs for inter-hospital transfers and medical evacuations across and within remoteness categories. These costs cannot be homogeneously grouped using remoteness indicators. NT Health notes that currently, only proxies are available to classify patient travel and additional data items would need to be developed. NT Health considers that patient travel is not technically feasible for ABF given patients cannot currently be classified into resource-homogenous groups that take into account travel status and distance travelled.

NT Health recommends that travel costs be block funded while data development work is progressed. NT Health looks forward to working with IHPA to develop a block funding approach to ensure that patient travel costs are appropriately funded.

### 5.1.2. Specified intensive care unit eligibility criteria and adjustment

**Consultation question/s or issue**

- What factors should IHPA consider in reviewing the Specified Intensive Care Unit eligibility criteria and adjustment?

**Adjustment review**

NT Health notes that the ICU price adjustment factor should reflect costs of the numerous activities that occur in the ICU setting. This includes higher costs associated with mechanical ventilation, non-invasive ventilation, increased medical and nursing staffing ratios and continuous renal replacement therapy.

**Eligibility criteria**

NT Health welcomes IHPA undertaking a review of the ICU eligibility criteria. NT Health notes that the current eligibility criteria is based on total ICU hours and mechanical ventilation hours. NT Health

recommends that the role of mechanical ventilation in determining ICU eligibility should be reviewed. This is noting that changes in ICU service mix may have occurred over time to reflect contemporary clinical practice and better cater for patient experience, while still carrying high cost. For example, mechanical ventilation may have reduced over time in favour of non-invasive ventilation noting that this may lead to improved patient outcomes[2]. Furthermore, the ICU eligibility criteria should take into account other high cost treatments provided in the ICU setting, such as continuous renal replacement therapy.

## 5.1.3. Indigenous adjustment

**Consultation question/s or issue**

- What factors should IHPA consider in reviewing the Indigenous adjustment?

NT Health recommends that IHPA's review of the Indigenous adjustment include consideration of the disparity in hospital care and services faced by Indigenous people. NT Health notes that Indigenous people experience high rates of premature mortality and chronic disease burden.[3] Driving better health outcomes for this vulnerable cohort requires equitable access to effective hospital services.

NT Health notes that Indigenous people face significant barriers in accessing effective healthcare services. These barriers include a lack of cultural safety, distrust of the health system, and communication and language barriers between staff and the patient. The Indigenous adjustment in the NEP ensures public hospitals can help address these issues through providing supports such as:

- Accredited interpreter services and clinical staff training to address language barriers.
- Incorporating Aboriginal liaison officer and Aboriginal health practitioner teams as a key component of care to improve trust and help create a feeling of cultural safety for patients.

NT notes there are opportunities for reform to develop a strategic approach to improve the responsiveness of hospitals to the health needs of Aboriginal and Torres Strait Islander people. NT Health recommends that IHPA investigate incorporating an incentive based adjustment into the national funding model. This will provide a mechanism to help further address access barriers by improving the ability for hospitals to tailor service delivery to respond to health needs that are important to Indigenous people. This would align with the proposed system design guideline to promote equity of access.

## 5.1.4. Genetic services and socioeconomic status

**Consultation question/s or issue**

- What evidence is there to support increased costs for genetic services or socioeconomic status?

NT Health recommends that IHPA investigate whether area-based measures such as those used by the Commonwealth Grants Commission (CGC) are suitable to support review of the impact of socio-economic status on service delivery costs. NT Health notes that the CGC uses separate measures for Indigenous and non-Indigenous people to recognise the influence of socio-economic status on healthcare costs, separate

[2] New South Wales Agency for Clinical Innovation 2014. *Non-invasive Ventilation Guidelines for Adult Patients with Acute Respiratory Failure*
[3] Australian Institute of Health and Welfare 2016. *Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011*.

to other cost factors such as remoteness[4]. This is noting that socio-economic indices based on the whole population in a given areas may not reflect the status of Indigenous people.

IHPA may wish to investigate whether the following area-based indices enable appropriate classification, in addition to other characteristics such as remoteness:

- Indigenous Relative Socioeconomic Outcomes index (developed by the Australian National University)

- Non-Indigenous Socioeconomic Index for Areas (developed by the Australian Bureau of Statistics)

In addition to socio-economic status, NT Health recommends that IHPA consider the influence of homelessness on the costs of service delivery. For instance, homeless patients in the NT often experience extended inpatient lengths of stay as a lack of housing and familial supports places these patients at additional risk of clinical deterioration post-discharge and outpatient care attendance is likely to be poor.

## 5.2. Harmonising price weights across care settings

**Consultation question/s or issue**

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

IHPA should carefully review clinical practices across jurisdictions to ensure that services delivered across different settings can be appropriately classified into resource-homogenous groups. NT Health is concerned that harmonisation may inappropriately group patients where services differ.

NT Health recommends that chemotherapy price harmonisation should not proceed until further analysis is undertaken on how services differ varies across jurisdictions and service settings. For instance, chemotherapy patients in the NT are predominantly admitted when they require intravenous delivery of medications and additional monitoring by clinical staff. Comparatively the non-admitted setting is generally reserved for low-complexity oral delivery of medications. Complexity in the admitted setting could be differentiated using ACHI procedure codes such as *96199-00 Intravenous administration of pharmacological agent, antineoplastic agent* and *96203-00 Oral administration of pharmacological agent, antineoplastic agent*.

NT Health also recommends applying transitional arrangements and price stabilisation in circumstances where price harmonisation is deemed appropriate.

## 5.3. Unqualified newborns

**Consultation question/s or issue**

- What factors should IHPA consider in investigating whether methodology changes are required for funding unqualified newborns?

NT Health recommends that IHPA consider implementing an adjustment for specialist medical/nursing services provided to unqualified newborns. NT Health notes this could be achieved by identifying neonate and congenital ICD-10-AM diagnosis codes relating to specialist treatments. In the NT, common diagnosis codes recorded for unqualified newborns includes *P92.8 Other feeding problems of newborn* (nurse lactation

[4] Commonwealth Grants Commission 2020. *Report on GST Revenue Sharing Relativities 2020 Review — Volume 2 (Part B)*

consultant attendance) or *Q38.1 Ankyloglossia* (surgical treatment for tongue-tie). NT Health notes that a price adjustment could potentially operate in the same way as existing treatment-based adjustments for dialysis and radiotherapy.

## 5.4. Setting the national efficient price for private patients in public hospitals

### 5.4.1. Private patient funding neutrality

**Consultation question/s or issue**

- For NEP21, IHPA implemented an updated private patient methodology that ensures financial neutrality and payment parity with respect to all patients, regardless of whether patients elect to be private or public.

NT Health looks forward to continuing to work collaboratively with IHPA and the National Health Funding Body to understand how its private patient methodology will operate in practice, as well as expected Commonwealth funding implications.

### 5.4.2. Private patient correction factor

**Consultation question/s or issue**

- Are there any objections to IHPA phasing out the private patient correction factor for NEP22?

NT Health recommends that a comprehensive review of national private patient cost reporting be undertaken as part of the Independent Financial Review (IFR) process to provide assurance on IHPA's decision in relation to the removal of NT private patient costs for NEP21 and to support a decision on the national phase-out of the private patient correction factor. NT Health notes that IHPA removed the private patient correction factor for the NT in NEP21 despite a recommendation that this decision be deferred until such a review could be undertaken.

# 6. Setting the national efficient cost

**Consultation question/s or issue**

- A low volume threshold is used to determine whether a public hospital is eligible to receive block funding.

NT Health recommends that IHPA develop a separate low-volume threshold for block funding eligibility of very remote facilities. NT Health notes that there are currently two thresholds, one for hospitals in major cities and another for facilities in all other areas. NT Health considers that it is appropriate for very remote facilities to be subject to an eligibility threshold separate from facilities in regional areas. This is noting that additional cost pressures faced by very remote facilities makes it more difficult to achieve economies of scale required for the ABF model to be suitable. For example, block funding of Gove Hospital has continued to be suitable given its legitimate and unavoidably high cost profile due to its remoteness. This is despite exceeding IHPA's low volume threshold for several years.

# 7. Future funding models

**Consultation question/s or issue**

- What other considerations should IHPA have in investigating innovative models of care and exploring trials of new and innovative funding approaches?
- What innovative models of care or services are states and territories intending to trial for NEP22?

NT Health recommends that IHPA consider the following when exploring innovative models of care and funding approaches:

- **Jurisdictional variation and barriers:** Future funding models should account for the different clinical pathways and care cost drivers that exist across jurisdictions. In particular, funding models must be sufficiently flexible to adapt to varied access and cultural needs.

- **Funding stability:** IHPA should compare alternate funding models to the existing ABF model to identify and address any potential risk of under-funding.

- **Primary care interface:** Funding models should consider the critical role of primary care access in improving continuity of care and avoiding hospitalisation. In particular, any risk sharing/incentive implicit in funding models should appropriately reflect the Commonwealth's responsibility in ensuring access to an adequate level of primary care services.

# 8. Pricing and funding for safety and quality

## 8.1. Evaluation of safety and quality reforms

**Consultation question/s or issue**

- What should IHPA consider when developing evaluation measures for evaluating safety and quality reforms?

NT Health notes that the introduction of funding penalties for sentinel events, hospital acquired complications and avoidable hospital readmissions has increased the complexity of the national funding model. NT Health recommends that evaluation measures assess whether safety and quality penalties have achieved the following:

- Improved patient outcomes.

- Incentivised providing the right care, in the right place, at the right time.

- Decreased avoidable demand for public hospital services.

- Created signals in the health system for the need to reduce instances of preventable poor quality patient care, while supporting improvements in data quality and information available to inform clinicians' practice.

NT Health recommends that IHPA's evaluation consider the impact of the following:

- Existing processes or programs implemented by state and territory health authorities. For instance NT Health rolled out an escalation system called "REACT" in 2018-19. This program provides a mechanism by which patients, carers and families are encouraged to escalate concerns if they notice something is not right. This program has helped to empower patients and families as partners working in collaboration with health care providers to drive safety and quality outcomes.

- Clinician awareness and response to penalties. This will enable an assessment of a direct causal link between funding penalties and clinical performance.

- Other extenuating factors which may impact safety and quality outcomes e.g. COVID-19.

## 8.2. Avoidable and preventable hospitalisations

**Consultation question/s or issue**

- What pricing and funding approaches should be explored by IHPA for reducing avoidable and preventable hospitalisations?
- What assessment criteria should IHPA consider in evaluating the merit of different pricing and funding approaches for reducing avoidable and preventable hospitalisations?

NT Health recommends that any pricing or funding approaches for avoidable and preventable hospitalisations must be informed by evaluation of existing price adjustments to ensure they result in positive and consistent behavioural changes. For example, any new pricing or funding approaches for safety and quality should not be introduced if existing adjustments are shown to have introduced unnecessary financial penalty.

NT Health recommends that IHPA should also take into account the following when considering pricing and funding approaches for avoidable and preventable hospitalisations:

- **Direct preventability:** Hospitalisations should not be considered preventable if they are not within the direct control of LHNs. For instance, NT Health notes that Hepatitis B is considered a vaccine-preventable condition. However, a significant number of hospitalisations for patients with Hepatitis B are not preventable as the vaccine was not widely available before 2000.

- **Primary care interface:** IHPA should consider the level of access to primary care services at the local level when determining whether hospitalisation is preventable. NT Health notes that improvements to service access in remote Indigenous communities is a key reform area for the Commonwealth under the Addendum.