Pricing Framework for Australian Public Hospital Services 2022-23

Department of Health Submission to the IHPA

Queensland Health (QH) welcomes the opportunity to provide feedback on the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022–23* (the Framework), released on 9 June 2021 by The Independent Hospital Pricing Authority (IHPA) for public feedback.

In order to provide representative feedback on the Framework, the Department of Health consulted with all areas of QH including the department's divisions and 16 Hospital and Health Services (HHSs). HHSs were advised that feedback can also be provided directly to IHPA.

QH responses to the questions included in the consultation paper on the Framework, are below. QH has provided additional comments at the end of the submission in relation to areas not specifically referenced in the consultation paper on the Framework.

1. *What feedback do you have on IHPA's proposed approach for using the 2019–20 cost and activity data to assess the short term activity and potential pricing impacts of COVID-19 on NEP22?*

The assertion that three months of 2019-20 cost and activity data has been impacted by the Coronavirus Disease 2019 (COVID-19) is not correct. Queensland HHSs have stated that COVID-19 pandemic effects were seen in activity data as early as January 2020, therefore examining the first nine months, or final three months, of 2019-20 will not yield a complete cost profile. QH considers that the entire period from January 2020 to June 2020 was affected by the impact of COVID-19.

It would seem appropriate to complete analysis of the 2019-20 activity and National Hospital Cost Data Collection (NHCDC) data, before developing specific proposals for consultation with jurisdictions, as to what data to use for the 2022-23 National Efficient Price (NEP) determination, if any at all.

QH supports IHPA's intention to undertake specific costing studies to estimate the impacts that the factors described in the Framework are likely to have on costs in 2020-21 as this issue will also be a significant challenge for the 2023-24 NEP determination.

2. *Are there any recommendations for how IHPA should account for COVID-19 in the coming years?*

COVID-19 and its complications must be recognised as long term, chronic conditions. Consideration should also be given to the pricing and costing implications for the sustained pressure expected on demand for mental health services as an ongoing result of COVID-19.

There needs to be an acknowledgement that suspected COVID-19 patients may have a higher cost related to Personal Protective Equipment (PPE) and other resource costs as these patients have been treated as if diagnosed with COVID-19. This may not be consistently managed across jurisdictions.

The consequences of COVID-19 impact not only on direct patient services but also on the supply chain for critical consumables. For example, sterilisation wraps which are made of the same raw material as surgical masks, were in high demand during the pandemic. The key supplier invested more of this raw material into mask production in 2019-20 which resulted in supply shortfalls for the manufacture of sterilisation wraps. This has several flow on impacts, the most significant being a planned reduction in surgery, with the scarcity of sterilisation wraps meaning that QH cannot 'ramp up' or increase activity to address the full extent of wait lists created due to the delay of elective surgery. QH recommends that the use and availability of PPE, including the mark up and write down of supply chain over the course of the 2019-20 to 2021-22 years is considered in the development of the NEP, and explicitly address the interaction with the Commonwealth's supply and funding of PPE above the 'normal' use pre-COVID-19.

QH recommends that IHPA also reviews pricing for virtual care (including evolving models of care such as email, telephone and video modalities) to ensure it reflects the resources required to effectively deliver care in this form. Questions to be considered include:

- Is it appropriate to maintain provider centric pricing for recipient-end telehealth or move to specialty specific pricing for all telehealth services?
- Should modality pricing for non-admitted services be refined? For example, under the National model, telephone consultations are considered equivalent to face to face consultations, however it is accepted that telephone consultations have the potential for lower non labour costs than face to face consultations and their increasing use may dilute the price of face to face consultations increasing pressure of healthcare delivery and resource management.

3. *Do you support the proposal to establish standard development cycles for all classification systems?*

A standard development cycle would be helpful in ensuring currency of the classification. However, this may need to be varied with regard to expected major versus minor updates, with more lead time being allocated to expected major classification changes.

A staggered implementation cycle with admitted and non-admitted classification changes occurring in separate years would spread the load for jurisdictional system updates and training across the years. This would also provide IHPA with more time to ensure that issues with groupers etc are resolved before release.

Ideally, new / significantly changed classifications should be available (with grouper support and draft weights) approximately 12 months before scheduled implementation (similar to the upcoming Australian Mental Health Care Classification (AMHCC) implementation) to enable a sufficient shadow period for evaluation.

4. *Is there a preferred timeframe for the length of the development cycle, noting the admitted acute care classifications have a three-year development cycle?*

A three-year cycle for established classification systems seems acceptable, including a staggered implementation for different classifications. There does however need to be a degree of flexibility built in the schedule to allow for unexpected updates / changes outside of cycle.

5. *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?*

QH supports the implementation of 'placeholder' codes during the identification of emerging diseases and interventions.

Changes to established classifications should be driven by changes to clinical practice, the cost of service delivery and / or evolving new technologies. It should be noted that the introduction of a new clinical treatment might introduce a radical change in the resource usage associated with management of the patient, sufficient to be regarded as a significantly different treatment from a clinical perspective. However, the overall cost might still remain similar which should not negate the requirement for a change in the classification.

QH also expects that any future changes to Australian Coding Standards are only introduced to the classifications used for pricing after there has been dual coding and significant sampling of these changes, and including the flow on implications across the prior years for certainty of the back cast application. Any introduction of changes is to be transparent and reported through the IHPA Technical Advisory Committee (TAC) and Jurisdictional Advisory Committee (JAC) well in advance of changes being introduced, including the assessment of complexity changes.

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

QH recognises there has been variable feedback from clinicians regarding the introduction of a frailty measure to the classification. However, QH believes the introduction (into the Geriatric Evaluation and Management (GEM) and non-acute care types) of a frailty measure utilising data that is already collected within the patient episode is a reasonable step towards increasing the inputs into the classification.

It is acknowledged that there is no clear, universally endorsed definition of frailty and the use of a scale to assess the risk of frailty is different from an actual measure of frailty. As such, QH would support the continued efforts of IHPA to work in consultation with Geriatricians to agree the suitable measures that could further refine and validate the proposed frailty measure for Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 5 into future classification updates. Clinician input and support is vital to this process.

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

There is already an administrative burden on health services which must be acknowledged. However a key consideration for recommencing the non-admitted care costing study is whether the non-admitted activity across health services has 'normalised' following the pandemic.

Many services have adapted since the pandemic, to incorporate more virtual care and telehealth options, particularly for vulnerable or immobile patients.

Another consideration would be whether IHPA could support a parallel automated data collection for the costing study as it is noted that information systems have evolved since the implementation of the Tier 2 Non-admitted Services Classification (Tier 2). As a first step IHPA should assess whether jurisdictions can provide and support data differently, and the extent to which clinical and administrative systems and platforms can be used to link information that might support a different classification.

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

QH does not consider the Australian Mental Health Care Classification (AMHCC) fully developed and therefore able to transition to full pricing for admitted services for NEP22. One of the major issues being that the phase of care remains unsupported by mental health clinicians. As the phase of care continues to be refined, the classification should continue to be shadow priced.

Significant issues also remain regarding stand-alone, block funded facilities versus acute facilities, with vastly different patient profiles and length of stay, not accounted for in the classification. Further comments in relation to this topic are provided for question 17.

The bundling process used in the classification does not consider that multiple mental health teams based in different facilities may treat the same patient during the same period. At a State level this may work for a payment model once all costs are attributed and accounted from cross HHS services to the right patients but fails the ability to implement within the State. Calculations on payments are made to the HHS based on the location of the patient and their National Weighted Activity Unit (NWAU) calculation, not a distribution of NWAU for each source team providing care that may be across multiple HHSs. This may be a specific issue for Queensland, but further analysis is required across all jurisdictions to confirm the methodology of attribution of costing for forensic services and other statewide specialist mental health services.

The costing of services outside of the admitted patient component is still relatively new and although all jurisdictions, except for the Northern Territory, submitted mental health care activity data for the community setting in 2018-19, this data remains not sufficiently robust to commence shadow pricing. This is evidenced in the IHPA TAC papers from 5 November 2020, which shows that nationally only 29 per cent of mental health phases were costed.

QH reiterates its position that community mental health services cannot be considered for shadow pricing until all jurisdictions are in agreement the model is robust and consistent nationally.

As raised in the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021*–22, there is also the need for enhanced alignment between the requirements for the AMHCC and the underlying / source data used by the AMHCC. For example, there is a disconnect between the AMHCC requirements and the base protocol for the National Outcomes and Casemix Collection, which is a key source of data supporting the AMHCC.

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

There are considerable additional costs that are not adequately captured by existing adjustments within the national pricing model. The reinvestigation of an adjustment for patient transport in rural areas would present an opportunity to consider what other data can be collected to inform rural models of care and service delivery. To transfer patients for care in rural and remote areas requires the use of chartered flights, both fixed wing and helicopter and includes the resources of the Royal Flying Doctor Service (not emergency evacuations).

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

The recognition of Intensive Care Units (ICU) and the minimum standards for these are available on the College of Intensive Care Medicine of Australia and New Zealand resources IC-1-Minimum-Standards-for-Intensive-Care-Units.pdf (cicm.org.au) and as such where a hospital meets these requirements the ICU should be recognised. Jurisdictions already provide the data elements to report ICU hours where care has been provided in these centres and it is recommended that the IHPA Clinical Advisory Committee consider the suitability of this approach, without the reliance on mechanical ventilation hours.

11. What factors should IHPA consider in reviewing the Indigenous adjustment?

IHPA currently applies a multivariate least squares weighted regression model to estimate the extent to which the variation in the mean cost per weighted episode is explained by each adjustment factor.

For 2020-21 this resulted in a four per cent Indigenous adjustment being applied to admitted acute, admitted subacute, emergency department and non-admitted patient episode flagged as eligible via a patient's Indigenous status being recorded as of Aboriginal and / or Torres Strait Islander origin.

However, admitted First Nations people are much more likely than non-Indigenous Australians to leave hospitals without completing treatment, with the most recent reporting by the Australian Institute of Health and Welfare pointing to the age-standardised proportion of First Nations Australians leaving hospital against medical advice or being discharged at their own risk being six times as high in comparison to non-Indigenous Australians (three per cent compared with 0.5 per cent). (Source: https://www.aihw.gov.au/reports/indigenous-australians/cultural-safety-health-care-framework/contents/module-2-patient-experience-of-health-care)

With the shortened average length of stay of First Nations patients compared to other Australians the inclusion of these abbreviated patient episodes is likely to be pulling down the Indigenous adjustment.

Accordingly, IHPA is requested to investigate this factor to ensure it is not distorting the Indigenous adjustment, with the affect also likely to be impacting First Nations emergency department patients who are recorded as 'Did not wait' or 'Left at own risk after treatment commenced'.

QH also suggests that IHPA examine the additional cost of Aboriginal and Torres Strait Islander (ATSI) Health Practitioners in the delivery of care to First Nations people. ATSI Health Practitioners are contributing to Closing the Gap in Queensland through the delivery of culturally safe and accessible clinical services. The profession is a vital workforce that is culturally and clinically capable, and effectively positioned to meet the health needs of individual First Nations peoples and communities.

All states and territories acknowledge the importance of Closing the Gap initiatives and are actively investing in strategies to improve health equity for First Nations people. There is specific funding recognised in the QH budget for indigenous health care activities, for example the highlights for 2021–22 include:

- Additional funding of $37.8 million over 2 years from 2021–22 to support implementation of the Growing Deadly Families Aboriginal and Torres Strait Islander Maternity Services Strategy 2019–2025, provided funding to support the development of First Nations Health Equity Strategies across the 16 HHSs, to uplift First Nations workforce training and capacity, and to embed the Institute for Urban Indigenous Health Connect Plus program in South East Queensland.

It would be beneficial to explore whether the investment in indigenous health programs and prevalence of ATSI Health Practitioners is reflected in the cost of service delivery for this cohort of patients; if so, the national adjustment should be reflective of these specific contributions. In support of the valued changes in models of care it is further recommended that a separate cost category is considered to be included in the NHCDC.

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

Genetic services within Queensland are administered by Genetic Health Queensland (GHQ) which is a statewide service that provides clinical genetic services by a team of specialist healthcare professionals. GHQ accepts referrals for individuals with a known or suspected genetic condition or a family history of a known genetic condition. GHQ staff have cited a number of issues with costing / pricing for genetic services including:

- There is a significant volume of work performed by both the consultant / registrar and counsellor in pre-clinic and post-clinic work-up which is reflected in the absorbed cost of the clinic where the patient is present, however this does not actually reflect the range and scope of the profile of care and effort that is provided by this specialist team. It is recommended that the capture of the reporting where the patient is not present for non-Multiple Health Care Provider (MHCP) clinics is made available for Genetic Services to better reflect the pathway of these services. It is noted that this would require some changes to the local capture of activity against the clinical record, both at the centre and at the patient home hospital. It should be noted that GHQ staff have advised that for the majority of cases, pre and post clinic work-up is longer than the actual patient appointment.
- GHQ staff routinely attend service events delivered by multidisciplinary teams, however as per the Tier 2 requirements, service events are reported once (with the MHCP indicator designating that three or more clinicians were involved in the consultation), and attributed to the clinical specialty most representative of the care delivered to the patient. Although the activity will attract the multidisciplinary clinic adjustment, this does not adequately compensate for the high cost / specialised nature of genetic services. Further work is required to address the cost reported for these to support a change in MHCP clinics where genetic services are utilised.
- GHQ is responsible for costs associated with blood collection, extraction and storage of deoxyribonucleic acid (DNA). QH has recognised that this issue significantly impacts the cost profile for patients reported at HHSs other than Metro North HHS as these do not have the full cost incurred at GHQ. This is to be addressed locally and reviewed to ensure that cross HHS services are accurately attributed with all inputs.
- A further complication to clinical costing is episode linking parameters. As per the Australian Hospital Patient Costing Standards intermediate products are generally matched based on date of service 30 days before and 30 days after an outpatient clinic attendance. Complex genetic test can be performed over two to four months and at the conclusion of the patient's testing, tests will be performed for family members. Although prescribed as part of the patient's original appointment, these subsequent pathology tests will not be attributed to that appointment due to the time between the original appointment and pathology test. This issue will also understate the total cost of the patient's appointment, as these tests will be orphaned in the NHCDC and not part of the data submission.

With the demonstrable increase in genetic services in recent years and the continuing anticipated expansion of these services, QH recommends that IHPA work with jurisdictions to undertake a costing study specifically in relation to genetics to explore cost drivers and the increased demand for services.

QH has been assessing the health need of its population and is using socioeconomic status as one of the factors in determining health need as an index. As this is work in progress QH is happy to discuss with IHPA any the results arising from this work and the observed cost of care.

13. What evidence can be provided to support any additional adjustments that IHPA should consider for NEP22?

QH has previously raised, through the Fundamental Review of the NEP conducted in 2019, that it supports the adoption of a percentile-based approach to setting diagnosis related groups (DRG) length of stay inlier bounds. Whilst the existing L3H3 methodology produces a reasonable distribution of inliers and outliers across all DRGs, the results at the individual DRG level are significantly different.

QH also suggests that IHPA reconsider the application of the multidisciplinary clinic adjustment for procedural clinics (Tier 2 10.xx series) and not apply for this series. As per the The METeOR MHCP indicator definition:

In the context of reporting non-admitted activity data for activity based funding, 'multiple health care provider' means three or more health care providers who deliver care either individually or jointly within a non-admitted patient service event. The health care providers may be of the same profession (medical, nursing or allied health). However, they must each have a different specialty so that the care provided by each provider is unique and meets the definition of a non-admitted patient service event.

Based on this definition procedural clinics such as endoscopies meet the MHCP criteria because the presence of an anaesthetist, gastroenterologist and a specialist endoscopy nurse, however the presence of these practitioners is expected for an endoscopy and the costing / pricing of endoscopies reflects the contribution of these clinicians.

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

In general, QH is supportive of price harmonisation where there is strong evidence that the cost of care and resources for the same product / administration route are the same across admitted and non-admitted settings.

In the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021-22*, IHPA proposed harmonisation of prices for dialysis and chemotherapy for NEP21 and QH would like to reaffirm its concerns with harmonisation of prices for these. In reality QH considers that the services delivered admitted and non-admitted are different, with different resource inputs.

Whilst the delivery of some classes of intravenous chemotherapy may hold significant clinical risk and / or be administered over a period of hours, other forms of chemotherapy may be administered subcutaneously or orally with minimal clinical time requirements and at lowered risk. It is recommended that these two areas are the focus of new classification(s) or innovative funding models rather than price harmonisation.

IHPA needs to provide further information to enable clear differentiation between resources across settings but also various types of chemotherapy administration routes and the duration that the patient is undergoing active treatment.

Treating cancer has become an increasingly sophisticated field requiring additional specialised support facilities and expertise given to patients during and post chemotherapy such as pharmacists, oncologists, medical emergency team response and specialised care units.

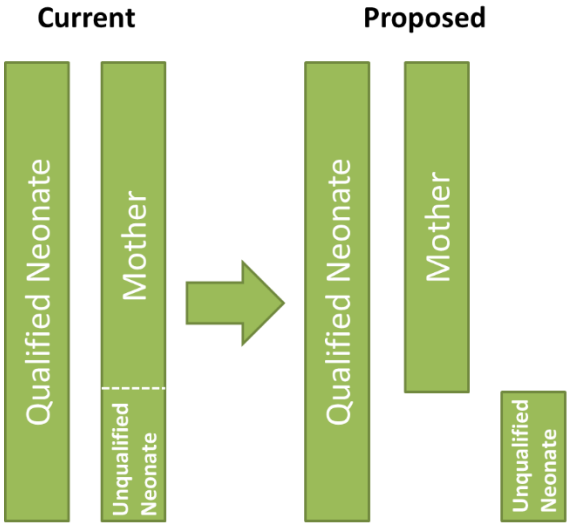
The process of price harmonisation is too simplistic for the cancer patient cohort, and effectively will provide an equal weighting to the non-admitted price which is predominantly driven by one jurisdiction and appears to be subject to variations in costing or counting service events.

QH suggests that price harmonisation may be considered for some surgical procedures, where no other ongoing care is required, such as colonoscopy or nasendoscopy.

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

Queensland stakeholders have cited that the bundling of unqualified newborns with the mother's DRG in the existing national pricing approach does not properly reflect care needed and provided by hospital neonatal services to neonates who are with their mother, as a separate funding item. The perception is that unqualified neonates are not funded, and it drives perverse resourcing allocation for the care of babies, and potentially worse drives a model of care that does not keep the newborn with the mother. As noted in the Framework, neonates with an acute qualification status are funded as a separate line item, while those with an unqualified status have funding for their care bundled with the funding for the mother's admission. This has implications for identifying appropriate funding of neonatal services (for care provided outside of a neonatal ICU / special care nursery), as well as appropriate recognition of the whole of neonatal service delivery, when planning future services.

In exploring a state funding model localisation where funding for unqualified babies is separated from the mother's payment, QH has identified that the unqualified neonates would best fit a separate adjustment per "Pxxx" DRG. This would result in a reduction in activity based funding (ABF) calculated NWAU attached to the mother's episode of care but would separately recognise the care provided to the unqualified neonate. Following is a diagrammatic representation of the current and proposed Queensland funding arrangements for maternity and neonatal patients:



QH would welcome the opportunity to work further with IHPA in relation to this proposal.

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

QH has previously supported the phasing out of the private patient correction factor, but does seek an impact assessment of this change by jurisdiction, including the back casting implications when not applied.

17. *What are the potential consequences of transitioning block funded standalone hospitals that provide specialist mental health services to ABF?*

QH has major reservations in relation to transitioning block funded standalone hospitals that provide specialist mental health services to ABF. For these facilities in particular, the nature of the patient care, length of stay (including leave taken), treatment type and highly specialised, resource intensive care, including high security for those Classified patients or subject to a Forensic Order, indicates that the patient cohort would not be suitable for setting an average efficient price based on other mental health services, and therefore do not lend themselves to an ABF environment.

More time is needed to allow understanding and stabilisation of the AMHCC model, and to improve data integrity and coverage before a transition to ABF could be considered, including the suitability of the AMHCC against Forensic admissions. More analysis would be required and testing of both cost and funding under ABF, compared to the current approach.

It should also be noted that two facilities currently recognised as block funded standalone hospitals, providing specialist mental health services (Kirwan Rehabilitation Unit and Charters Towers Rehabilitation Unit), will transition to being Residential Mental Health Care Services from 1 July 2021.

18. *What other considerations should IHPA have in investigating innovative models of care and exploring trials of new and innovative funding approaches?*

QH provided the following feedback in response to the 13 May IHPA JAC agenda item *Discussion paper on future funding models for Australia's public hospitals*:

Scope of the proposed models

Queensland supports the proposal to investigate new pricing and funding models involving bundled or capitation style payments for patients receiving care across multiple settings and / or for patients with chronic conditions receiving care over an extended period.

Queensland notes that the development of innovative funding models will be an ongoing process over the life of the National Health Reform Agreement (NHRA) 2020-2025. The development of specific models involving bundled and capitation payments for trial in 2022-23 is a positive first step in this process. Queensland notes that the limitation to 'hospitals' is problematic in a bundled and capitated model given the multi-provider and payor mix that exists in Australia. Any development on innovative models must address the inherent need to work across the primary, community and acute settings for improved patient outcomes.

Queensland considers it would also be appropriate to enable the Commonwealth and State/s to agree to trial innovative funding models in 2022-23, including in areas not covered by the detailed methodology proposed in the discussion paper. It would be appropriate for IHPA to provide technical advice in the development of such trials, following agreement between the Commonwealth and State/s. It may be appropriate to refer to this option specifically under Next steps.

It is also noted that clauses C17 to C22 of the NHRA call for a range of activities in relation to Paying for Value and Outcomes, including developing a National Health Funding and Payments Framework, and developing and trialling a broader range of funding and payment reforms, potentially including outcomes-based payments, blended funding models and pooling of payment streams across programs and providers. It would be useful to note that IHPA can be expected to play a key role in the development of such innovative funding models in future years.

There are several challenges and critical success factors that need to be overcome for initiatives to be viable and sustainable. Below is a summary of the key issues identified for consideration in the development of future funding models.

Patient as the focus

The extent by which the new funding model results in positive changes to patient equity, clinical outcomes and outcomes that matter to patients is a critical element of any bundled or capitation model to ensure the delivery of high-quality healthcare services is maintained. Clause C19 of the Addendum to the NHRA 2020–25 specifically states the exploration of funding and payment mechanisms to create stronger incentives for providers to:

a) focus on the outcomes that matter to patients, including through the utilisation of Patient Reported Measures;

b) improve patient equity, namely inequities in health care provision, access to health care, and health outcomes;

c) improve clinical outcomes, including the outcomes that matter to patients, and experiences of health care;

d) deliver best-practice clinical care; and

e) focus on the entire patient journey, not just individual parts of it.

More generally, it is important that trials are evaluated in terms of their outcomes. Evaluation could focus on two broad questions.

- To what extent do the new funding models result in changes to models of care? Clearly, there is limited benefit in adopting new funding models if these do not result in different models of care.
- If the changes do result in changes to models of care, how does this affect outcomes – e.g. health outcomes (including clinical outcomes and patient report measures), cost efficiency, etc.?

Determination of the funding amount

Clarity is sought on the methodology for determining the funding amount under the bundling and capitation approaches. For example, under bundling, would the average cost patients identified as in-scope be used to determine the funding amount or would a typical treatment pathway be agreed and the amount based on the funding that would otherwise be paid under an ABF model?

Size and Structure of Initiatives

It may be realistic for trials to initially just focus on developing one or two workable models with conditions with easily identifiable cohorts, standardised and proven clinical pathways involving minimal cross sector care, and ideally, clearly measurable clinical outcomes. The development of clear criteria for potential providers to meet would then offer a more suitable platform to conduct pilots / trials.

Cultural factors to consider

Culture change is a key barrier to alternate approaches and, unless addressed, alternate funding models are likely to be insufficient for achieving meaningful and lasting change. Clinicians and consumers need to be invested in a process of shared decision making. This links with the health literacy reform / work stream in the NHRA.

Next steps

Queensland suggests the following process for consideration:

- It is suggested that jurisdictions agree on a small number of funding models to be developed in 2022-23, covering selected chronic conditions and selected care pathways.
- IHPA would then develop detailed funding models for these selected chronic conditions / care pathways, with strong engagement from the Clinical Advisory Committee and other relevant clinical groups, and from the JAC and TAC.
- Individual States could then opt in or opt out of these models in 2022-23. For jurisdictions opting to implement models in 2022-23, they could implement them on a Statewide basis or in particular HHSs or hospitals.

In addition, the Commonwealth and State/s could agree to trial innovative funding models in 2022-23, in areas not previously identified. IHPA could provide technical advice in the development of such trials, following agreement between the Commonwealth and State/s.

It would also be appropriate to ensure that where States do implement trials in 2022-23, they are not disadvantaged financially. For instance, this could be done by continuing to report on an ABF basis, while implementing the trial at the State or HHS level, supported by a back cast guaranteed funding value and agreed uplift for growth across the years of trial.

19. What innovative models of care or services are states and territories intending to trial for NEP22?

Queensland priorities for models to be developed include for Kidney and Diabetes in the chronic disease category and Ophthalmology, Ear, Nose and Throat (ENT), Gastroenterology, Orthopaedic joint replacement in the potentially bundling cohort, noting that much more understanding on the care across all providers is needed for whatever cohort is agreed to work.

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

The development of a national safety and quality framework is supported, however the issues currently faced by jurisdictions with regard to data matching and linkage must be addressed.

The initiation of a patient outcomes monitoring pilot to determine a standard method to determine how the perceived quality of care is identified by the patient, would allow this to be developed into a model that could be used by all facilities. Currently the ad-hoc approach does not provide a sufficient level of rigor to allow comparative evaluation between services.

21. What pricing and funding approaches should be explored by IHPA for reducing avoidable and preventable hospitalisations?

As IHPA only has jurisdiction over hospital activity and the activities to prevent avoidable hospitalisation lie in the delivery of quality primary care, any strategies will need to recognise this i.e. hospitals cannot be penalised for primary care failures. While there is certainly opportunity for increased secondary prevention within hospital activity (e.g. cardiac rehabilitation, specialist chronic disease management, opportunistic vaccination whilst in hospital) there currently exist significant barriers to hospitals providing this – this includes the short term funding cycle which does not recognise the longer pay-back period of any secondary prevention investment. Additionally, the national funding model which persists in linking funding to increased activity does not incentivise prevention. Any strategies should focus on building primary care capability (specialists can support this if funded to do so) and recognising and rewarding secondary prevention.

IHPA should also consider more holistic, patient-centred approaches to pricing / funding that drive / incentivise improved safety, quality, and outcomes for patients. Rather than standalone adjustments for avoidable and preventable hospitalisations, safety and quality should be incentivised through value-based funding approaches, such as bundled pricing and capitation payments linked to long term reforms in the NHRA. For example, bundled pathways for elective surgery would typically exclude payment for preventable/avoidable readmission(s), while 'year of care' funding for chronic disease would exclude funding for potentially preventable presentations / admissions. Development of these value-based approaches must be data-driven and evidence-based – time-limited trials would help provide this data / evidence base.

22. What assessment criteria should IHPA consider in evaluating the merit of different pricing and funding approaches for reducing avoidable and preventable hospitalisations?

QH suggests that IHPA consider the following assessment criteria for the provision of care that

- Targets root causes of the problem (rather than symptoms, as is currently the case).
- Incentivises high value activities / models of care that reduce the need for hospitalisation (rather than simply penalising for activity that is considered unwanted / undesirable).
- Is holistic and patient-centred (i.e. takes account of the entire pathway / continuum of care; focuses on cohorts of patients – categorised by condition and risk – rather than categories of activity).
- Leads to improved patient outcomes, as confirmed by robust and independent evaluation (i.e. rather than evaluating 'success' of the approach by a reduction in hospitalisations, the end / ultimate outcomes of care should also be evaluated)
- Provides appropriate alignment of strategies with responsibilities.
- Assures there is a fair, risk adjusted assessment of 'acceptable' levels of potentially preventable hospitalisations.

Other issues not included in consultation questions

Pharmaceutical Benefits Scheme (PBS) price weights in all Tier 2 clinics

As raised in the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021–22*, QH has identified that some Tier 2 clinics, which in practice would not receive funding for PBS-listed medications, still have a PBS price weight, (e.g. allied health). Officer-level discussions with IHPA confirmed that this is due to a practice of allocating residual PBS costs, which could not be linked to a non-admitted service event, across all Tier 2 clinics. QH recommends this practice should exclude non-admitted clinics that would not receive funding for PBS-listed medications. This will ensure the price weight is only associated with services with prescribing rights.