SA Health response to IHPA Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022-23

Government of South Australia

SA Health

Response Overview

On 9 June 2021 the Independent Hospital Pricing Authority (IHPA) released its *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022–23* for public comment. SA Health welcomes the opportunity to provide feedback and is supportive of the continual improvements to the framework.

The following response has been developed following consultation within the Department and across LHNs. Responses to the questions included in the consultation paper are below with additional topics not accompanied by questions provided at the end of this submission.

Please contact Krystyna Parrott, Acting Director Funding & Costing with any questions.

Section 2 - Impact of COVID-19

2.2 Impact of COVID-19 on future determinations

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?

Clearly caution will be needed using the 2019-20 cost data in setting the National Efficient Price (NEP) and National Efficient Cost (NEC) determinations. IHPA's proposed approach seems reasonable given the datasets submitted have a determined pre and post COVID-19 split, and all COVID-19 data is marked as such, which will support analysis of potential pricing impacts on NEP22. Consideration could also be given to using 2018-19 data for the three months where the 2019-20 Covid-19 impacted data is not robust enough.

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

Due to the significant changes in public hospital services resulting from the COVID-19 response, the pricing model may need greater flexibility to account for the increase in costs experienced. Ongoing elevated service costs due to the requirement for COVID-19 safe work practices such as the increased use of Personal Protective Equipment, regular diagnostic COVID-19 testing, and increased staffing have an immediate funding impact. Waiting for the data to be recognised in the NEP price weights and adjustments based on cost and activity data in three years may have as yet unrealised impacts.

Section 5 - Classifications used to describe and price public hospital services

5.1 Standard development cycles for all classifications

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

SA Health supports the proposal to establish a standard development cycle for all classification systems. It is suggested a staggered cyclical approach be implemented to allow for forward planning of resources which is paramount to enable system changes to be adequately executed.

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 development cycle is supported, striking a balance between the incremental benefits of classifications maintaining clinical currency versus the resources required to implement the changes to accommodate a new classification.

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?

SA Health has no feedback at this stage.

5.3 Subacute and non-acute care

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

SA Health welcomes IHPA's comprehensive review of the admitted subacute and non-acute care classifications. This approach is essential to ensure that classification systems maintain currency with the change in technology and healthcare practice. SA Health acknowledges IHPA has taken on board feedback provided as part of the public consultation process. Once finalised, to assess the impact on changes to funding, a period of shadow funding will be required to evaluate prior to implementation. SA Health will continue to work collaboratively towards the next stages of the classification.

5.5 Non-admitted care

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

Prior to recommencing the non-admitted care costing study, states and territories would benefit from adequate notification of the commencement date to select site participants and allocate resources required to commit to the study. Clear guidelines for minimum data submission requirements including data quality assurance processes for data submissions should be provided to ensure all jurisdictions submit comparable data for a valuable study. Understanding of the funding and resources IHPA will provide to support the costing study will assist in informing planning and decision making.

5.6 Mental health care

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

SA Health is supportive of IHPAs proposal and welcomes the opportunity to progress using AMHCC Version 1.0 for NEP22 in the admitted care setting following its second year of shadow pricing as per the NHRA addendum. Whilst SA Health understands there is still development work to do, the transition should proceed swiftly with refinement of the system over time.

Early clinician engagement is key to ensuring pricing for admitted mental health care. It is recommended there be early engagement with the states and territories to clarify what is required for the data set, to facilitate adequate engagement.

Further work is required prior to the implementation of AMHCC Version 1.0 pricing for community mental health due to missing data elements from community collections and therefore cost structures which are significantly different from admitted patient services.

Overall, SA Health believes the eventual transition to AMHCC will benefit the commonwealth and state partnership focus to improve mental health information.

Section 6 - Setting the national efficient price

6.2 Adjustments to the national efficient price

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

Whilst SA supports the adjustments for patient transport in rural areas, there are potential costs, that do not appear to be included in adjustments for very remote rural sites aside from the patient and establishment remoteness loadings. For instance, at times country LHNs are required to pay the Royal Flying Doctor Service. As such, SA Health recommend IHPA commission a study into pricing for patient travel as part of the unavoidable cost variations to obtain greater understanding on the complexities of patient transport

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

Improved models of care in specified ICU's means that ventilation may only be one factor of complexity, albeit a significant one. Part of a review should also include discussions with key jurisdictional stakeholders to understand how ICU models of care are maintained.

What factors should IHPA consider in reviewing the Indigenous adjustment?

SA is not requesting consideration for any changes to the indigenous adjustment at present.

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

Genetic in services are dependent on pathology and state differences in service models need to be appropriately recognised. Genetic outpatient services are typically multidisciplinary which makes it difficult to attribute all costs to a service event.

Socioeconomic status (SES) is still not a robust indicator and unless there are specific ICD codes that indicate SES then it is difficult to perform adequate analysis.

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

SA Health suggests the consideration of a Disability Based Services adjustment. NDIS patients who are unable to gain care in a community setting are causing blockages. SA will be willing to provide costing data necessary to determine the service impact.

6.3 Harmonising price weights across care settings

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

SA Health strongly supports the continued review of haemodialysis and chemotherapy where activity is provided in both outpatient and inpatient service categories. SA has been and still is supportive of price harmonisation for chemotherapy. Data IHPA provided on this topic showed that for most jurisdictions the cost was agnostic of setting. There is little difference to care provided as outpatient compared to inpatient, rather it is a policy decision. SA requests a review of the costing data used to create the price weights for this activity to better understand price weight differences between the settings.

6.4 Unqualified newborns

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

SA Health believes the current methodology is restrictive towards contemporary models of care where newborns increasingly stay with the mother. The current qualification status where hospitals do not receive separate funding and limiting qualified newborns to designated ICUs does not reflect current models of care

There are concerns that as no funding is given for treatment of a newborn whilst in same room as mother, this poses the unattractive suggestion that the newborn may be separated. This model of care is not considered the best experience of care from the perspective of mother or baby.

Funding should be considered for a wider range of services and based on the care provided, not the site where the care is provided and it is recommended consideration be made to remove the criteria requiring the infant *'admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special* care' in order to be qualified.

In the best-case scenario, it is believed all babies should be counted as patients, yet the current Australian Health Care Agreements and Health insurance restrictions hinder this progression.

Reference is made to the use of the term 'unqualified' when referring to a newborn patient that does not meet any of the three criteria required for qualification. This term may be considered offensive with unintended impacts and it is suggested this be reconsidered and rephrased.

6.5 Setting the national efficient price for private patients in public hospitals

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

Work is already underway to phase out the correction factor in the costing process with the main work involving system updates.

SA can partially comply with costing standards pertinent to this subject and it should be noted that:

- Rights to private practice earnings are included in doctor's earnings and that these are either brought into the costing ledger directly from the general ledger or through Third Party expense adjustments brought in from ROPP Trust Accounts. Consistent with the Australian Hospital Patient Costing Standards, all patients are costed in the same manner using the doctor's total income and this occurs regardless of the patient's election status.
- Private pathology income is not able to be determined as it is infeasible to trace pathology performed based on doctor's referral back to public hospital doctors as distinct from tests ordered for patients seen in the community. Private patient pathology income is therefore excluded from patient costing systems.
- In addition, SA has a number of smaller hospitals where third party radiology contracts prevent the gathering of data to support the allocation of all private medical costs back to individual patients.

Essentially SA has no objection to the phasing out of the correction factor but needs to be able to allow for adjustments to the costs for SA pathology and radiology.

Section 9 - Setting the national efficient cost

9.2.1 Standalone hospitals providing specialist mental health services

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

SA Health are anticipating standalone hospitals to all transition to ABF with AMHCC. In SA the standalone specialize mental health hospitals are already funded on an ABF basis for Commonwealth funding.

Section 10 - Future funding models

10.3 Next steps for alternate funding models

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

As the delivery of healthcare continues to change how and where healthcare is carried out it is important to consider whether alternative future funding models can adapt flexibly to achieve the highest quality care and best possible patient outcomes. The exploration of new funding model approaches continues to be an area of high interest given the relatively limited models that are in scope are in pilot phase.

SA Health recognises the possible benefits of bundled payments, however it is recommended jurisdictions agree on a care plan with strong costing data to support pricing. SA Health also supports capitation type payments for patients with chronic conditions provided they closely align with outcome assessments and have clear KPIs. The implementation of a unique identifier is the first step in progressing towards future models.

It would be welcomed if IHPA increased its collaborative presence with groups such as the Health Chief Executives Forum (HCEF) which operates to deliver health services more efficiently through a coordinated approach on matters of mutual interest to enable a greater understanding of what is going on in this area.

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

SA Health has commenced investigating innovative models of care such as the new My Home Hospital and the Mental Health Co-Responder program (MH-CORE). Both programs are currently underway with the intention being to provide feedback and advice to other jurisdictions in future.

Section 11 - Pricing and funding for safety and quality

11.5 Evaluation of safety and quality reforms

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

SA Health is significantly invested in hospital avoidance programs and sentinel event reporting across the health systems and the implications on both clinicians and patient outcomes. This is evident in both the cost model and activity. However, the key issue IHPA needs to consider with developing new safety and quality measures is the manner in which jurisdictions can integrate them into existing systems to enable appropriate reporting/measurement.

11.6 Avoidable and preventable hospitalisations

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

Before exploring approaches for funding/pricing avoidable and preventable admissions a robust definition is required. This will need to be easily managed by jurisdictional systems so there is visibility of these patients. It will also need to be understood that some avoidable/preventable admissions are not due to hospitals rather a gap in primary care which is outside of IHPAs remit. Future consideration could involve looking at the broader picture of how the primary health system is functioning to fit within the hospital system when looking at 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?

SA Health has no additional criteria to propose at this stage.

Other issues not included in consultation questions

5.4.1 Considering the use of AECC for emergency services

SA Health supports the continued improvement of data collection for all hospital services. The use of AECC for Emergency Services is supported, in theory, however it must be recognized that some smaller sites may have difficulty in collecting robust diagnosis codes. It is recommended that any changes to this requirement be worked through in conjunction with AIHW given SA's preference of one submission multiple use.

9.3 New high cost, highly specialised therapies

SA Health has concerns new health technologies and high cost therapies will understandably impact the NEP. Some of these therapies are more expensive than the typical treatment but do result in shortened length of stays. LHNs, particularly CALHN and WCH are starting to collect data that may be beneficial for further investigation into this area.

For more information

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