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Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Dear Mr Downie

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

Thank you for the invitation, as part of the public consultation process, for Tasmania to provide comment on the Independent Hospital Pricing Authority's *'Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022-23'.*

Please find attached the submission from the Tasmanian Department of Health.

Thank you for the opportunity to comment.

Yours sincerely

Ross Smith
Deputy Secretary
Policy, Purchasing, Performance & Reform

20 July 2021

Attachment 1. Tasmanian DoH Submission

Attachment 1.

Responses to the Consultation Questions - IHPA Consultation Paper on the Pricing Framework for Public Hospital Services 2022-23

General comments from Tasmania

Hospital in the home (HiTH) – Given that this care has a potentially different cost structure which will vary in comparison to in-hospital care, Tasmania requests that IHPA investigate admitted HiTH encounters with the view of determining if the differing cost structure of the HiTH service is adequately described in the current NWAU.

The 2021-22 Tasmanian funding model uses the NEP and NWAU model, which deflates the payment to private admitted events, to ensure the principle that the States' funding model is financially neutral in the admitted patient setting. Tasmania believes, because of changes to the Pharmaceutical Benefits Scheme, general pharmaceutical benefits, and the Medicare rebate, a level of uncertainty in the private sector has been introduced as many Health insurers may not have had time to update their schedules. This could lead to the situation where the Casemix and revenue amount in the Hospital Casemix Protocol will be very different than the base data used for back-casting. Tasmania does not oppose review and refinement of the MBS and PBS to ensure the rebate systems are working as they should. However, because of the changes to the MBS and PBS, Tasmania recommends IHPA monitor the situation in case there are unintended consequences as a result of the new financial neutral requirements.

In relation to financial neutrality, Tasmania requests IHPA undertake analysis of the cost of privately referred non inpatients (PRNIP) and develop a negative adjustment to the NAP NWAU for PRNIP. This would remove some of the current data burden that the current data matching is placing on the State and Hospital system.

National Benchmarking Portal –Tasmania requests IHPA to explain how the privacy issue will be respected to ensure that patients cannot be identified and that their personal information is protected; and, where services are contracted out, commercial-in-confidence arrangements are respected. This is practically important given the size of Tasmanian data set and the potentially for very low numbers of some patient cohorts.

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?

In general, the Tasmanian Finance and Business Support Unit is supportive of 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. Tasmania is currently experiencing increased costs for cleaning, security, infection control, etc and these costs are eligible for funding through the NPA on COVID-19 Response, so it wouldn't be appropriate to adjust the NEP for these costs at this stage.

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

Tasmanian believes the impact of the inability to access care due to lockdown policies and suspension and cancellation of services such of elective surgery, the reduced emergency department attendances and the reduction in activity typically presenting during Autumn and Winter such as Influenza, bronchiolitis, other community transferable infectious diseases and Covid-19 during 2019-

20 makes it difficult to quantify the long term impact on health data, cost, models of care and staffing levels.

In Tasmania the post Covid-19 period has seen an increase in costs related to the models of care, staffing and equipment:

Models of care:

- Retention of hot and cold zones that have been established to prevent the potential spread of COVID-19
- Increased infection controls
- Social distancing required changes in patient locations or a reduction in patient numbers leading to capacity constraints and higher costs
- Increased time in theatre due to cleaning and PPE preparation
- A greater acceptance of non-admitted patient activity delivered via telehealth
- Increased Hospital in the Home and community-based programs
- Increases in costs of preparedness – capacity building "in case" scenario.

Equipment:

- Telehealth infrastructure costs, capital costs.

Staffing:

- Increased use of agency staff due to requirement to back- fill staff while awaiting COVID results.
- Corresponding increase in sick leave.
- Increased requirement as out of hospital care and treatments increase with the ability of clinicians to work outside of the hospital campus
- Nursing staff rotating through the ICU and ED required upskilling.
- As leave has been restricted, there has been an increase in annual leave accrual and the accruals for the leave loadings.

Tasmania is still developing an understanding of the long-term impacts on hospital services in the post COVID-19 on the clinical service profile of 'business as usual'. Currently, Tasmania only produces an 'annual' cost study, and has therefore been unable to provide a monthly or quarterly allocation of activity to costs across the post COVID-19 period, making it difficult at this stage to estimate the impact of any cost variation outside of normal operations and processes within the 2020-21 data set.

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?

Tasmania supports standardised development cycles for the classification systems, once each new classification has undergone the initial implementation settling-in and refinement period needed, which could vary in length based on the complexity of each new classification.

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

Tasmania supports the concept of ongoing three-year development cycles. However, allowance must continue to be made for other existing established IHPA policy initiatives eg the annual development of new health technologies process, and other similar processes, to allow interim changes to a classification system, as required.

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?

Tasmania requests the ABF pre-eminence guideline is updated to reflect the requirement of the Addendum for ABF to be not only practical, but also appropriate (Clause A3).

Tasmania would support IHPA reviewing the decision to not include the exercise physiology classes in the clinic nurse specialist/allied health led services of classes in the Tier 2 Non-Admitted Services Classification.

With the development of the National Health Genomics Policy Framework Clinical the Tasmanian Clinical Genetic Services has seen an increase in activity by clinical geneticists which is transparently identified and costed with the use of the clinic 20.08 Genetics. There is no category for services delivered by genetic counsellors as allied health providers in the 40 series - Allied health and/or clinical nurse specialist intervention. Anecdotally, the General Medicine code 40.53 has been applied in some jurisdictions. This could be considered a barrier to the development of a model of care. As such, Tasmania would support IHPA developing a 40 series - Allied health and/or clinical nurse specialist intervention for genetic counsellors.

In line with Schedule C of the Addendum to the Health Reform Agreement, bundled payments and Value based health care, Tasmania suggests IHPA should consider consolidating the classification system to as few as possible to enable the ABF classification systems to be setting neutral. IHPA should consider the inclusion of subacute clinical scores (FIM, RUG-ADL) into the classification to enable transition from two data collection systems (currently disparate systems in Tasmania) into a single data collection process.

This would align with the principle of administrative ease and reduce the burden of data collection on the system.

IHPA could consider including sub-acute data collection within the inpatient/acute data collection using ICD to capture clinical scores to enable a single data collection process.

5.3. Subacute and non-acute care

5.3.1. AN-SNAP Version 5.0

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

Tasmania's submission, in May 2021, under the *Consultation Paper on the Development of the National Subacute and Non-Acute (AN-SNAP) Patient Classification Version 5.0,* remains relevant.

5.5. Non-admitted care

5.5.2. A new non-admitted care classification

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

Tasmania is not participating in the costing study but would like to be kept informed on the study's progress and its results. Tasmania will continue to work though the Non-Admitted Care Advisory Working Group, and the Technical and Jurisdictional Advisory Committees.

5.6. Mental health care

5.6.3. Mental Health Phase of Care

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

Tasmania supports the concept of pricing with AHMCC, however suggests the classification is not yet robust enough for use in the community. Tasmania believes that pricing using AMHCC within the community mental health setting is premature at this point and does not consider shadow pricing relevant.

Tasmania is concerned that pricing using AMHCC is premature in the Tasmanian environment and at this point does not consider the application of AMHCC in mental health mature enough to migrate from the shadow environment at this stage.

As one of the smaller jurisdictions, with competing resource pressures, Tasmania remains concerned at the quality and quantity of the AMHCC data currently available in Tasmania.

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?

Tasmania is supportive of IHPA assessing an adjustment for patient transport in rural areas. Tasmania is unable to provide linked patient level data elements and completed costs at this stage. Also, in Tasmania there could be issues, in relation to patient transport services prior to the admission commencing because of data collection and structural issues in relation to who provides the service.

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

Tasmania believes that:

- There is an impact of obesity (such as: obese class 2 or 3 i.e. BMI > 35) on the cost of care and length of stay which is not fully recognised in the national ABF model. There are additional costs for these patients such as the need for reinforced / different wheelchairs, beds, imaging machines (some patients need to be scanned at veterinary facilities), theatre and morgue facilities etc. as well as increased costs associated with the complexity of treating patients where 'normal' treatment guidelines are inappropriate or insufficient.
- The Critical Care component costs should be reviewed, as a priority, and particularly for invasive ventilated patients, to develop a weighting if an invasive ventilated patient is managed in a regional Critical Care Unit. The current exclusion of ICU units below 24,000 hours of ICU care, of which at least 20 per cent involves mechanical ventilation, effectively reduces the Commonwealth contribution in regional centres. The costs involved in mechanical ventilation of a patient are the same irrespective of location. A critical care unit is more resource-intensive than a general ward area and, currently, this is not fully recognised in the national ABF model.

Tasmania recommends that IHPA look into the fixed-cost nature of the smaller intensive care units, whether those units are ABF-funded or not ABF funded and ensuring the model support these services being provide to the patient, where clinically appropriate and not disadvantaging Critical Care units being provided where the state has identified a community need.

What factors should IHPA consider in reviewing the Indigenous adjustment?

While there may be issues with the ability to identify Indigenous patients within the data sets, Tasmania recommends IHPA consider the impact of the following on the episode costs:

- Patients (including Admitted child and adolescent mental health services) with a mental health condition receiving care where the admitted care type is not mental health and the primary diagnosis is not a mental health issue.
- Patients with socioeconomic disadvantage and health inequality (for example Homeless Patients)

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

In consultation with the Geneticist Clinicians they have indicated that they are concerned that the current pricing cycle of the National Efficient Pricing model may not enable the model to respond quick enough to recognise changes in models of care. They also have concerns that activity provided by genetic health care providers is applied inconsistently across jurisdictions and that the establishment of a 40 series - Allied health clinic, to be used by genetic counsellors, may assist in aligning the reporting in the public system.

The Geneticist Clinicians believe especially the advancements in technology and the broadening to genomic testing have resulted in rapid expansion in genetic/genomic testing, which has become part of mainstream healthcare. With less than 90 percent of genetic tests provided across Australia covered by Medicare and anecdotal evidence that the Medicare rebates does not cover the cost of care in the private sector, the Geneticist Clinicians believe the public sector admitted product may not reflect the higher acuity of care provided.

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

Tasmania would support IHPA investigating the unbundling the Neonatal ICU component of the DRG price for MDC15 Newborns (qualified) and Other Neonates, to provide consistency for all patients treated in a PICU and create a more transparent and equitable model when it comes to the length of stay in Neonatal ICU.

6.3. Harmonising price weights across care settings

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

Tasmania is generally supportive of the proposed harmonisation, as the cost of care and resources for the same product / administration route are the same across admitted and non-admitted settings. Tasmanian has concerns:

- About harmonisation of prices for chemotherapy and is concerned that important clinical information will be lost, as the current outpatient collection and reporting systems do not contain diagnosis and comorbidity information which underpins the DRG classification system.
- That amalgamating pricing of non-admitted and admitted settings will create pricing compression and would recommend further investigation of the pricing of non-admitted dialysis and chemotherapy.

Tasmania would suggest there is enough cost difference between the various methods of delivery (subcutaneously, Intra-Muscular, Intravenous, Intraperitoneal, Intra-Arterial, orally etc) to warrant greater segregation within the current end classes of 10.11 Chemotherapy treatment.

6.4. Unqualified newborns

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

Tasmania recognises that funding for newborn infants who are not recognised as patients (qualified) has challenges in the current framework the National Health Reform Agreement functions under. With clinical processes respecting the evidence that indicates the mother and baby should remain together where possible, babies who were once cared for within the Special Care nursery are now cared for on the postnatal ward.

Tasmania would like to see changes that allow IHPA to price newborn care where clinical care is provided on postnatal wards with their mothers rather than within the Special Care nursery. The funding model should not discourage the mother and baby dyad remaining together where possible, as such babies who require care such as phototherapy, assisted feeding, drug administration and monitoring create additional work for the clinical staff and Tasmania does not believe the current methodology, where the cost of care is allocated to the mothers' AR-DRG adequately funds the care within our public hospital maternity centres when clinical care is provided on postnatal wards with their mothers rather than in a nursery.

Tasmania would support IHPA investing whether there is a costing difference when newborns are effectively cared for by their mothers and when newborns are receiving clinical care, such as described above at the mother's bedside.

Tasmania supports IHPA developing an adjustment to the funding model for maternity that ensures there is no incentive, not treat the mother and baby dyad as a single unit but enables the variation in cost between the classes of newborns discussed above. This will not require the removal of the current arrangements for Qualified neonates.

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

6.5.1. Phasing out the private patient correction factor

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

The 2020-25 NHRA strengthens the commitment to ensuring equitable access to public hospitals for all Australians. However, Tasmania strongly recommends IHPA does not remove the private patient correction factor adjustment. Tasmania notes that consistency and standardisation of arrangements has yet to be achieved.

Tasmania is working towards implementing best endeavours for the 2020-21 NHCDC submission. However, compliance with Business Rule 1.1A Medical expenses for public and private patients is subject to the availability of data and expenditure information not often held by the departmental clinical costing unit, public hospital clinical costing unit or clinical costing units and, as a result, the units are unable to identify actual payments made for private patients in billing systems.

Section 9: Setting the national efficient cost

9.2. The 'fixed-plus-variable' model

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?

The Tasmanian Government is committed to improving health system governance, linking outcomes to funding improving financial governance across the Tasmanian public hospital system. The introduction of an ABF model has the potential to support a better interface between patient care and funding.

However, because of the hospital size and cost profiles of the Tasmanian Stand-Alone Mental Health facilities the proposed shift to ABF from the current block model may pose a potential risk to funding of Mental Health services in Tasmania.

Tasmania has concerns that the Australian Mental Health Care Classification may not adequately define that clinical practices within the individual units within the six sites of Tasmanian Stand-Alone Mental Health facilities.

Section 10: Future funding models

10.3. Next steps for alternate funding models

Tasmania strongly supports considered work to develop alternate funding and payment mechanisms that enable a system-wide shift to outcomes that matter to patients rather than a focus on performance and cost savings. Funding solutions also need to support different mechanisms of service delivery, models of care and care integration.

10.3.2. Trialling innovative models of care

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

Tasmania believes IHPA should:

- Consider workforce issues such as the impact on recruitment, retention and working practices across the system
- Examine any implementation to data and information capture
- Focus on patient outcomes not just system outcomes

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

Limitations with the current General List criteria and Legislative framework inhibits a Rapid Access Inreach Service from being in-scope. However, Tasmania has begun developing and implementing a Rapid Access Inreach Service that provides GPs and other primary care health professionals with rapid access to staff specialists in the North and North West of Tasmania. The Rapid Access Inreach Service provides care to people with chronic and complex healthcare needs, particularly during early acute exacerbations of chronic conditions.

As GPs and other community-based health professionals provide the majority of care to people with chronic conditions such as asthma, cancer, cardiovascular disease, diabetes, musculoskeletal conditions and stroke, General medical specialists will be providing services at healthcare sites, such as GP practices, Residential Aged Care Facilities, District Hospitals and Community Health Centres, with the expectation of providing people with chronic and complex healthcare needs with the help they need to manage their health and wellbeing – and therefore there is an expectation of reduced demand on our public hospital emergency departments.

The Rapid Access Inreach Service is still working with key stakeholders including specialists, GPs, primary care providers and consumers to:

- Finalise the service model
- Develop supporting materials (eg. patient management plans, patient referral forms, promotional materials, policies, and procedures), and
- Develop integration with existing community health services.

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?

It is important that stakeholders are actively involved in evaluations from the beginning and throughout the process. Stakeholders may include clinicians, networks, Local Health Districts, patients and their carers, other agencies, peak bodies, community members and leaders.

Tasmanian believes IHPA should consider:

- Tools that have been provided to assist clinicians in evaluating performance
- To what extent has the program been implemented at the hospital operational level?
- To what extent have behaviours changed?
- What is perceived to be the value of the program to the stakeholders?
- How do differences in implementation affect program outcomes?

Tasmanian representatives on the Australian Commission on Safety and Quality in Health Care , and IHPA Technical and Jurisdictional Advisory Committees, will work with IHPA as it develops evaluation measures.

11.6. Avoidable and preventable hospitalisations

Tasmania is looking forward to being able to analyse this activity with the tools to be provided by IHPA/3M. Tasmania currently has concerns at the poor reporting of IHI in jurisdictions, which reduces the ability to report hospital avoidable admissions compared to states and territories that have unique identifiers across their whole systems already.

With Tasmania's reliance on private contracted services, Tasmania has concerns that it doesn't have enough clinical control over treatment processes contracted out by the public sector at this time.

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

Tasmania has concerns that without a nationally consistent admission policy framework, local admission policy arrangements may reduce the ability to identify same-day ambulatory (non-admitted) index admitted events or readmitted events.

With many states updating admission policies since the 2017 review by the Australian Institute of Health and Welfare into the variation in hospital admission policies and practice, IHPA should recommission a review of jurisdictional hospital admission policies and practices to review differences in admission protocols practically in the same-day admitted area between states and territories.

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

It is important that the evaluation of pricing and funding approaches must be based on good evidence of the system's ability to prevent hospitalisations. Factors such as sociodemographic, access to primary health care particularly in chronic conditions where there is inevitable physical deterioration need to be measured.