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Mr James Downie
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Dear Mr Downie

Thank you for the opportunity to comment on the Independent Hospital Pricing Authority's consultation paper on the pricing framework for Australian public hospital services 2022-23. Please refer to the attachment for Victoria's response.

Victoria understands the role funding and pricing play in supporting the delivery of better and safer care as well as leading to a sustainable and effective public hospital system. Victoria supports the Independent Hospital Pricing Authority's recognition that pricing should seek to support funding solutions that deliver efficient high-quality care and have a focus on patient outcomes.

If you have any queries about Victoria's response, please contact Mr Richard Bolitho, Director, Funding and Budget on 03 9456 3302 or at richard.bolitho@health.vic.gov.au.

Yours sincerely

**Denise Ferrier**
Executive Director
State-wide Programs, Budget and Performance Support
Commissioning and System Improvement

12/07/2021

VICTORIA State Government

# Consultation paper on the pricing framework for Australian public hospital services 2022-23

Victorian Department of Health response

July 2021

VICTORIA State Government | Health and Human Services

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# 1. Introduction

Victoria welcomes the opportunity to comment on the Independent Hospital Pricing Authority's (IHPA) *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022-23* (the framework) and is supportive of the continual improvements to the framework. The framework forms part of the IHPA's annual process for establishing a national activity-based system for the pricing of public hospital services in Australia, in support of the efficiency and transparency goals of the National Health Reform Agreement (NHRA).

The framework is an opportunity to further refine and improve the pricing models introduced in 2012-13 and revised in subsequent years. Victoria is generally supportive of the direction of the national pricing framework development and has used its response to provide input into how to further mature aspects of the national pricing model.

Victoria looks forward to working with the IHPA to ensure that the expectations of governments as detailed in the Addendum to the NHRA are achieved.

# 2. Impact of COVID-19

**Consultation questions**

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

Victorian health services have been significantly impacted by the direct and indirect effects of COVID-19, especially in late 2019-20 and first half of 2020-21. This includes:

- Significant changes for in-scope activity, including:
    - Reductions in elective surgery to enable health services to prepare for and treat patients diagnosed with or suspected to have COVID-19.
    - Changing utilisation patterns in emergency department presentations and patients admitted from emergency as a result of both a range of public health measures and changing patterns of community behaviour.
    - Flow-on impacts on admitted and non-admitted sub-acute services as a consequence of fluctuating emergency and elective surgery activity.
    - Increase in other activity, such as COVID-19 testing and provision of support for private aged care facilities, disability providers, and other supported residential services impacted by COVID-19 outbreaks.
- Changes in models of care. These include:
    - Significant increase in the provision of health care in non-admitted settings.

- Increased use of shared care arrangements.
- Remote patient monitoring; development of services for patients with post-acute COVID disease, sequelae of COVID-19 infection and the emergence of chronic COVID-19.
- Greatly expanded use of telehealth.

In Victoria, COVID-19 related costs continue to be incurred by health services as they continue to ensure all health care can be delivered in the current COVID-19 active environment. This includes supporting physical distancing and infection control requirements. Examples of these include:

- Increased use of Personal Protective Equipment (PPE).
- Additional training in use of PPE and measures to promote safe PPE use, such as PPE spotters.
- Increased use of additional staff to support the delivery of admitted and non-admitted COVID-19 services, resulting from staff furlough, leave, and deployment to other critical services such as aged care.
- Additional security and support staffing to monitor and manage COVID-19 safety measures and public health directions.
- Additional staffing related to increases in Infection Control teams.
- Increased frequency of cleaning, increased cleaning time, and greater use of single use products.
- Provision of support to ensure ongoing care of residents located in residential aged care facilities where outbreaks have occurred.
- Additional staffing costs to support testing of hospital staff, and staffing for public health COVID-19 testing facilities.

The operating environment of Victorian hospitals is significantly different as hospitals transition into a new COVID-19 normal. Increased infection controls, application of social distancing requirements and changes in the model and location of service delivery all impact on the cost profile of in-scope services priced under the National Efficient Price (NEP) determination.

The challenge for IHPA is determining the appropriate price weight and NEP in the COVID-19 normal environment, especially where, for Victoria, the costs associated with the longer-term changes in the hospital operating environment are only now becoming apparent. Victoria notes that the IHPA cost model is based on a three-year lagged cost data and may not reflect the full impact of recent changes in cost profile.

It could be envisaged that all health systems will need to maintain higher levels of PPE use than previously experienced, more stringent infection prevention and control measures, and maintain public health measures such as social distancing for the medium term. It is also expected that a proportion of these costs will be embedded as a structural uplift to average costs as improved infection control practices are likely to continue in the longer term.

Victoria supports IHPA undertaking a review to understand the impact COVID-19 has had on the National Hospital Cost Data Collection (NHCDC) for 2019/20. We are looking forward to the insights and trends drawn from this analysis and discuss the implications of the findings on the cost data and subsequent use for pricing. It is important to acknowledge that individual states and territories have experienced varied impacts of COVID-19 and that a national pattern may not reflect each states unique circumstances.

Victoria is keen to understand how the NEP 22, which will have limited access to 2019-20 COVID-19 costs reported in 2021, can include the extent of additional costs incurred or changes to operating models and patient activity levels. It is highly likely that NEP 22 could under-price activity, when compared to the actual expenditure incurred by hospitals, without some further adjustment being made by the IHPA to mitigate the financial risk to all jurisdictions.

Separately, there will be a 'yet unknown' costs to health services due to chronic conditions arising from patients exposed to COVID-19. These extra costs could manifest over time as increased demand, increased comorbidities and increased complexity. A recent study identified that the majority of patients had at least one symptom 6 months after onset[1], while a 15-year study on patients who recovered from SARS still had reduced lung diffusion capacity[2]. The cost data collection could adjust over time with these trends and inform future national efficient prices and recognition could be given to this factor as a future cost driver.

Victoria supports:

- The continued work by IHPA with jurisdictions to determine the cost impact of COVID-19 though use of cost and financial reporting systems to address the impact of COVID-19 on IHPA determinations and classification systems.
- That IHPA includes the reporting of telehealth video consultations in emergency departments and works with jurisdictions to examine the costs and funding of this activity. Victoria believes it should be recognised by IHPA as these services are an important model of care to keep Victorians healthy and well in the new COVID-normal environment.
- That IHPA review existing reporting requirements, funding models and classifications to support changes to service delivery models, for example; use of telehealth in emergency departments, the treatment of post-acute COVID disease, sequelae of COVID-19 infection and chronic COVID-19. This might include the inclusion of a COVID-19 flag to the non-admitted national data collection, subject to views on the adequacy of the Tier 2 classifications.

[1]Huang, Chaolin et al. 6-month consequences of COVID-19 in patients discharged from hospital: a cohort study. The Lancet, 2021 Jan;397(10270):220-232. doi:10.1016/S0140-6736(20)32656-8

[2]Zhang, P., Li, J., Liu, H. et al. Long-term bone and lung consequences associated with hospital-acquired severe acute respiratory syndrome: a 15-year follow-up from a prospective cohort study. Bone Res, 2020 Sept:8(8). doi:10.1038/s41413-020-0084-5

# 3. The Pricing Guidelines

The Pricing Guidelines provide guidance on IHPA's role in pricing Australian public hospital services. Over the years of operation of consecutive NEP Determinations there may be opportunity for these overarching guidelines to be consolidated. For example, it is unclear whether timely-quality care is achieved through operation of the national funding model, or whether this is through policy settings set by system managers.

With the development of innovative models of care, as well as innovative funding models, consideration could also be given to the role of Activity Based Funding (ABF) in system funding as part of any review of the guidelines.

In recognition of this guideline's interaction elsewhere, and to minimise undesirable and inadvertent consequences, Victoria notes that the funding mechanism proposed to achieve private patient neutrality may overstate the actual adjustments and result in modelled rates lower than actuals. Consequently, it could lead to untoward financial imposts on States and Territories.

Understanding the impact of the mechanism both in terms of the difference between actuals and modelled and private patient rates in public hospitals will be important to ensure visibility of the models predictive accuracy and on health services response to this funding adjustment overtime.

# 4. Scope of public hospital services

COVID-19 required jurisdictions to quickly introduce new or expanded approaches to ensure the delivery of services to patients, such as increased use of telehealth, hospital in the home and other home and community-based services.

While some of these services are considered in scope for funding under the NHRA, they are often funded the same as an in-hospital episode. For example, there is no differentiation between hospital in the home and in hospital admitted patient funding, even though the cost structure is different. In some cases, in-scope activity that is provided in a non-hospital setting is considered out of scope for funding under the NHRA.

Victoria believes that the scope of public hospitals, and the associated pricing framework and NEP determination, should be reviewed to ensure that it reflects the changes in the provision of services introduced during COVID-19 and supports the funding of services in all settings.

One example of this is the possibility of telehealth as a direct substitute for emergency presentations, currently requiring the physical presence of a patient at hospital, could be reflected in a future general list.

Victoria looks forward to working with the IHPA to ensure the general list reflects contemporary and best clinical practice to achieve better and safer care for patients alongside innovative models of care.

# 5. Classifications used to describe and price public hospitals

**Consultation question**

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

Victoria is supportive of the proposal to establish standard development cycles for all classification systems to provide stakeholders with certainty regarding timing of new versions which in turn assists stakeholders to plan for education programs and factor in expected implementation costs.

**Consultation question**

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

Victoria does not have a preferred timeframe. The admitted acute care classifications have only just moved to a three-year development cycle so it remains to be seen whether this cycle length is appropriate in the future. Maturity of a classification should also be considered when determining the length of the development cycle.

**Consultation question**

- 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?

Victoria agrees with the measures outlined by IHPA.

**Consultation question**

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

While the COVID-19 situation and activity in the non-admitted setting continues to stabilise, given recent outbreaks, it is unlikely that Victorian health services will be in a position to allocate resources to participate in the non-admitted costing study recommencing prior to December 2021. If IHPA sought to progress this further, Victoria would be seeking a similar level of support that was previously offered to health services to enable the costing study, subject to health services capacity to participate in the current environment.

Separately, from 1 July 2021, most Victorian health services will be required to report at an episode level an indication of the health condition or diagnosis contributing to reason for providing the service. This list has been modified to incorporate the Australian Non-Admitted Care Classification presenting condition short list and may assist with the ongoing development of the non-admitted costing study.

**Consultation question**

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

Victoria notes that at the time of writing, the final version of AN-SNAP version 5 has not yet been agreed. States and Territories need to be able to assess the analysis and implications to

understand the impact of moving to the final version of AN-SNAP version 5 before providing a definitive comment to this consultation question.

Victoria also notes that section A42 of the Addendum to the NHRA specifies a two-year shadow period should apply unless a different period is agreed by the Commonwealth and a majority of States and Territories.

**Consultation question**

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

Admitted Mental Health

Victoria believes the recently submitted 2019-20 admitted mental health activity and cost data needs to be made available to all States and Territories before Victoria can determine whether there are any impediments to pricing of admitted mental health using version 1 of the AMHCC for NEP22, noting that to date both the poor quality and consistency of cost and activity data, and unresolved problems with the inter-rater reliability of the AMHCC have created impediments to the use of the current AMHCC for pricing purposes.

Community Mental Health

Victoria believes the relatively under-developed nature of the activity and cost data for community mental is a significant barrier to full pricing of community mental health for NEP22. The current under-developed nature of the community mental health data means that it will be difficult to have confidence in a funding model that is based on it.

The impact of the longstanding inter-rater reliability issues with three of the five current mental health phases of care also represents a more significant issue for the community arm of the AMHCC than the admitted arm.

Victoria does not support full pricing for community mental health using version 1 of the AMHCC for NEP22. It is essential that shadowing continues for NEP22, in accordance with section A42 of the Addendum to the NHRA, to enable deficits in data quality and consistency to be addressed.

Victoria welcomes the IHPA's recent decision to review version 1 of the AMHCC. Given the ongoing inter-rater reliability issues and decision to review other aspects of the AMHCC, Victoria recommends that the IHPA defer the pricing of the community arm of the AMHCC until the next version of the AMHCC is available.

# 6. Setting the National Efficient Price

**Consultation question**

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

Victoria is supportive of adjustments to the NEP having regard to legitimate and unavoidable variations in costs based on an evidence-based approach. The IHPA model continues to grow in complexity with a growing array of adjustments. For every additional proposed adjustment, it is recommended that IHPA concurrently examine opportunities to consolidate other adjustments where they can concurrently explain the same variation in costs.

Victoria supports the IHPA investigating the level of evidence to support an adjustment for patient transport in rural areas. Victoria's support for a new adjustment depends on the level evidence to support to support it. Care needs to be exercised to ensure that there is no double up between existing loadings for rurality and a potential new loading that is focused on medical transfers and transport costs in rural areas.

**Consultation question**

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

Victoria is supportive of this review particularly in light of adoption of the National Weighted Activity Unit to fund Victorian health services from 1 July 2021, which has highlighted the disparity between the service delivery settings and the classification criteria for Intensive Care Units (ICU).

The IHPA's National technical specifications outline the current criteria be eligible for the ICU adjustment for hospitals that report more than 24,000 ICU hours and have more than 20 per cent of those hours reported with the use of mechanical ventilation.

A volume-based threshold for eligibility for the ICU adjustment helps to minimise a risk that health services provides ICU services unnecessarily due to a funding incentive. The current threshold, however, means that health services which currently deliver ICU services are not recognised, and may not be adequately funded to cover the associated higher costs than the average system wide AR-DRG classifications. The inherent pricing signal is that health services which provide ICU capacity, should not be, although there is a clear clinical and population needs based rationale for doing so.

State-wide capability and availability are ever more important factors for consideration for ICU loading eligibility since the COVID-19 pandemic. Victoria recognised through its prior activity-based funding model that smaller health services do incur significant costs to deliver ICU capability when delivering services below the thresholds currently outlined in IHPA's criteria.

These Victorian health services provide important state-wide capability and availability for ICU services that need to be recognised in the national ICU adjustment.

Victoria recommends that IHPA consider:

- The Meteor references that are contained in national reporting specifications (cost and activity) and whether the existing funding model adjustments should be updated to reflect contemporary clinical practices and models of care, in particular, the clinical aspects of the ICU, and qualifications according to Section B.3.3 of the IHPA NHCDC manual.
- A potential two-tier ICU adjustment, defined primarily by clinical need to provide ICU service, but where observed cost and volume differentiate the tiers. This will avoid

inadvertent inference that implies ICUs should not be delivered at certain sites and/or there is no additional cost to deliver ICU for those health services. It also signals that jurisdictions as system managers are able to manage ICU services in line with clinical best practice and population needs through the national funding model.

*ICU as defined in METeOR: 327234, is a designated ward of a hospital which is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. Note: Coronary Care centres, unless part of a Critical Care Department, should be the same as Standalone High Dependency Units, unless they meet the criteria for Critical Care departments in their own right (e.g. ANZICs LI or L2 ICU).*

**Consultation question**

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

The national reporting approach allows for the identification of Aboriginal and Torres Strait Islander patients in health service patient level records. It is generally recognised, however, that activity-based reporting under-represents the level of investment required to improve Aboriginal and Torres Strait Islander patient outcomes through cultural safety initiatives.

A deficiency in cultural safety will result in reporting bias. For example, an Aboriginal and/or Torres Strait Islander patient may refuse to identify due to fear about being treated differently or being stereo-typed, or they may simply avoid accessing health care as they or someone they know has had a bad experience with a health service in the past. In the long term, avoiding seeking early health care could lead to higher levels of chronic disease and higher costs of care.

Victoria has chosen to block fund hospitals to support improvements in cultural safety and continues to acquit this funding against initiatives delivered by the hospitals. This funding is in addition to the Indigenous based loadings in the national funding model. A number of shadow measures (indicators) have been introduced to facilitate performance conversations with hospitals, such as discharge against medical advice and did not wait trends. In the longer term, it is expected that investments in cultural safety initiatives will lead to better health outcomes for Aboriginal and Torres Strait Islander patients.

Victoria recommends that IHPA consult with jurisdictions' Aboriginal health divisions to develop a list of block funded services that can be added to the general list. On this basis, a national approach could be agreed that provides clarity on the conditions required to allow certain programs to be added to the general list with expected outcomes. This approach recognises there are varied initiatives that support improvement of cultural safety, tailored in response to needs in local communities and not able to be represented in the activity and cost data at this point in time.

In the longer term, the collection of this type of information in a nationally consistent way could lead to the development of a standalone capitation model that rewards improvement of longer-term health outcomes for Aboriginal and Torres Strait Islander people.

Victoria supports IHPA undertake a costing study with the purpose of revising the indigenous adjustment. Consideration should be given as to whether the costs captured in the data are averaged at ward level before being attributed back to patients and whether this needs to be addressed in the loading set.

**Consultation question**

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

Genetic services

Victoria supports the IHPA investigating any available evidence to support an increase in costs for genetic services. Victoria currently maintains clinical genetic service funding as a grant, separate from the national funding model in recognition that there are a range of different genetic services with different cost pressures and associated genetic/genomic tests. Victoria will be undertaking further work to better understand these issues prior to transitioning genetics in Victoria into the national funding model approach.

Consequently, any additional evidence developed by IHPA or other parties to support the refinement of the model and ensure funding alignment with service expectations and delivery would be welcomed.

Victoria considers that costs associated with genetic services should reflect the varying complexity of different types of genetic consultation (e.g., cancer, reproductive, adult, paediatric), alongside differing costs associated with genetic testing or genomic sequencing. Prior published evidenced (Fennel et al, 2009)[3] noted the complexity of genetic consultation and observes that *"Historical data are consistent with the concept that clinical genetics requires more time to review and diagnose patients than many other medical specialties. Evolution of increasingly complex diagnostic testing over the past three decades has further increased patient management requirements".*

Socioeconomic status

A recently published research paper (Yong and Yang, 2021)[4] presents evidence using Victorian hospital administrative data that socioeconomic disadvantaged patients tend to incur higher hospital costs and longer utilization by about 20% and greater incidence of in-hospital adverse outcomes by up to 80% than non-disadvantaged patients.

Further analysis demonstrated that hospital adverse outcomes indirectly contribute to about a quarter of the observed difference in hospital costs between socioeconomic disadvantaged and non-disadvantaged patients. While the paper defines socioeconomic status based on the use of social services, such as housing assistance and low-income assistance programs, using SEIFA to define socioeconomic status was observed as providing a similar result.

Victoria recommends IHPA investigate the impact of social economic disadvantage and if appropriate, determine a variable that can reflect the attributable impact.

[3]Fennell AP, Hunter MF, Corboy GP. The changing face of clinical genetics service delivery in the era of genomics: a framework for monitoring service delivery and data from a comprehensive metropolitan general genetics service. Genet Med. 2020 Jan;22(1):210-218. doi: 10.1038/s41436-019-0602-2. Epub 2019 Jul 11. PMID: 31292527.

[4]Yong J, Yang O. Does socioeconomic status affect hospital utilization and health outcomes of chronic disease patients? Eur J Health Econ. 2021 Mar;22(2):329-339. doi: 10.1007/s10198-020-01255-z. Epub 2021 Jan 3. PMID: 33389255.

**Consultation question**

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

Victoria believes that the introduction of price harmonisation is a significant change that should be carefully considered and planned before any progress occurs as it could impact on admission criteria and associated policies.

Given the current differences in practices across states and territories there is significant risk of unintended consequences if changes are introduced without detailed consultation and planning across system planners and health services. Any introduction should also consider the impacts it may have on the development of future models of care.

**Consultation question**

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

Victoria supports review of funding arrangements for unqualified newborns. Evidence shows that separating babies from their mothers after birth has long-term detrimental effects on breastfeeding, mother-baby attachment and mothers' mental health.

For some babies changes in treatment and models of care mean additional care could be safely provided at the mothers bedside, however provision of this care requires additional nursing/midwifery support not currently appropriately reflected in the DRG price.

Some examples of newborn care provided at the bedside, consistent with the delivery of care at a level 2 newborn service as per the Capability frameworks for Victorian maternity and newborn care[5], are demonstrated below:

- care for mildly unwell newborns ≥ 37+0 weeks gestation or newborn birthweight of ≥ 2,500 grams
- short-term care for minor conditions not requiring specialist medical treatment including:
    - mild respiratory distress (oxygen therapy requirement ≤ 30 per cent for less than six hours)
    - incubator care for less than six hours
    - single light phototherapy
    - commencement of gavage feeding, in preparation for transfer.

[5]State of Victoria, Department of Health and Human Services, March 2019, available at: https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/maternity-newborn-care.

**Consultation question**

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

Victoria supports the phasing out of the private patient correction factor where feasible that accords with a timeframe for States to comply with the Australian Hospital Patient Costing Standards Version 4.0.

# 7. Data Collection

Victoria looks forward to continuing work with the IHPA to develop, refine and maintain systems as necessary to determine the NEP and National Efficient Cost (NEC), including classifications, costing methodologies and data collections, and to develop appropriate data specifications and to acquire, validate and maintain data.

# 8. Treatment of other Commonwealth programs

Victoria is supportive of the IHPA discounting Commonwealth funding provided to public hospitals through the National Blood Agreement and Commonwealth pharmaceutical programs, as well as for the following Commonwealth funded Commonwealth funded pharmaceutical programs being removed prior to determining the underlying cost data for the NEP determination:

- Highly Specialised Drugs (Section 100 funding)
- Pharmaceutical Reform Agreements – Pharmaceutical Benefits Scheme Access Program
- Pharmaceutical Reform Agreements – Efficient Funding of Chemotherapy (Section 100 funding).

# 9. Setting the National Efficient Cost

**Consultation question**

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

Victoria notes that the potential movement of standalone hospitals listed in Appendix B to the NEC Determination has not been recently discussed in detail at IHPA working groups or committees.

Victoria believes that there are circumstances where activity-based funding is not the most appropriate funding option for some standalone facilities. Detailed discussion should occur at the IHPA Technical Advisory Committee about whether some categories of hospitals providing specialist mental health services should continue to be block funded.

Victoria considers that the circumstances of forensic mental health services require particular attention. This is because there are significantly different service models and patient characteristics in forensic mental health facilities when compared to other specialist mental health services, including very long-term admission and low patient turn over.

# 10. Future Funding Models

**Consultation question**

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

Hybrid models

Hybrid models are emerging in the delivery of health care, for instance those that deliver acute and subacute care concurrently. The cost differential between the care types discourages early access to a subacute model of care even if the patient has acute medical needs, however, there is clear benefit for older people with multidimensional care needs if they could access it earlier.

Hospital substitution through Hospital in the Home (acute and subacute) is a priority for Victoria in light of population growth, capital costs and ongoing pandemic response. Health services are currently incentivised to admitted patients for care in the home, rather than using non-admitted models, as admitted funding covers the elevated costs associated with workforce travel whereas non-admitted funding does not. This creates cost inefficiencies and a non-admitted home-based care pricing trial could help identify the suitability of expanding the non-admitted model.

There is also interest among Victorian health services in piloting a transition care program equivalent for patients facing barriers to discharge arising from delays in accessing NDIS packages, medium term accommodations and/or specialist disability accommodations. Victoria understands that NSW is working with IHPA on a costing study to capture the costs associated with these discharge barriers and would encourage that these findings be shared.

Remote monitoring

During the COVID-19 lockdowns, health services have operated virtual care models to monitor those at risk of admission to hospital. Such remote monitoring includes approaches where patients are trialled into levels of monitoring from self-reporting to more intensive daily or twice daily contacts. IHPA should consider whether funding rules around remote monitoring (i.e., not funding activity that involves a health service providing care for patients using remote monitoring technology without a direct patient/clinician interaction) are contemporary practice that should be included, as there are strong views from health services that the existing approach is not consistent with current best clinical practice.

Bundled payments

Victoria supports trialling of bundled payments and the key design elements specified by the IHPA. It should be noted that bundles designed to improve adherence to best practice pathways may create efficiencies but may also lead to an increase in cost. It may be that pathways could be designed separately from the AR-DRG starting point.

Bundled payments may also be appropriate for chronic disease treatment as seen in the Netherlands where bundled payments are using extensively in the long term for chronic diseases. The hypothesis being that they support adherence to a best practice pathways, especially those with who are multimorbid and can benefit from well-coordinated care. This will need to be considered carefully noting recent results regarding the long-term effects of the hypothesis remain inconclusive while the corresponding healthcare expenditure has increased[6].

The Productivity Commission's recent case study *Innovations for chronic health conditions*, provides a useful summary of enablers for models of care for people with chronic health care needs. Victoria is interested in working with the IHPA to trial models (particularly for stroke and orthopaedics, where key enables including capture of outcomes via registries is available) subject to project costs, registry access and sector capacity.

[6] Karimi M, Tsiachristas A, Looman W et al. Bundled payments for chronic diseases increased health care expenditure in the Netherlands, especially for multimorbid patients, Health Policy, June 202;125(6):751-759 doi: https://doi.org/10.1016/j.healthpol.2021.04.004.

**Consultation question**

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

Victoria continues to work with IHPA through the Jurisdictional Advisory Committee, to identify and develop sustainable funding models that can support more innovative models of care.

The department has sought continued recognition of the HealthLinks initiative on the General List of in-scope public hospital services in 2022-23. As part of this, Victoria is exploring the learning from the establishment of Healthlinks, and other capitation models, to inform how the operation of these models can be refined in the future.

A proposal was also submitted for the use of tele-health in emergency, urgent care, aged care and correctional facilities, as this was a model employed during the COVID-19 pandemic.

# 11. Pricing for Quality and Safety

**Consultation question**

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

Victoria recommends that IHPA consider:

- Whether implementation of pricing for quality and safety has the intended impact of improving patient outcomes in the short and long term. It is especially important to monitor impact on vulnerable groups such as indigenous populations, non-English speaking background and low socio-economic status.
- Whether patient experience is maintained or improved.
- That data quality is measured to effectively monitor changes in coding behaviour. This will ensure the data collected accurately monitors safety and quality.
- Whether clinical variation is reduced. It is important to understand whether providers are adopting a learning culture for improving quality and safety and providing models of care that are evidence based.

**Consultation question**

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

Models that are multidisciplinary have a greater chance of providing interventions that reduce preventable hospital admissions. Avoidable and preventable hospitalisations occur largely due to gaps in primary care and other service platforms such as private residential aged care facilities. Victoria's Residential-In-Reach (RIR) program addresses this gap by reducing admissions to hospital from residential aged care. This is funded as a non-admitted service despite providing specialist multidisciplinary care.

Incentives to prevent avoidable hospitalisations should not be focussed on levying further funding reductions on health services when these occur, further reducing the resources and capacity of health services to invest in prevention. Instead, the efforts in reducing avoidable hospitalisations should be focused on admission prevention activities such as RIR and HARP in a way that is consistent with contemporary best practice (i.e., enabling the use of remote monitoring and peer workforces as appropriate). These activities also attract a higher commonwealth contribution, thereby recognising that avoidable hospitalisations are arising from gaps in commonwealth funded sectors rather than health service failures.

Victoria notes that it has requested the Commission provide an evidence base for clinical guidance that will be used to inform pricing and funding models aiming to reduce avoidable and preventable hospitalisations. Pricing and funding approaches should consider:

- The potential perverse incentives that may be created by using funding levers to reduce hospitalisations – for example the disproportionate penalisation of disadvantaged/vulnerable communities with both poorer average health status and limited access to alternative care providers i.e., regional or indigenous backgrounds.
- Funding incentives that support preventative care that are community based, multidisciplinary and evidence based.
- How to ensure patients with complex needs are not disadvantaged.

**Consultation question**

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

Victoria recommends that IHPA consider:

- Appropriate evidence-based care pathways existing in the community.
- Complex patients are provided quality and safe care.
- Learning culture supported for providers.
- Patient preferences are enabled.