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File reference
EDOC2022/292463

Joanne Fitzgerald
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Via Email: secretariatihpa@ihpa.gov.au

Dear Ms Fitzgerald

RE: Consultation Paper - Pricing Framework for Australian Public Hospital Services 2023-24

Thank you for the opportunity to provide comment on the Independent Hospital Pricing Authority's (IHPA) *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023-24* (the Consultation Paper).

NT Health faces unique challenges in delivering health care services, as a result of significant geographical and cultural barriers. To manage these challenges, it is essential that the national pricing model promotes equity of access to hospital services and ensures the financial stability of the public hospital system. NT Health's submission is attached and provides feedback on these issues.

I welcome further discussion between IHPA and NT Health on this submission. If you require further information on this matter, I encourage you to contact Mr Stathi Tsangaris, Executive Director Funding and Performance, on (08) 8999 2590 or at Stathi.Tsangaris@nt.gov.au.

Yours sincerely

Dr Frank Daly
MBBS FACEM GAICD FLWA
Chief Executive
13 July 2022

Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023-24

Northern Territory Submission

NORTHERN TERRITORY GOVERNMENT

Contents

1. Foreword

This submission provides feedback on issues highlighted in the Independent Hospital Pricing Authority's (IHPA) *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023-24*, particularly where there may be potential impacts to equity of access to hospital services or the financial stability of the Northern Territory (NT) public hospital system.

2. Impact of COVID-19

Consultation question/s or issue

- Are there any specific considerations IHPA should take into account for assessing COVID-19 impacts on the 2020–21 data in the development of NEP23?

COVID-19 continues to impact NT Health through increased service delivery costs, reductions in hospital capacity due to staffing pressures and delayed hospital treatments. NT Health supports IHPA's proposed plan to assess COVID-19 impacts on 2020-21 data and test the assumptions adopted for NEP22.

COVID-19 created supply chain issues Australia wide when outbreaks hit in 2020 and caused the cost of consumables to increase. While supply has slowly increased over the past two years, costs have not reduced to pre-COVID-19 levels. This step change in costs is likely to endure for the foreseeable future, particularly as high inflation is anticipated over the coming year. NT Health request IHPA provide assurance to jurisdictions that the pricing model will appropriately account for the cost increases.

NT Health continues to experience subdued activity levels as backlogs of elective surgery and reduced hospital capacities remain. Capacity constraints, largely due to the furloughing of staff and challenges in attracting and retaining specialist nursing and medical staff, are placing increased pressures on the NT Health system. NT Health are also experiencing clear staff migration patterns away from the Territory as the border closures, accrued leave and work pressures of the past two years are incentivising staff to move closer to their support and families networks in south east Australia. These pressures as a consequence of COVID-19 are likely to endure as jurisdictions compete to retain and attract skilled labour in remote areas, including the provision by some states of financial incentives and bonuses.

The interruptions to the Health system through COVID-19 have led to delayed health care for many residents of the NT. A number of outpatient clinics were postponed or delayed due to COVID-19 protocols, outbreaks and reprioritisation of staff. Consequently NT Health are now experiencing the presentation of more progressed illness into the hospital system. NT Health request IHPA assess the impact of changes in acuity and length of stay profiles and provide advice on whether adjustments within the pricing mechanism are required for NEP23.

The COVID-19 environment continues to evolve and a system based on historic data with a significant time lag does not allow for adaptive and responsive pricing. It is imperative that IHPA investigate mechanisms to allow the model to respond to significant in year changes to ensure hospital funding can account for the variables affecting the actual cost of providing health care services.

3. The Pricing Guidelines

Consultation question/s or issue

- IHPA has reviewed the Pricing Guidelines in 2022 and considers that further amendments are not required.

NT Health notes IHPA's current fairness guideline advocates for equitable access and that existing adjustments in the national pricing model are designed to reflect the legitimate and unavoidable additional cost of treating particularly for Indigenous people and those that live in remote areas. However, as the funding mechanism does not allow for historic inequalities to be factored into patient complexity, the effectiveness in achieving equitable outcome is constrained.

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

> ***Equitable access to close the gap:*** *The ABF model should improve access to healthcare with the aim of improving health outcomes for disadvantaged populations.*

Many Indigenous people face additional barriers to accessing effective healthcare services, particularly in communities where significant cultural and linguistic barriers still exist. These barriers can hinder the ability for Indigenous people to feel comfortable when seeking required medical treatment and the ability to effectively communicate health concerns to medical professionals.[1] It would be beneficial for pricing model design to incorporate incentives for jurisdictions to reduce the barriers that many Indigenous people still face and in turn improve health outcomes.

NT Health recommends IHPA introduce a more comprehensive design guideline to ensure that current and future funding models facilitate equitable access to healthcare by enabling pricing mechanisms to reduce barriers and work towards closing the gap for disadvantaged people in Australia. For example creating an innovative model to appropriately fund tailored service delivery for the health needs of disadvantaged Indigenous people.

4. Scope of public hospital services

Consultation question/s or issue

- IHPA is required to facilitate the exploration and trial of new and innovative approaches to public hospital funding, to improve efficiency and health outcomes.

NT Health note the requirements of the National Health Reform Agreement (NHRA) to facilitate exploration and trial new and innovative approaches to public hospital funding. NT Health encourage IHPA to work with the Health Reform Implementation Group (HRIG) within this space to ensure the work programs align and that the two bodies are complementary in their investigations for new approaches to support public hospital funding.

[1] IHPA's Jurisdictional Advisory Committee Meeting Paper 8 April 2021, Commonwealth Department of Health – Improving outcomes for Aboriginal and Torres Strait Islanders.

5. Classifications used to describe and price public hospital services

5.1. Admitted acute care

Consultation question/s or issue

- Are there any barriers or additional considerations to using AR-DRG Version 11.0 to price admitted acute services for NEP23?
- Do you support IHPA's proposal to refocus some resources on projects that prepare for ICD-11 implementation? Please provide suggestions for any specific 'readiness' projects you would like to see progressed.

Using AR-DRG Version 11.0 to price for NEP23

NT Health notes that IHPA will provide a statement of impact as required under the NHRA. NT recommends that this statement present the impacts of the introduction of AR-DRG Version 11.0 at a jurisdictional level in order for jurisdictions to anticipate and plan for potential funding impacts for 2023-24 given there will not be a shadow pricing period.

ICD-11 Implementation

NT Health is supportive of IHPA undertaking projects to prepare for ICD-11 implementation. IHPA should consider how the new classification will impact local information systems and coding workforces, particularly the training and system adaptations that will be required prior to implementation. Consideration should also be given to how ICD-11 will impact the financial stability of the health system and what transitionary arrangements should apply.

5.2. Subacute and non-acute care

Consultation question/s or issue

- Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP23?

NT Health recommends that IHPA continue to shadow price admitted subacute and non-acute services using AN-SNAP Version 5.0 for NEP23. As 2022-23 is the first year of shadow pricing, data is not yet available for analysis to determine its funding impacts and stability of the model. The earliest this data will be available is December 2022, and this will only be one quarter of data. Further NEP22 is based on a set of assumptions to account for COVID-19, therefore the second year of shadow pricing will provide transparency to jurisdictions regarding whether COVID-19 may or may not have had an impact on the classification introduction.

Consistent with IHPA's *Alterations to the National Pricing Model Framework*, a shadow pricing period of at least two years should be used to ensure that changes do not result in any unintended financial consequences.

5.5. Mental Health Care

Consultation question/s or issue

- Are there any barriers or additional considerations to using AMHCC Version 1.0 to price community mental health care for NEP23?

NT Health does not agree to proceed to pricing of community mental health care for NEP23 using AMHCC Version 1.0 due to the following impediments during the shadow pricing period:

- **Impact of implementing the service contact model:** The new pricing model introduced for the NEP22 shadow pricing period utilises the number of service contacts provided within an episode as the driver of funding. This is a significant change from the previous model which calculated funding on the basis of length of stay. This modification also requires NT Health to implement system changes to ensure the capture of service contact data as individual events. NT Health has concerns regarding the ability to provide completed data and assess the stability and performance of the model within the remaining one year shadow pricing period. NT Health recommend IHPA restart the two year shadow pricing period in 2022-23, to provide a complete two years of shadow pricing based on the new model.
- **Potential to unfairly penalise regional and remote areas:** The Taylor Fry Quality Assurance Review of the NEP22 and NEC22 notes the current community model fits poorly across several variables including patient and treatment remoteness, particularly for remote and very remote areas. NT Health's 2022-23 submission raised similar issues with the pricing of admitted mental health under the AHMCC classification. Under-pricing in remote and very remote areas weighs heavily on some jurisdictions, including the NT. Our large remote population could potentially cause a reduction in funding under the AMHCC Version 1.0 given the under-priced. Further analysis is required to ensure that ABF payments are fair and equitable, and properly reflect legitimate and unavoidable costs of service delivery in line with the Pricing Guidelines.
- **Potential inaccurate pricing:** NT Health is concerned with volatility of the model and its ability to accurately drive pricing given only four jurisdictions are currently able to report the data. The model is expected to be volatile as more data is incorporated. It is imperative that the model is monitored and evaluated for appropriateness across all jurisdictions and therefore there is great benefit in shadow pricing for an additional year.

NT Health recommends that IHPA continue to shadow price community mental health care for NEP23 to allow a full two year shadow period for the new model. This will ensure that data completeness issues and remote pricing issues are able to be analysed and addressed prior to pricing under AMHCC Version 1.0.

6. Setting the national efficient price

6.2. Adjustments to the NEP

Consultation question/s or issue

- Are there any adjustments IHPA should prioritise investigating to inform the development of NEP23?
- What cost input pressures that may have an impact on the national pricing model and are not included in the NHCDC should be considered in the development of NEP23?

6.2.1. Adjustments

NT Health supports IHPA reinvestigating an adjustment for patient transport, reviewing the Specified Intensive Care Unit eligibility criteria, reviewing the Indigenous adjustment and considering a new adjustment for socioeconomic status. NT Health reiterates the NT's position on these elements below.

Reinvestigation of an adjustment for patient transport in rural areas

IHPA's analysis of patient travel costs as part of the development of NEP21 found that existing remoteness adjustments in the national pricing model do not adequately capture the cost of patients transferred between hospitals. There is significant variation in costs for inter-hospital transfers and medical evacuations across and within remoteness categories. NT Health also note that IHPA, upon advice from the Commonwealth Grants Commission (CGC) in 2021, concluded that patient travel costs are already accounted for through the GST distribution model and therefore IHPA are unable to undertake further work on a transport adjustment.

NT Health disagree with IHPA and the CGC's conclusion that transport costs are already appropriately accounted for through the GST methodology. The GST assessment is based on state expenditure as reported through government finance statistics and then proportionately distributed on a per population basis with an adjustment for remoteness. There are a number of assumptions involved within the formulas and the proportionate split of hospital and non-hospital transport services remains fixed for each five year review period. IHPA's assessment that transport is already account for, albeit in a per capita model with a 5 year fixed data cycle, does not align with the overarching pricing guideline of fairness or the process guideline of evidence-based. Further the guidelines state ABF should be used where practical and appropriate to ensure efficient cost and outcomes. In line with IHPA's calculation of other hospital services and adjustments, which the CGC also assess in order to calculate the GST relativities, the NT request IHPA investigate a more appropriate mechanism to fund patient transport. The NT reiterate that this assessment is within IHPAs remit and should be prioritised in order for equitable access to healthcare to be upheld.

Review of the Specified Intensive Care Unit eligibility criteria and adjustment

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

Review of the Indigenous adjustment

NT Health recommends that IHPA's review of the Indigenous adjustment include consideration of the disparity in hospital care and services faced by Indigenous people. Indigenous people face significant barriers in accessing effective healthcare services including institutionalised racism, a lack of cultural safety, distrust of the health system, communication and language barriers between staff and the patient, remoteness and affordability.[3] NT Health believe that the barriers are more significant for Indigenous people residing in communities and homelands compared to those within major cities. IHPA should

[2] New South Wales Agency for Clinical Innovation 2014. *Non-invasive Ventilation Guidelines for Adult Patients with Acute Respiratory Failure*
[3] IHPA's Jurisdictional Advisory Committee Meeting Paper 8 April 2021, Commonwealth Department of Health – Improving outcomes for Aboriginal and Torres Strait Islanders.

investigate adding an indigenous population density factor into its adjustment to acknowledge the difference in barriers faced by different groups of Indigenous people. Driving better health outcomes for the most vulnerable of cohorts requires equitable access to effective hospital services.

There are opportunities for reform through a strategic approach to improve the responsiveness of hospitals to the health needs of Indigenous people. NT Health recommends that IHPA also investigate an incentive based adjustment into the national funding model to incentivise local hospital networks to improve accessibility for Indigenous people. This will provide a mechanism to further address barriers by improving the ability for hospitals to tailor service delivery and respond to health needs that are important to Indigenous people. This would align with the proposed system design guideline to ensure equitable access to close the gap.

Consideration of a new adjustment for socioeconomic status.

NT Health recommends that IHPA investigate whether area-based measures such as those used by the CGC are suitable to support review of the impact of socio-economic status on service delivery costs. NT Health notes that the CGC uses separate measures for Indigenous and non-Indigenous people to recognise the influence of socio-economic status on healthcare costs, separate to other cost factors such as remoteness[4]. This is noting that socio-economic indices based on the whole population in a given areas may not reflect the status of Indigenous people appropriately.

NT Health recommend that IHPA investigate whether the following area-based indices enable appropriate classification, in addition to other characteristics such as remoteness:

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

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

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

6.2.2. Cost Input Pressures

NT Health encourage IHPA to consider all states enterprise bargaining and medical officer agreements for NEP23, and how these differ to the 2020-21 costs that are the basis of the model. A new EBA for administrative staff was introduced into the NT for 2021-2025 which saw a bonus payment of $4000 in the initial year and $2000 for each year thereafter. There are no scheduled pay rises in addition to these payments, however the previous EBA included 2.5 per cent pay rises in each year. The enterprise agreement for medical officers is currently undergoing negotiations and the wage growth and structure of this agreement have not yet been determined.

6.3. Other Adjustments

Consultation question/s or issue

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

- Which initiatives to refine the national pricing model should IHPA prioritise investigating?
- What additional data sources are available to support refinement of the national pricing model in relation to adjustments, price harmonisation, unqualified newborns, private patients or organ donation?

Harmonising price weights across care settings

NT Health supports review of 2020-21 activity and cost data to determine the feasibility of price harmonisation. NT Health reiterates the requirement for thorough investigation into clinical practices across jurisdictions to ensure it is appropriate to classify services across different settings into resource-homogenous groups. It is imperative that harmonisation does not inappropriately group patients where services differ. NT Health also recommends applying transitional arrangements and price stabilisation in circumstances where price harmonisation is deemed appropriate.

Setting the National Efficient Price for Private Patients in Public Hospital

NT Health continue to work with IHPA and the NHFB in regards to private patients in public hospitals. The NEP22 determination updated the private patient adjustment from a calculated price to a funding reduction for the delivery of private patient services. The formula and application within the model continue to be refined.

8. Future funding models

Consultation question/s or issue

- How is virtual care delivery captured in information systems and data collections?
- IHPA is proposing to investigate the inclusion of emergency department telehealth video consultations in the NAPEDC NMDS and Emergency service care National Best Endeavours Data Set for 2023–24. Are there any other examples of innovative models of care and services related to virtual care that IHPA should also consider investigating?
- What changes, if any, to the national pricing model should IHPA consider to account for innovative models of care and services related to virtual care?

Virtual Care Delivery and Emergency Services

Currently virtual care delivery is captured by NT Health in a limited manner within non-admitted patient records. NT Health will investigate its ability to report emergency department telehealth video consultations in the NAPEDC NMDS and Emergency service care National Best Endeavours Data Set for 2023–24. NT Health support IHPA's proposal to investigate the inclusion of emergency department telehealth data within the national datasets. Further NT Health propose IHPA investigate the most appropriate funding model for these services.

Currently services are funded as non-admitted, however, the cost drivers of emergency care delivered via telehealth are believed to be significantly different to standard non-admitted telehealth services. The provision of emergency care through telehealth has substantial cost overheads for a service that by design is unpredictable in its use. The funding model needs to take into account that these services are in essence an emergency department, albeit only seeing patients virtually. This model of care contributes to improved patient outcomes and there is likely savings potential in keeping some patients out of the Emergency Department and Hospital settings.

Other Examples of Innovative Models of Care

Medical Retrieval and Consultation Centre (MRaCC) in Alice Springs was launched in 2018 to provide a medical retrieval service for acute care cases, inter-hospital transfers and repatriation of patients back to country. MRaCC was designed to better streamline communication processes during emergency retrievals; to bring the current system into line with national developments in Retrieval Medicine practice; and to enhance the quality of the retrieval service and decrease risk to acutely sick patients. MRaCC provides a 24-hour, single-point-of-contact emergency consultation service for all clinicians and for sick patients.

MRaCC is currently funded through the non-admitted patient model and is coded to general medicine. NT Health propose that IHPA investigate this model of care alongside the delivery of virtual emergency care, as the two may align although this service offers more than just virtual emergency care.

Exploration of Innovative Models of Care

Regarding the general exploration of innovative models of care NT Health reiterate that IHPA consider the following:

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

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