Pricing Framework for Australian Public Hospital Services 2023-24

Department of Health Submission to the IHPA

Queensland Health (QH) welcomes the opportunity to provide feedback on the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24* (the Framework), released on 8 June 2022 by The Independent Hospital Pricing Authority (IHPA) for public feedback.

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

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

1. *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?*

Wage policy:

Per Question 7 below, the Queensland Government put in place a wage freeze for 2020-21. This impact is showing up in the early analysis undertaken by IHPA and presented in its Technical and Jurisdictional Advisory Committees. For example, in 2020-21 Queensland recorded a reduction in costs per National Weighted Activity Unit (NWAU) across admitted patients and emergency department presentations. The value of the deferred wage increase has been reported in the National Hospital Cost Data Collection data quality statement and Queensland looks forward to working with IHPA on how this type of cost deferral can be managed in the development of NEP23.

COVID-19 therapies:

Medicines approved for use by the Queensland Health COVID-19 Therapeutics Working Group and those medicines controlled by the National Medical Stockpile (NMS) (the latter not currently a cost if from the NMS) would need to be considered in the treatment of COVID-19. These costs should be separately assessed for expected use in 2022-23 and 2023-24. A link to the COVID-19 therapies guidelines is available to review each of the decision pathways and medicines Clinical guidelines | Queensland Health

2. *Are there any barriers or additional considerations to using AR-DRG Version 11.0 to price admitted acute services for NEP23?*

QH does not consider there are any barriers to using Australian-Refined Diagnosis Related Group (AR-DRG) Version 11.0 to price admitted acute services for NEP23.

3. *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.*

Yes, QH supports IHPA's proposal and suggests consideration be given to seeking pilot sites to trial projects. The International Classification of Diseases 11th Revision (ICD-11) code structure is currently not supported by QH information systems due to the length of the code(s) depending on the patient's episode diagnosis / characteristics and the inclusion of special characters (separators used for clustered codes).

To illustrate the differences in formatting between the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) and ICD-11, a patient with a urinary tract infection due to E. coli and penicillin resistant would have been coded under ICD-10-AM as follows:

- N39.0 Urinary tract infection, site not specified
- B96.2 Escherichia coli [E. coli] as the cause of the disease classified to other chapters
- Z06.51 Resistance to penicillin

The equivalent ICD-11 code would be GC080/MG50.26, which represents:

- GC08.0 Urinary tract infection, site not specified, due to Escherichia coli
- Associated with MG50.26 Penicillin resistant Escherichia coli

QH suggests that the code structure be segmented into sub-groups / sub-codes (similar to the current approach under ICD-10-AM) to create a manageable format to ease system constraints.

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

Queensland understands that AN-SNAP Version 5.0 represents a modest refinement on AN-SNAP Version 4.0. However, the full impact of the changes will need to be assessed.

The incorporation of the Frailty Related Index of Comorbidities (FRIC) into the classification for geriatric evaluation and management and non-acute episodes of care was supported by QH as it utilises already captured International Statistical Classification of Diseases and Related Health Problems (10th revision) (ICD-10) diagnostic codes meaning there would be no additional reporting burden on jurisdictions.

As the FRIC is a modification to the Hospital Frailty Risk Score that was developed as a screening tool to identify at risk patients 75 years and older, the FRICs ability to predict cost is still to be fully tested. QH recommends that IHPA continues discussions with jurisdictions on the matter of determining a suitable frailty measure to achieve the best outcome.

QH recommends IHPA shadow AN-SNAP Version 5.0 for two years per clause A42 of the National Health Reform Agreement (NHRA). Although the changes are modest, QH has not had sufficient time to assess the new classification ahead of the Pricing Framework consultation.

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

In its response to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022–23*, QH did not support shadow pricing community mental health using the Australian Mental Health Care Classification (AMHCC). QH reiterates its position that community mental health services cannot be considered for pricing using AMHCC until all jurisdictions are in agreement the model is robust and consistent nationally. The most significant issue, which has been supported by evidence produced via IHPA projects, is that there is limited inter-rater reliability. Until this is appropriately addressed the risk for pricing community mental health care using the AMHCC is too high. Furthermore, the impact of removing 'assessment only' as a phase needs to have sufficient time to be considered.

6. *Are there any adjustments IHPA should prioritise investigating to inform the development of NEP23?*

Avoidable Hospital Readmissions Adjustment:

QH suggests that IHPA undertake a review of avoidable hospital readmissions adjustments to ensure that the adjustment is meeting the policy intent, which is to appropriately penalise hospitals to drive a reduction in avoidable readmissions. QH is concerned that there are instances whereby the wrong hospital is penalised as a result of a readmission. This can occur because the methodology only covers Activity Based Funding (ABF) hospitals and excludes block and private hospitals. As a result, it is possible that the index episode occurred at a block or private facility that could have occurred between two admissions to an ABF hospital. There should also be a review to ensure that the index episode is clinically related to the readmission episode as the methodology assumes a clinical relationship based on the readmission diagnosis coding and interval period.

First Nations Adjustment:

QH has previously outlined concerns with the Indigenous adjustment, which for 2022-23 was determined as a three percent adjustment applied to admitted acute, subacute and non-acute, mental health, emergency department and non-admitted patient episodes.

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

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

Length of stay:

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

Multidisciplinary clinic adjustment:

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

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

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

Intensive Care Unit:

Previous pricing framework consultations have specifically included consultation questions regarding facility specific classifications including the Specified Intensive Care Unit (ICU) eligibility, and more recently through IHPA committees the Specialised Children's Hospital eligibility criteria has also been raised.

QH reiterates previously supplied feedback regarding Specified ICU eligibility and recommends that the IHPA Clinical Advisory Committee consider removing the reliance on mechanical ventilation hours and recognise the ICU status of facilities through the minimum standards as published by the College of Intensive Care Medicine of Australia and New Zealand (IC-1-Minimum-Standards-for-Intensive-Care-Units.pdf (cicm.org.au)).

Specialist paediatric hospitals:

QH welcomes IHPA commitment to conduct a review of the criteria for specialist paediatric hospitals as part of the 2023-24 Pricing Framework development.

7. *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?*

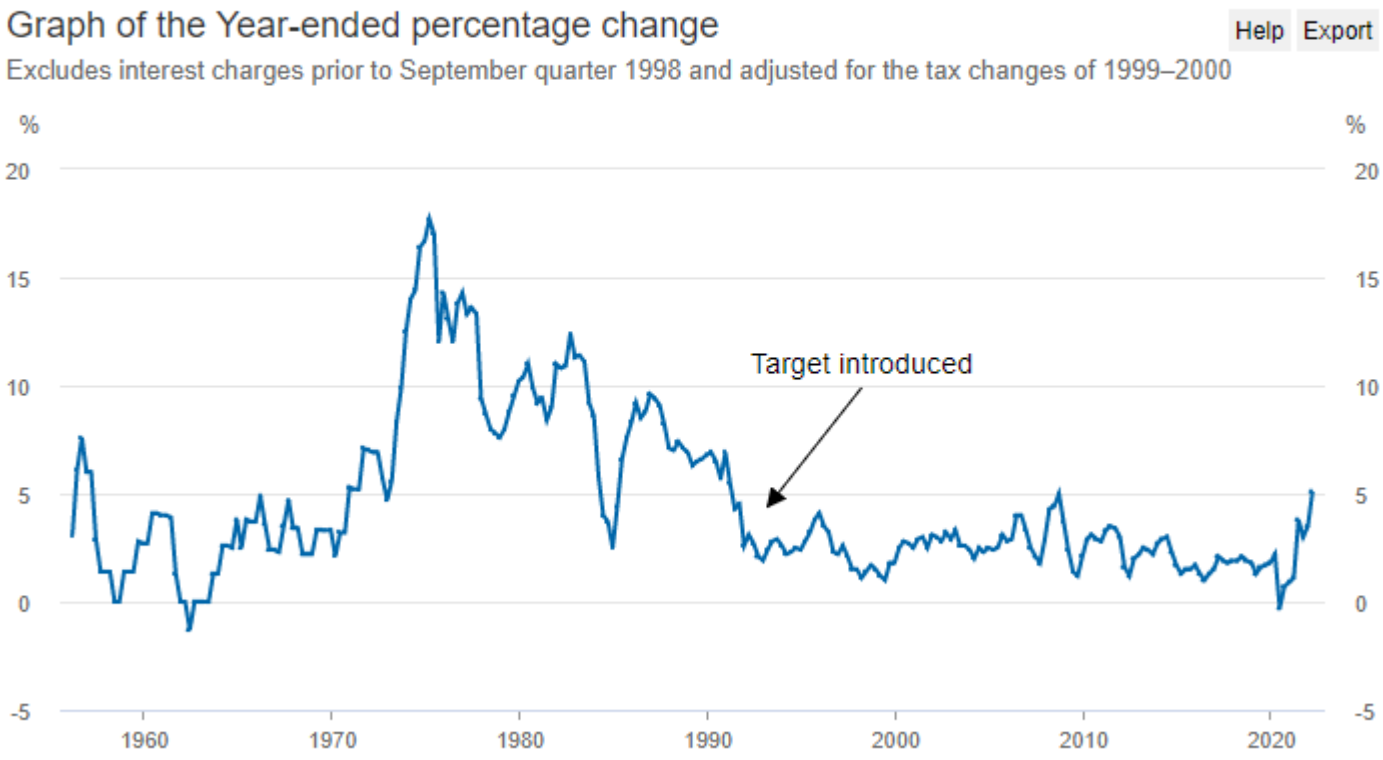
The most significant cost impact in the National Hospital Cost Data Collection (NHCDC) for 2020-21 was the temporary wage freeze announced by the Queensland Government in June 2020. Wage rises of 2.5 per cent due within the 2020-21 financial year were delayed, with two wage rises of 2.5 per cent each occurring in the 2021-22 financial year. In effect, salaries and wages rates were unchanged in 2020-21 and increased by 5 per cent in 2021-22.

QH believes that IHPA should recognise the impact of the wage freeze in the determination of the 2023-24 National Efficient Price (NEP) as the wage freeze was not permanent and if not adjusted the NEP would not adequately compensate for actual costs incurred in 2023-24. QH provided IHPA with the details of the quantum of salary and wage costs temporarily avoided in 2020-21 in the data quality statement of the NHCDC.

There has been a significant increase in general inflation in Australia to around 5 per cent (see chart below) which is particularly evident in energy and transport costs. Even after excluding 'volatile' items, the Reserve Bank of Australia's measures of underlying inflation have all increased to around 4 per cent from around 1.5 per cent over the past 5 years. The current approach to indexing the hospital

costing model to generate the hospital pricing model relies on historic inflation which was particularly low. This approach will likely result in under-compensation for actual costs.

Last updated: 27 April 2022



Sources: ABS; RBA

8. Which initiatives to refine the national pricing model should IHPA prioritise?

In the consultation paper IHPA has highlighted the following initiatives, many were put on hold last year due to the Coronavirus disease (COVID):

- Harmonisation of price weights across care settings (not progressed for NEP22)
- Separate pricing for unqualified newborns (not progressed for NEP22)
- Setting the NEP for private patients in public hospitals
- Phasing out the private patient correction factor
- Organ donation, retrieval and transplantation (development of strategy deferred due to COVID-19)

Supported initiatives:

Newborns

QH has previously highlighted that the bundling of unqualified newborns with the mother's DRG in the existing national pricing approach does not properly reflect care needed and provided by hospital

neonatal services to neonates who are with their mother, as a separate funding item. Many services once managed in a special care nursery or neonatal intensive care unit which are now provided at the mother's bedside. Examples of such procedures include:

- 570 – Non-invasive ventilatory support
- 1611 – Other phototherapy of skin
- 1916 – Generalised allied health interventions
- 1920 – Administration of pharmacotherapy
- P03 – Fetus and newborn affected by other complications of labour and delivery
- P80 – Hypothermia of newborn
- P92 – Feeding problems of newborn
- R06 – Abnormalities of breathing
- R29 – Other symptoms and signs involving the nervous and musculoskeletal systems
- Z03 – Medical observation and evaluation for suspected diseases and conditions, ruled out

The perception is that unqualified neonates are not funded, and it could drive perverse resourcing allocation for the care of babies, and potentially worse, drives a model of care that does not keep the newborn with the mother. As such, QH supports prioritisation of separate pricing for unqualified newborns.

Private patient correction factor

QH has no concerns with phasing out the private patient correction factor.

Organ donation, retrieval and transplantation

QH cautions that Queensland is not similar to other state and territory models in the facilitation of organ donation, retrievals and transplantation. There is substantial variation in the cost of organ donation and retrievals in Queensland – the major variation being transport. DonateLife Queensland supports approximately 30 hospitals state-wide for organ donation, which includes the private sector. The DonateLife Queensland state based organ and tissue donation agency is located in Brisbane, as are the three transplant units, Princess Alexandra Hospital, The Prince Charles Hospital and Queensland Children's Hospital and the Tissue Typing lab and Pathology Queensland. The distances and modes of transport that DonateLife Queensland staff and the Transplant surgical teams travel are extremely high in Queensland owing to the fact that Queensland has a relatively high population dispersion away from the capital.

Below are the numbers of 'actual' organ donors in Queensland (over 7 years) noting that 2019 was the last 'normal' year pre-COVID.

Queensland Donors by Calendar Year						
2015	2016	2017	2018	**2019**	2020	2021
72	106	105	94	**106**	86	91

As an example of the high costs faced in Queensland, in 2019, 20 per cent of actual donors required at least one charter aircraft for surgical retrievals. Where the thoracic organs are being retrieved as well as abdominal organs from a donor, two aircraft are used to carry the surgical teams, eskies and surgical equipment. Conservatively speaking, at least one charter aircraft was used for 20 donors in this year. Currently, the cost of a charter flight between Brisbane and Cairns is between $30,000 and $40,000. It is anticipated with rising fuel prices, these costs will also potentially increase.

QH notes that the cost of organ donation includes incomplete cases. Whilst there were 106 actual donors (organs retrieved) in 2019, there were another 39 cases of documented ‘intended’ donors, where the case was worked up, consent achieved, tissue typing and serology bloods activated, sent and tested, organs allocated and surgical teams mobilised. However, the organs were not retrieved due to medical suitability identified after clinical investigations or the patient did not meet the criteria of Donation after Circulatory Death and no organs were retrieved. The same amount of work by DonateLife Queensland staff and transplant teams (physicians and surgeons) is performed on an intended donor, including potentially flying to a regional centre in Queensland, therefore the cost of donation, in some cases, and retrieval will be almost the same as an actual donor.

Partially supported initiatives:

Price weight harmonisation

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

QH has previously highlighted to IHPA concerns around proposals to harmonise prices for dialysis and chemotherapy. In reality QH considers that the services delivered admitted and non-admitted are different, with different patient pathways and resource inputs.

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

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

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

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

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

Not supported initiatives:

Setting the NEP for private patients

QH believes that IHPA's work in developing a methodology for ensuring private patient financial neutrality has been completed and that the implementation of the adjustment is more appropriately handled by the National Health Funding Body (NHFB) as the entity responsible for the national funding model (as opposed to national pricing model).

Due to data limitations, the impact of back-casting, and accrual vs cash accounting, the modelled estimates of funding reductions associated with private patient neutrality have been shown to not align with the policy intent of the NHRA clauses. QH has provided feedback to the NHFB to consider alternative approaches to implementing the NHRA clauses.

Other initiatives:

Virtual care pricing

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

- what are appropriate parameters to identify and classify virtual care given the non-admitted classification model is limited in scope and specificity, an appropriate data set to determine the course of care and patient management is able to be appropriately recognised/recompensed.

9. *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?*

QH is already supplying activity data for unqualified newborns and organ donation episodes. As per the Australian Hospital Patient Costing Standards, the cost for unqualified newborns is grouped with the mother's episode of care. However, HHSs cost the episodes separately and the episode costs are combined as part of NHCDC preparation. QH can supply separate mother and unqualified newborn cost data to support this review.

10. *What cost pressures for regional or remote hospitals should be considered in the development of NEC23?*

There are considerable additional costs that are not adequately captured by existing adjustments within the national pricing model. Equalising costs is not necessarily equitable for rural and remote hospitals.

Workforce:

Over the past two years, workforce costs for rural and remote hospitals have increased in line with amplified competition and demand nationally. Traditionally, rural and remote hospitals have always had a high reliance on locum and agency workers to fill gaps resulting from long-standing challenges in permanent recruitment of staff, or to facilitate staff leave. These temporary arrangements cost more to the hospital than a permanent staff member. Over the past two years, with border closures and a lack of international arrivals, these locum and agency staff have been in short supply nationally.

Transport:

To transfer patients for care in rural and remote areas requires the use of chartered flights, both fixed wing and helicopter and includes the resources of the Royal Flying Doctor Service (not emergency evacuations). Similarly, if an HHS is able to backfill staff internally, there may be additional costs associated with transportation to get the staff member to and from a remote site, sometimes involving charter flights.

11. *What specific areas of the Local Hospital Networks and Public Hospital Establishments National Minimum Data Set would you recommend IHPA focus on when developing its independent quality assurance process?*

Following the May Jurisdictional Advisory Committee meeting, QH provided detailed feedback regarding validations conducted prior to submission of the Public Hospitals Establishment (PHE) data each year. QH welcomes the opportunity to work collaboratively with IHPA to improve the quality of this collection however the state recommends that IHPA consider expanding the scope of the NHCDC to include non-patient products which would enable the single collection to fulfill both NEP and National Efficient Cost determination requirements.

12. *What should IHPA consider when transitioning standalone hospitals providing specialist mental health services to ABF?*

Per advice provided for the 2022-23 Pricing Framework consultation QH has major reservations in relation to transitioning block funded standalone hospitals that provide specialist mental health services to ABF. For these facilities in particular, the nature of the patient care, length of stay (including leave taken), treatment type and highly specialised, resource intensive care, including high security for those Classified patients or subject to a Forensic Order, indicates that the patient cohort would not be suitable for setting an average efficient price based on other mental health services, and therefore do not lend themselves to an ABF environment. After the more acute phase, patients generally will be in a transition phase of care resulting in more leave. However, the hospital is required to ensure acute level staffing and beds are available at any time during this period if a patient deteriorates. IHPA should consider that there are fixed underlying costs for patients in this care setting that the AMHCC will not accurately reflect.

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

It should also be noted that two facilities currently recognised as block funded standalone hospitals, providing specialist mental health services (Kirwan Rehabilitation Unit and Charters Towers Rehabilitation Unit), transitioned to being Residential Mental Health Care Services from 1 July 2021. Therefore, the facilities report services against the Residential Mental Health Care National Minimum Dataset (NMDS) rather than APC NMDS.

13. How is virtual care delivery captured in information systems and data collections?

Queensland has been capturing and incentivised virtual care delivery for admitted and non-admitted service categories via:

- QH Admitted Patient Data Collection for admitted inpatient care e.g. telehealth, telehandover, local reporting systems (Store and Forward Assessment Data Collection tools for store and forward assessments event)
- QH Non-Admitted Patient Data Collection for outpatient services e.g. telehealth / telephone mode of delivery

That are two main scenarios of virtual emergency department (ED) care:

1. The patient is physically present at a QH public hospital ED or emergency service and that hospital seeks clinical consultation from another hospital's ED.
2. The care provider is from a public hospital ED or emergency service, but the patient is not physically present in an ED or emergency service.

Under both of these reporting scenarios, information describing virtual ED care is not currently captured electronically during the routine capture of other information about the patient's care. During 2022-23, QH will be working to better automate the data reporting processes but a longer view is needed to set business rules and update information systems to routinely capture this activity, and to establish changes to data collections to routinely report this activity.

Data capture has been proven to be possible as this is automated for the Metro North Virtual ED, where the same information as an in-person visit is being captured for virtual patients.

14. 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?

Queensland supports the proposal 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.

Intuitively, providing care outside the traditional hospital setting can only benefit both the patient and the health system. However, delivering high value care and improving patient outcomes should be the key focus for exploring innovative models of care. While reducing healthcare utilisation and hospital admissions are likely to be significant benefits of such models, it should not be the key driver. This is discussed further in our response to question 15.

There is increasing specialist consultation between hospitals and general practitioners (GPs) where the patient may or may not be present. The effort for shared care should be explored.

15. 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?

QH supports the current national pricing model but believes further development and improvement is warranted.

Innovative models of care must work across primary, community and acute care settings to achieve improved patient outcomes. As such, associated funding models need to work across the Australian

multi-provider and payor mix, and not limited to only hospitals. Ideally, funding models also need to be flexible enough to enable local solutions.

Clauses C17 to C22 of the NHRA call for a range of activities in relation to Paying for Value and Outcomes. Developing innovative models of care and funding models presents an opportunity to measure outcomes that matter to patients and explore outcomes-based payments without penalties or other financial disadvantage.

It is essential that evaluation is undertaken and occurs across a reasonable timeframe to enable meaningful findings. The evaluation will be key in determining if the funding model has had the desired effect of enabling innovative models of care, improving patient outcomes and providing benefit to the healthcare system.

Alternative funding models are unlikely to achieve meaningful long-term change without addressing cultural issues which are a key barrier to alternate approaches. For example, clinicians and consumers need to be invested in a process of shared decision making. This links with the health literacy reform / work stream in the NHRA.

Rather than approaching funding reform in a standalone manner, reform should instead be considered as part of a broader problem-solving approach, beginning with analysis of where health outcomes are sub-optimal and for who, designing models of care to address the root causes of suboptimal or inequitable outcomes, and then analysing if current funding approaches prevent or impede delivery of the new care model.

Further work is also needed nationally to better articulate which alternate funding approach is best suited to each type of healthcare challenge and objective, from cost reduction to reduced inequity to improved outcomes. For example, bundled funding can be effective in reducing unwarranted cost variation but care needs to be taken in setting the price as a price set too low may limit the flexibility in how care is delivered. Stated aims of the NHRA reform of Paying for Value and Outcomes will not be met through funding reform unless a more nuanced and outcomes-focussed approach is adopted.

In addition, the Australian healthcare system needs to establish evidence for models of care that are successful at keeping people well and out of hospital. It is only through changing the healthcare trajectories of future generations that financial sustainability of the health system can be assured. Globally there is limited evidence of successful models of care and their cost-effectiveness over a lifetime.

The NHRA makes allowance for states and territories to trial innovative funding models and that alternative funding methodologies can be introduced to ensure the state or territory is not penalised through undertaking a trial. At present, QH is exploring the following funding models such as:

- Residential Aged Care Facility Acute Support Service (RaSS). This model partners with Residential Aged Care Facilities (RACFs) and GPs to provide alternate care pathways for frail, acutely unwell persons in RACFs to:
    - Reduce the risk associated with hospitalisation (e.g. pressure injuries, falls, infections)
    - Enhance service delivery an avoid unnecessary test, procedures and hospital presentations
    - Improve transitions of care and ensure follow-up care evaluation is undertaken post discharge.