SA Health Response to IHPA Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023-24

15 July 2022

Government of South Australia

SA Health

Response Overview

On 8 June 2022 the Independent Hospital Pricing Authority (IHPA) released its *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023-24* for public comment. SA Health welcomes the opportunity to provide feedback and is supportive of the continual collaborative improvements to the framework.

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

Please contact Krystyna Parrott, Associate Director, Activity Based Management and Funding (Health.ABF@sa.gov.au) for further clarification on the response.

Section 2 – Impact of Covid-19

2.2 Plan to Assess COVID-19 Impacts on NEP23

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? (pg 7)

SA was supportive of the adjustments to price that IHPA made for 2022-23 to account for ongoing costs that have stemmed from the COVID-19 pandemic (ie PPE and cleaning). For the National Efficient Price 2023-24 (NEP23) there are a few areas that should be considered in relation to COVID, these are:

- The impact of Rapid Antigen Tests on the cost of delivering services.
- The differing thresholds for patients to be in hospital with COVID, differing lengths of stay by jurisdiction does not necessarily relate to complexity rather models of care being used.
- The impact of clearing hospitals to prepare for new outbreaks, as outbreaks occurred at different times this will not be consistent across jurisdictions. This will be seen in changes to operating theatre throughput as elective surgery was postponed to create capacity. Another example is that cohorts of patients, ie lung cancer, who would attend hospital for care but instead had to be cared for primarily at home due to the need for isolation.
- Costs of diagnostic services could be impacted by the changes in throughput in hospitals that could make some areas seem inefficient instead of being accounted for with the changes associated with COVID.
- COVID has put a great stress on organ donation and transplantation services nationally. Both donation and transplantation teams have had to navigate impacts on hospitals, COVID restrictions, a reduction in flights and border closures. These challenges, coupled with caution from the transplant sector in terms of COVID risk to recipients, have resulted in a national decrease of close to 20% in the number of transplant recipients from pre-COVID levels, and a similar reduction in deceased organ donation. SA have managed to keep their rates above pre-pandemic levels. Despite this, COVID has also fast tracked many clinical practice improvements, an example in SA is fast tracking local surgeons to retrieve organs on behalf of interstate colleagues, stopping or reducing the need for interstate retrieval teams conducted organ retrievals, which comes at a large cost.

Section 5 – Classifications Used to Describe and Price Public Hospital Services

5.1.5 Streamlining Clinical and Technical Input

Are there any barriers or additional considerations to using AR-DRG Version 11.0 to price admitted acute services for NEP23? (pg 16)

South Australia is not aware of any barriers to the implementation of AR-DRG V11 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? (pg 16)

If implementation of ICD-11 will go ahead then it is prudent to start looking at how it can be introduced into the classification systems in a staged approach rather than all at once.

- The first priority should be to undertake a cost benefit analysis on the ability to change digital health systems to accommodate the new code structure.
- A review of how ICD-11 has been implemented internationally, what were the lessons learned, especially where improvements can be made.
- A review of how ICD-11 interact with the Australian Classification of Health Interventions.

5.2.1 AN-SNAP Version 5.0

Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP23? (pg 16)

South Australia has already provided comments AN-SNAP V5 during the development stages and support the introduction of frailty related index to assist in better classifying care for patients.

5.5.3 Community Mental Health Care

Are there any barriers or additional considerations to using AMHCC Version 1.0 to price community mental health care for NEP23? (pg 18)

There are still concerns about the data quality and coverage of the community mental health data and the ability to price adequately. SA is committed to moving to AMHCC and has implemented the admitted classification for 2022-23 in public hospitals. With the community component there is a need for further shadowing of the classification while jurisdictions improve the data collection and costing.

With the implementation of the admitted component of AMHCC the DRGs are a default classification should the data not be robust enough to group to an AMHCC class. Consideration needs to be given to how the community block funded services will be funded (and backcast) if the data is not available, especially as those areas that may have data collection issues, ie smaller more remote services that cannot afford to lose out on funds.

Section 6 – Setting the National Efficient Price

6.2 Adjustments to the National Efficient Price

Are there any adjustments IHPA should prioritise investigating to inform the development of NEP23? (pg 21)

SA supports IHPA annually reviewing the costs associated with transport in rural areas, this can be a financial pressure in the more remote areas as options for transporting patients are limited.

Continued investigation of organ retrieval and transplantation is important, as the activity is better captured the costs of this service should become more identifiable.

While it may not be practicable for 2023-24 there is a need to understand the cost/price impact of long stay patients that cannot be separated due to insufficient accommodation requirements. For example, hospitals are holding on to NDIS patients while appropriate accommodation is organised, and this can be at a higher cost than what price weights allow. These issues are now common in the system and data collection systems should be reviewed to include flags that enable more robust analysis of the costs of these patients to occur.

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? (pg 21)

There are two key areas that IHPA should look to capture additional cost data to determine the impact that they have on price and price weights.

- Patient security costs are increasing and would benefit from a review to understand the impact on cost of care going forward. There is a component that should be captured through the AMHCC as additional security is required due to increased need in mental health beds but this is not the only area where it is used.
- There would be a benefit to capturing technology costs that are part of patient care. With the move to electronic medical records IT is an area that is expanding in scope and costs. Better understanding of the costs involved would enhance the pricing of services but also provide administrators with an understanding of what the impact of IT is on cost/price. This would include guidance on how to consistently include costs that should be apportioned to the NEP for EMRs.
- Guidance on how to consistently include costs in relation to Public Private Partnerships (PPPs) would be beneficial. Should PPP be dealt with like depreciation? We believe a number of PPP costs should be included in the costing as they can be provided by insourced labour.

Which initiatives to refine the national pricing model should IHPA prioritise investigating? (pg 23)

The harmonisation of chemotherapy costs must be a priority, whether a patient is admitted or not for the service has more to do on administrative practices than models of care.

As mentioned in the response to the first question the impacts of COVID must be considered when determining NEP23.

With the medical workforce being stretched over the pandemic there are costs associated in retain staff. Depending on location and clinical speciality there can be disparate costs associated with salaries and wages across the system.

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? (pg 23)

- While SA costs unqualified newborns as part of the birth parent's separation there is support to disaggregate these costs to ensure that full costs of caring for newborns are appropriately captured.
- Work is underway to link blood product data to the costing dataset which can be provided once finalised. There is also scope to look at expanding the data collections (for costing) to include organ donation costs, ie tissue typing. As the quality of data improves IHPA should revisit the costs and classification of organ donation and transplantation.
- Where possible SA will provide any additional data related to the costs of chemotherapy services to show that our costs are agnostic of setting.

Section 7 – Setting the National Efficient Cost

7.3 Quality Assurance of Public Health Expenditure Data

What cost pressures for regional or remote hospitals should be considered in the development of NEC23? (pg 26)

One of the big costs for regional and remote hospitals is the cost of attracting and retaining clinical and ancillary staff. Where local clinicians are not available then there is the added cost to the system of transporting them to locations so that patients can get care closer to home.

There are also the added costs of locating services in these areas, for example renal dialysis. Dialysis is a service that can be provided in the home, however regional patients will still require clinical support to be available.

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? (pg 26)

Nil

Section 8 – Future Funding Models

8.3 Trialling Innovative Models of Care

How is virtual care delivery captured in information systems and data collections? (pg 30)

In South Australia virtual care is captured like all other care, admitted type care is captured in admitted systems and non-admitted in the corresponding systems. Most data collections allow for location or type of care to be collected to identify this activity, except for emergency care which is now starting to occur in the virtual space.

When setting up new virtual care SA aims to collect the associated national datasets to ensure that activity can be submitted where valid.

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? (pg 30)

SA supports the inclusion of telehealth video consultations for emergency care. Our data collections already capture this data so there would minimal change required to add this to national submissions.

Bundled payments are of interest in SA sites and with the implementation of the IHI there will be scope to revisit this area.

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? (pg 30)

Virtual care has a different cost profile and in the development of new classification (ie non-admitted) the location should be considered when determining resource allocation.

Additional Responses

5.3 Emergency Care

SA supports the continuation of the Urgency Disposition Groups (UDGs) for the next few years due to the need to transition some smaller rural hospitals to electronic medical records systems. The majority of emergency presentation will be classified under the Australian Emergency Care Classification there are still sites where it is currently not feasible to collect a diagnosis code for classification purposes.

6.4 Unqualified Newborns

The classification of newborns as qualified and unqualified is an area that requires review. While IHPA are not proposing to review the criteria in the legislation regarding this care type SA believes that IHPA are the appropriate body to advocate for the change. Legislation needs to start accounting for new models of care that provide better care for the parents and child but do not fit into the legislative description. For example phototherapy machines can be wheeled into private rooms enabling newborns to receive the acute care they need but can stay in close contact with the parents, and keep ICU beds free for those newborns requiring continuous care.

For more information

Activity Based Management and Funding
Provider Commissioning Performance
SA Health
Health.ABF@sa.gov.au

www.ausgoal.gov.au/creative-commons

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