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Dear Ms Fitzgerald

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 2023-24. 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 public hospital services have undergone significant change as a result of the COVID-19 pandemic response and looks forward to working with IHPA to assess the ongoing impact of COVID-19 on the activity and cost data and the potential impacts to the national pricing model.

If you have any queries about Victoria's response, please contact Ms Lucy Solier, Director, Funding Policy and Accountability on 03 9821 6006 or at lucy.solier@health.vic.gov.au.

Yours sincerely

Andrew Haywood
Executive Director
Funding Policy, Accountability and Data Insights
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VICTORIA State Government

Consultation paper on the pricing framework for Australian public hospital services 2023-24

Victorian Department of Health response

July 2022

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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 2023-24 (the framework) and is supportive of the continuous improvements to the framework. The framework forms part of 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 IHPA to ensure that the expectations of governments as detailed in the Addendum to the NHRA are achieved.

2. Impact of COVID-19

Consultation question

- 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?

Victorian health services have been significantly impacted by the direct and indirect effects of COVID-19 during 2020-21. Victoria supports IHPA's proposed analytical work and the undertaking of further consultations to understand the impact of COVID-19 as captured in the latest National Hospital Cost Data Collection (NHCDC) and activity data.

Victoria notes that individual states and territories have experienced varied impacts of COVID-19 and that a national pattern may not reflect each states unique circumstances. In particular, Victoria experienced a higher number of COVID-19 cases in 2020-21 compared to other states.

Victoria notes that there were significant changes for in-scope activity and changes in models of care as a result of COVID-19. This included reduced volumes of elective surgery activity in public hospitals due to COVID-19 demand and related restrictions on elective surgery, and increased use of telehealth for provision of non-admitted services.

Victoria considers that the increased numbers of public patients treated in private hospitals will need to be considered when evaluating the COVID-19 impacts on cost data. In Victoria, public patient activity undertaken by private hospitals under the Private Hospital Funding Agreement (PHFA) was reported only by the private hospital because the agreement was between the private hospital and the Victorian Department of Health. Usually, a public patient is treated in a private hospital under a contract arrangement between the public and private hospital and therefore both the public and private hospital report the activity. Victoria notes that this may impact on cost data.

The reduced rates of patients electing to be treated as private patients in public hospitals has also changed as a result of COVID-19. Victoria expects that private patient elections are unlikely to return to the level that existed prior to COVID-19 in the near future. It is important to note that this

has a varied impact across different health service and DRGs. For example, evidence is emerging that specialist birthing hospitals are unlikely to return to historical rates of private activity. This may relate to changed community preferences, as in response to COVID-19 almost all birthing services were delivered as public services, with the result that patients now perceive limited benefit to utilising their private health insurance for birthing services, especially in the context of a gap payment.

In light of these trends IHPA may need to consider the forward-looking case-mix profile for private activity in making private patient adjustments for certain DRGs. The Hospital Case-Mix Protocol collection taken over the COVID-19 period is likely to reflect even smaller sample sizes for certain types of specialist private patient activities and variability in average payments will arise.

Victoria considers that an approach to use small sample sizes from this dataset, or to carry forward prior year adjustments (that were calculated prior to COVID-19 impacts) needs to be thought through carefully taking into account the most likely case-mix profile for those DRGs that will apply in 2023-24. It otherwise risks over penalty for private patient accommodation and service adjustments, effectively leading to the extinguishing of patient choice.

In addition to impacts on the private patient service and accommodation adjustment, the drop off in private patients due to COVID-19 will impact the financial liability that could arise from the public private neutrality adjustment (PPNa).

As part of annual quarterly activity submission monitoring, IHPA now reports on the change in private and public activity. The PPNa provisions in the National Health Reform Agreement Addendum 2020-25 did not contemplate COVID-19 impacts. There is a lack of clarity on whether a financial liability that arises from the PPNa should be in reference to the proportion of private activity delivered in the prior year, or whether it should reference the level of private activity that existed prior to the impact of COVID-19.

Victoria looks forward to working with IHPA on understanding the impact of COVID-19 on cost data and the flow on impact to the National Efficient Price (NEP), particularly noting IHPA cost model is based on a three-year lagged cost data and may not reflect the full impact of recent changes in cost profiles.

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.

Victoria broadly supports introduction of changes to the funding model to meet the principle of public-private neutrality. As highlighted in its submission to the draft National Efficient Price 2022-23, Victoria recommends a single price, with no private patient deductions to the public NWAU, that provides a clear and unambiguous price signal to health services and patients that no financial incentive exists to elect to be either public or private patient. Differential contributions to base and growth and revenue offsets from private health insurance need not be considered relevant in that approach.

Victoria is increasingly concerned about unintended system wide consequences that arise from the IHPA's approach to the PPNa and private patient discounts more generally.

Clause A13 of the NHRA states the principle that funding models will be financially neutral with respect to all patients. There is no basis for the IHPA or the National Health Funding Body (NHFB) to calculate an asymmetric financial penalty arising from growth in private patient revenue or activity.

Victoria is eager to work with IHPA and the NHFB to ensure that the policy intent of Clause A13 of the NHRA is met.

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 model's predictive accuracy and on health services response to this funding adjustment overtime.

4. Scope of public hospital services

COVID-19 has 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, noting that many of these services may be needed on an ongoing basis.

Victoria looks forward to working with 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

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

Victoria does not anticipate any barriers to using AR-DRG Version 11.0 to price admitted acute services for NEP23.

Consultation question

- 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.

Victoria supports IHPA refocussing some resources on projects that prepare for ICD-11 implementation. In particular, Victoria considers that a gap analysis between the two classifications should be a priority if Australia is to take the opportunity to influence changes to ICD-11 while regular updates are still being made.

Victoria also considers that IHPA could begin to quantify the amount of post-coordination that is required to code an ICD-10-AM pre-coordinated condition in ICD-11. The extent to which stem codes will be adopted also needs to be determined, quantified and assessed against data reporting and policy needs.

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 NEP23?

Victoria recommends the usual two-year shadow period as prescribed by the NHRA. While Victoria has not identified direct barriers, analysis indicates that funding variances will occur within the state as a result of new and amended AN-SNAP classes and would benefit from another year of shadowing to better understand the financial impacts.

Consultation question

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

Victoria considers it would be premature for the Australian Mental Health Care Classification (AMHCC) version 1.0 to be used to price community mental health care for the NEP23.

As outlined in Victoria's advice on NEP22, Victoria considers the relatively under-developed nature of the activity and cost data for community mental health is a significant barrier to full pricing of community mental health in NEP23.

Victoria recommends that IHPA address the following queries and concerns before a decision is taken to price community mental health using the current version of the AMHCC:

- Opportunities to incorporate recalibrated Health of the Nation Outcome Scales (HoNOS) complexity classes (for classification performance improvement) into the AMHCC, noting this work is currently underway and is expected to be included in AMHCC version 1.1.
  - Victoria also recommends that the methodology for weighting funding classes in the AMHCC be revised to incorporate a more appropriate method (Principal Component Analysis) for identifying the 'distilled' importance of each scale in the HoNOS outcome measure which forms the basis of AMHCC complexity classes. This method is preferred by the Australian

Bureau of Statistics in defining Socio-Economic Indexes for Areas (SEIFA), a similar exercise in grouping and weighting relevant variables.

- A review of the use of Life Skills Profile (LSP) data in the AMHCC version 1.0.
  - The LSP is a dated clinical tool and its utility in contemporary funding models based on the AMHCC therefore needs to be reviewed. Analysis undertaken in Victoria also indicates that LSP scores are so closely correlated with HoNOS scores that LSP adds only marginal improvement to the predictive performance of the classification.

Victoria welcomes the opportunity to continue working with IHPA on version 1.1 of the AMHCC to inform the ongoing pricing of community mental health.

6. Setting the National Efficient Price

Consultation question

- Are there any adjustments IHPA should prioritise investigating to inform the development of NEP23?

Victoria notes IHPA cost model is based on a three year lagged cost data and may not reflect the full impact of recent changes due to COVID-19 in the cost profile. Victoria also notes the ongoing issue regarding price inflation is likely to be exacerbated in the coming years given the current economic environment.

Consultation question

- 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?

Victoria expects that there are likely to be enduring costs associated with the continued legitimate and unavoidable costs associated with the COVID-19 pandemic and is unable to confirm whether all COVID-19 costs are adequately represented in the 2020-21 Victorian Hospital Cost Data Collection. Victoria is aware that unavoidable costs, or drivers of cost increases are being incurred, but is unable to advise on these with precision until the expenditures have actually incurred. At this stage, the following have been identified as unavoidable costs or drivers of cost increases for Victoria:

- Super Guarantee - increase of 0.5%
- Medical indemnity – Victorian Managed Insurance Agency insurance up 10% across the sector
- Implementation of legislated Safe Patient Care Ratios
- Australian Medical Association (AMA) negotiated award outcomes
- Medical impact associated with 24/7 rostering
- Allied Health, Managers & Administration Officers Award - extra weeks leave
- Non-Emergency Patient Transport costs increasing by 12% - increasing over the next 3-5 years
- Microsoft license fees

Consultation question

- Which initiatives to refine the national pricing model should IHPA prioritise investigating?

Recognition of the cost of delivering ICU services as an adjustment in the National model

Victoria strongly recommends IHPA consider removing the specified list of ICU hospitals and allow all hospitals delivering ICU to receive a loading reflective of the cost of service. The criteria for eligibility applied by IHPA does not reflect contemporary clinical practice to deliver ICU services and does not allow for the flexibility required to deliver these services in response to surges in patient presentations that might occur due to the COVID-19 pandemic response.

Provision of ICU services is rightly based on clinical decisions and best practice, not based on funding-related factors. Victoria considers that IHPA's current approach to regulating eligibility is hindering innovative models of care, stymying clinical best practice and constraining jurisdictions' ability to respond flexibly to the needs of the population.

Victoria is eager to work with IHPA to resolve the lack of recognition of the cost to deliver ICU services for Victorian health services in the NWAU for hospitals not on the specified list of ICU hospitals.

Impact of the public private neutrality adjustment (PPNa) on public NWAU growth

Victoria considers that the current approach to PPNa incentivises growth of public NWAU over private NWAU. This response arises as health services seek to mitigate the risk of private patient financial penalties being applied.

Victoria notes that growth in public NWAU leads to an increased risk of breaching in the 6.5 per cent growth cap as per Clause A56 of the NHRA 2020-25.

Victoria supports IHPA's monitoring of these activity trends in order to assist State and Commonwealth discussions around whether the cap needs to be more flexible in response to growth in public NWAU that arises from the PPNa, in addition to other factors.

Victoria will continue to work collaboratively with IHPA to monitor and identify private activity trends so as to inform future discussions on fair and equitable funding arrangements.

Organ donation, retrieval and transplantation

Victoria considers that a costing study and classification review for organ donation, retrieval and transplantation should be prioritised. In March 2022 all state and territory Ministers of Health endorsed an action plan, developed in response to the *2018 National review of organ donation, retrieval and transplantation* (OD2T), that included requesting IHPA to complete a costing study and classification review for all aspects of OD2T including non-admitted pre and post organ transplantation care. Additionally, there is currently work underway to transition Nationally Funded Centres (NFC) to Activity Based Funding. The NFC program includes paediatric and intestinal transplantation programs.

Victoria considers the costing review of NFC and OD2T should be completed simultaneously to effectively manage commonalities in the program requirements.

Consultation question

- 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?

Price harmonisation

Victoria is supportive in principle of price harmonisation for common types of activities that occur across service streams. Victoria worked with IHPA in 2020 to provide feedback on the harmonisation of chemotherapy and haemodialysis price weights across both admitted and non-admitted service streams. Limitations were identified with the proposal to harmonise the weights as part of National Efficient Price 2021-22, causing progress to stall.

Harmonisation of price weights should consider other factors that explain variance in the price and cost structures. For example, different models of care, prioritisation of patient care, utilisation of ancillary support serves and/or bundling and hospital in the home, need to be better understood before the non-admitted activity can be validly compared with the admitted activity.

In the 2020 chemotherapy harmonisation analysis, the volume of non-admitted service events undertaken by one state was close to double that of Victoria, whereas the reported costs were around half. The stark difference in volume and costs is difficult to explain if it is assumed that the activities are like for like. This suggests that there are ancillary services supporting patient care, the costs for which are not being fully accounted.

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 this may have on the development of future models of care.

Unexpected consequences will arise if the admitted price weights are diluted by assuming the non-admitted activity is directly comparable. For example, well established models of care centred on patient outcomes could be disrupted if the admitted price weight is reduced too quickly. Health services will incur additional costs as a consequence of forced reconfiguration of services whereby harmonised admitted price weights no longer support the underlying cost of delivery. This could result in an unexpected increase in non-admitted activities that health service configurations are il-equipped to cater for, with no benefit to the patient.

Victoria is supportive of price harmonisation in relation to like-for-like activity delivered across different service settings; however, this is qualified by the need to ensure ancillary services that support different models of care are factored into the harmonisation analysis.

Unqualified newborns

Victoria is supportive of IHPA progressing work to explore how the national pricing model accounts for unqualified newborns. Where the terminology ‘unqualified newborn’ was once understood to mean a healthy newborn, it should be acknowledged that a qualification status of “unqualified” no longer necessarily means a newborn is healthy (as increasingly care is provided to an unwell newborn outside a neonatal intensive care unit or for only a few hours in a NICU). Similarly, a qualification status of “qualified” does not always represent an unwell newborn as a second or subsequent liveborn is reported as a qualified newborn but may not require any more care than a healthy (unqualified) newborn.

Victoria considers the current pricing model should be reviewed to ensure that the funding and costs of unqualified newborns are appropriately accounted for and support new models of care and advances in clinical practice.

Victoria further notes that clarity is required regarding whether unqualified days are excluded from DRG development given that they are excluded from grouping for NWAU calculation, noting that it would be inappropriate to include unqualified days for DRG development but to exclude for funding.

Organ donations

Victoria emphasises that any refinement review undertaken by IHPA regarding organ donation must include all aspects of organ donation, retrieval and transplantation (OD2T) including non-admitted pre- and post-organ transplantation care, as OD2T is a complex series of interlinked services. The OD2T service elements that need costing review, and possible sources of data to inform costs, are listed in Table 1.

Table 1: Organ donation to transplantation service elements and data sources to inform costing

Service Element	Data sources

Element 1
Initial Assessment & Transplant Waitlist (TWL) Management
(Potential Recipient)
	• Cost data collection
	• Lifeblood: For all tissue typing costs (including Virtual Cross Match)
	  ○ Tissue typing services are required across all service elements 1-8 and need to be allocated to service elements accordingly
	  ○ Tissue typing costs should factor in the cost of running and maintaining the Organ Matching platform.
	• Transplant unit/ Health services: For costs allegedly not captured appropriately such as
	  ○ extent of multidisciplinary medical consultations that occur across all elements 1-8 as required
	  ○ travel for both assessments & retrievals (noting travel may occur metro, regional, interstate via jet or road)
	  ○ donation costs incurred for element 2 until element 6 (ICU, ED, mechanical ventilation, medical suitability testing, medications, consumables, workforce)
	  ○ pharmaceuticals and treatments required across elements 1-8 (including desensitisation of recipients)
	  ○ workforce required across elements 1-8
	  ○ organ perfusion costs (consumables and workforce)
	• State Health departments
	  ○ Jurisdictional funding agreements for donation staffing (hospital and agency funded positions) and donation operations.
	  ○ Jurisdictional block grants for retrieval, tissue typing, transplantation, workforce and perfusion.
	• DonateLife agency: For all donation related operational costs including
	  ○ Medical consultant on call
	  ○ ongoing donor and family support, safety & surveillance
	• The OTA
	  ○ The OTA data analytics team can provide activity-based data to complement information provided by health services. For example timeframe per case donation workup, time for offer-acceptance process, retrieval team attendance and location. The activity data can be linked to clinical workforce requirements per service element to establish workforce costs.
	  ○ Electronic Donor Record maintenance and support costs.
	• Commonwealth
	  ○ Australian Organ Donor Registry personnel, maintenance and support costs

Element 2 Deceased Donation (Potential Donor)	
Element 3 Organ Allocation	
Element 4 & Element 5 Organ Offer & Organ Acceptance	
Element 6 Retrieval (Donor)	
Element 7 Transplantation (Recipient)	
Element 8 Post Transplantation (Recipient)	

7. Setting the National Efficient Cost

Consultation question

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

The main cost pressure for Victoria's Small Rural Health Services is the lack of staffing/workforce across the state leading to an increase in agency and locum costs. There are also additional costs as a result of COVID-19 which will likely be ongoing, for example, PPE, cleaning, security, and screening which are currently covered by COVID-19 funding.

Small Rural Health Services struggle to be competitive in the employment of personnel including finance officers and human resources experts as there are comparatively more high paid options in other sectors (i.e., non-health).

Consultation question

- 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?

Victoria looks forward to working with IHPA on the development of an independent quality assurance process and does not have specific areas of focus to recommend.

Consultation question

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

Victoria considers that there are circumstances in which activity-based funding is not the most appropriate funding option for some standalone facilities.

Victoria recommends that detailed discussions occur at IHPA Technical Advisory Committee as to 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, low patient turn-over and additional costs considerations.

8. Future Funding Models

Consultation question

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

Virtual care delivery is captured through a number of information systems and data collections which are outlined below. Victoria notes that there are limitations with the collection of this data which is also summarised.

- Victorian Admitted Episode Dataset (VAED): some admitted Hospital in the Home (HITH) activity is conducted virtually via video-conference. Currently, it is not possible to identify in the VAED the mode of care delivery i.e. whether care is delivered virtually via video-conference or face to face.
- Victorian Emergency Minimum Dataset (VEMD): some telehealth consultations provided by an Emergency Department (ED) clinician are reported in the VEMD. To be reported in the VEMD the patient must be physically present with a nurse or doctor at a public Urgent Care Centre, another ED or a RACS or correctional facility, and the telehealth consult must be equivalent to a face-to-face consultation (so both the remote ED clinician and the patient must interact). In 2022-23, work will be undertaken with Northern Health to enable reporting of 'virtual' ED attendances i.e. where the patient is at home and receives a consult from an ED clinician via video-conference (either in the presence of an ambulance officer, another clinician or where the patient self refers).
- Victorian Integrated Non-Admitted Health (VINAH) minimum dataset: services delivered via telehealth i.e. using some form of video-conferencing, are reported to VINAH. If the patient is in the physical presence of a health care provider at one health service and care delivery involves the participation of a health care provider from another health service via telehealth video consultation/conference, the contact should be reported by both health services.

Consultation question

- 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?

Victoria is supportive of embedding video consultations in emergency departments within the NAPEDC NMDS and Emergency service care National Best Endeavours Data Set for 2023–24. Victoria notes that COVID-19 has resulted in many services developing virtual models of care and are supportive of further investigations in this area.

Consultation question

- 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?

Victoria is supportive of changes to the national pricing model that incentivise utilisation of virtual care models and enable patients to receive high quality care outside of our acute hospital environment. For example, the inclusion of video consultations in emergency departments in IHPAs

2022-23 general list provides opportunities for health services to record virtual care activity within the VEMD, similar to a physical ED presentation, and to start to collect data on virtual care activity.

9. Pricing and Funding for Safety and Quality

Victoria continues to align with the national funding model where possible when pricing and funding for safety and quality. Currently Victoria is shadowing the Hospital Acquired Complication (HAC) adjustment, while continuing to apply a discount for avoidable sentinel events. Victoria is unable to shadow the national avoidable readmissions adjustment until such time as a technical approach to identify avoidable readmissions is developed. In each case, implementation will be guided by advice from Safer Care Victoria. Victoria will continue to work with IHPA on these matters.