Pricing Framework for Australian Public Hospital Services 2024-25

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 2024–25* (the Framework), released on 14 June 2023 by The Independent Health and Aged Care Pricing Authority (IHACPA) 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 IHACPA.

QH responses to the questions included in the consultation paper 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 significant barriers to pricing admitted subacute and non-acute care using AN-SNAP Version 5.0 for NEP24?*

QH is well prepared for Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 5 (V5) and will commence internal cost analysis from July 2023 to compare AN-SNAP Version 4 and V5.

IHACPA's decision to undertake the full two-year shadow pricing period is welcome, thus providing jurisdictions with adequate time to undertake a complete analysis of the impact of the introduction of AN-SNAP V5 in 2024-25.

2. *Are there any other areas in the AECC that IHACPA should consider as part of the classification refinement work program?*

QH considers that IHACPA should explore patients that require additional resources in the Emergency Department (ED) that otherwise may be admitted for further supervision, investigation or care. Examples include any procedural work such as cardio diversions and dislocation reductions that require sedation / regional block / nerve blocks etc. This could be recognized by a documented procedure code similar to the Australian Classification of Health Interventions (ACHI) codes and the price weight be more representative of the care provided to the patient.

3. *What clinical areas and/or structural features should IHACPA consider in the development of the EPD Short List Thirteenth Edition?*

QH considers that IHACPA should develop advice for jurisdictions to map external cause codes to the Emergency Care Principal Diagnosis Short List for both the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) twelfth edition and upcoming thirteenth edition.

4. *Are there any other proposed refinement areas for the Tier 2 Non-Admitted Services Classification for 2024–25?*

Australian Non-Admitted Patient Classification

The commencement of the Australian Non-Admitted Patient Classification Project is welcome, particularly as the approach aims to utilise existing health information such as that in the electronic medical record (eMR) systems. The development of new classifications is extremely resource intensive and this will significantly increase the administrative burden on stakeholders, particularly for clinical staff whose expertise is priceless, but their time is limited for participation in such activities.

As part of our feedback during development of the classification, QH will advocate for a patient centred approach to ensure there is a built-in benefit beyond just informing Activity Based Funding (ABF), but also ensuring the classification can be used to inform patient care (for example, by being clinically meaningful and incorporating the newer models of care such as those delivered virtually) as well as guide future policy / resourcing decisions.

It is hoped the new classification will further refine / define the potential overlap between admitted and non-admitted services and therefore be a more resilient predictor of cost.

Refinement of Tier 2 Non-Admitted Services Classification (Tier 2) for 2024-25

QH welcomes the continual improvements and refinements to the existing classification where indicated, to maximise the classification's ability to account for the broad spectrum of non-admitted services and cater for new and emerging models aimed at avoiding hospital admissions. The following specific suggestions are included for consideration:

- Broadly consider activities that reduce the need for patients to attend hospital including hospital-based specialists supporting general practitioners (GPs) in the community with patient management advice, both when there is a patient present and not.
- Consider development of a separate Tier 2 class for exercise physiology rather than being included under hydrotherapy.
- Creation of an Ophthalmology Procedural Tier 2 class to capture Intravitreal Injections (IVI) into the eye due to significant drug costs (~$900 for one eye).
- Home based subcutaneous immunoglobulin infusions (SCIg) – QH notes that IHACPA have proposed a new Tier 2 class for this activity in the Technical Advisory Committee (TAC) July 2023 meeting papers; QH supports this proposal as blood products for this intervention cost upwards of $2,000 per patient.
- It is critical that IHACPA consider virtual care as part of the new classification development as this evolving model of care is growing and offering the opportunity to challenge established care models in traditional settings.
- 10.20 – Simulation and Planning. A review of the cost weight or separation of the two into Simulation (patient present) and Planning (patient not present). The current price weight doesn't take into consideration the extensive time and resources required to deliver these services.
    - Simulation requires at least two to three Radiation Therapists, Doctor, computerised tomography (CT) scanner, possible additional magnetic resonance imaging (MRI), moulding of patient equipment for treatment accuracy and marking of patients' skin for re-alignment on treatment.

- Planning (patient not present) requires Medical Officer to mark up the CT scan, two Radiation Therapists to plan the treatment (can take up to two weeks for a complex plan), review by a Radiation Therapist and Physicist to ensure quality and final review by a Medical Oncologist.

Total Parenteral Nutrition (TPN) Concerns

QH stakeholder have raised concerns regarding data used for TPN (Tier 2 Non-Admitted Services Classification Class 10.17) pricing as a reduction in the national price weight has been observed over time. Local facility data from financial years 2020-21 to 2022-23 indicates that costs attributable to home delivered TPN are, on average, approximately $8,650 per patient / month for adults and approximately $18,450 per patient / per month for children which is above the current national price. QH is working towards improved processes for ensuring the accuracy of data submitted for Tier 2 class 10.17 and ensuring all attributable costs are accounted for in the costing submission.

5. *Following three years of shadow pricing and the development of risk mitigation strategies to support the transition to ABF, are there any significant barriers to pricing community mental health care using AMHCC Version 1.0 for NEP24?*

QH does not support the pricing of community mental health using AMHCC Version 1.0 for the 2024-25 National Efficient Price (NEP24) and instead supports a further 12 months of shadow pricing. QH appreciates the work that IHACPA is currently doing to assess the impact of transitioning the funding of community mental health from block into ABF. However, this exercise has so far highlighted significant discrepancies that will need to be resolved. [redacted] However, at the facility level there were significant differences between actual expenditure and the ABF estimate.

QH reiterates previously communicated concerns with the transition to pricing community mental health, due to the lack of robust costed activity data from all jurisdictions and the poor explanatory power of the model.

6. *Are there any other measures that will assist in transitioning community mental health care from block funding to ABF for NEP24?*

Per the response to Question 5, QH does not support the transition of community mental health care from block funding to ABF for NEP24. In addition to resolution of the issues raised in the response to Question 5, the transition to ABF would require:

- A safety net to mitigate jurisdictional funding risk.
- IHACPA should work with jurisdictions to ensure information technology (IT) systems are capable to incorporate the variables of Number of Contacts with Consumer present or the Number of Contacts without Consumer present.

7. *How did the COVID-19 pandemic response impact activity and cost data in 2021–22, such as through significant events like lockdowns, and how should these impacts be accounted for in the NEP and National Efficient Cost Determinations for 2024–25?*

Queensland had minimal lockdown periods during 2021-22 and as such activity was not impacted. However, the impact of lockdowns in earlier years and the associated pause in delivery of normal health care has led to patients presenting with more advanced disease now as the 'catch up' occurs. The later presentation of patients with more advanced disease will likely lead to an increase in costs and Diagnosis Related Group (DRG) acuity.

In addition to this, the Queensland government responded to the financial pressures associated with the pandemic by implementing a wage freeze across the public service. This freeze was unwound in 2021-22, meaning that healthcare workers received two wage rises in accordance with their relevant enterprise bargaining agreement.

8. *For NEP24, what evidence is available regarding the clinical management of patients with a COVID-19 diagnosis, including patients in an ICU, to support retention of the:*
- *COVID-19 treatment adjustment*
- *Temporary ICU measure for COVID-19 patients*
- *Temporary HAC and AHR measures for COVID-19 patients?*

QH supports the continuation of the COVID-19 treatment adjustment. COVID -19 remains a complex disease to manage with long COVID impacting chronic disease management. This is higher than other respiratory viruses.

QH also supports the review of the temporary measures introduced to ensure pricing remains relevant. For those patients who have a pathological COVID-19 infection that has rendered them in the Intensive Care Unit (ICU) (as opposed to those with a coincidental COVID-19 infection) there remains a protracted recovery phase. For non-specified ICUs, consideration could be given to applying the ICU adjustment based on the severity of disease. This differential could be made on whether the treatment has moved to additional pharmacological measures beyond such as dexamethasone and Baricitinib or Remdesivir, or by using the severity of illness scale with those deemed critically ill qualifying for the adjustment.

With regard to the exemption from safety and quality adjustments, the review should consider how much of an impact the exemption made as the adjustments are typically quite low already.

9. *To inform the review of the ICU adjustment:*
- *What available evidence demonstrates the underlying drivers of cost variation for complex ICUs?*
- *What additional or alternative measures, other than mechanical ventilation hours should IHACPA consider for inclusion in the eligibility criteria for a specified ICU?*

The ICU patient population has changed significantly in the past 10 to 15 years with increasing proportions of elderly patients having surgical procedures that require perioperative high dependency care.

Alternatives to invasive ventilation are becoming more common practice, and whist an important factor, the rate of mechanical ventilation may no longer be the only measure of complexity for ICUs as it has been estimated that less than half of all patients receive mechanical ventilation during their admission, indicating a trend away from mechanical ventilation as an indicator of ICU workload or complexity.

It has been suggested by QH specialist ICU clinicians that mechanical ventilation, whilst still significant, could form part of an assessment matrix to determine qualifying ICUs. Other considerations for inclusion in an assessment matrix could include measures such as:

- The minimum standards for ICU facilities as published by the College of Intensive Care Medicine of Australia and New Zealand
- Patient acuity score (disease severity)
- Predictors of ICU mortality such as the Australian and New Zealand Risk of Death (ANZROD) mortality predication model, the Sequential Organ Failure Assessment (SOFA) Score and / or the Acute Physiology and Chronic Health Evaluation II (APACHE II) Score
- One on one nursing requirement
- Inotrope and / or vasopressor requirement
- Invasive monitoring requirements
- Extracorporeal Membrane Oxygenation (ECMO)
- Plasma exchange
- Advanced heart failure management (intra-aortic balloon pumps and impella which is a percutaneous ventricular assist device)
- Advanced respiratory failure management (e.g. Management of decompensated pulmonary hypertensive patients)

With regard to the application of the ICU loading, QH previously provided the feedback below to IHACPA in response to a question raised at the TAC:

Consideration should also be given to the eligibility for dedicated tertiary and quaternary paediatric centres, without a Neonate ICU / maternity service to receive the full ICU loading, regardless of patient age. Episodes grouped to a newborn / neonate AR-DRG identified as 'bundled ICU' are significantly underfunded in dedicated paediatric sites. Information provided by the Queensland Children's Hospital (that does not have a Neonate ICU / maternity service) cites losses of over $50,000 per episode for patients receiving services such as highly specialised cardiac care, but do not meet the age threshold (i.e. <28 days old) to receive the ICU loading beyond what has been incorporated into the inlier price weight.

10. To inform the review of the paediatric adjustment?

- *What available evidence demonstrates the underlying drivers of cost variation between specialised and non-specialised children's hospitals*
- *what additional or alternative measures should IHACPA consider for inclusion in the eligibility criteria for a specialised children's hospital?*

QH recommends IHACPA consider the following available evidence to demonstrate the cost variation between specialised and non-specialised children's hospitals:

- Recommended nursing ratios on wards are higher than for adults which recognises the vulnerability of infants. Higher nursing ratios are required for children / infants because of some unique paediatric nursing requirements: for example, every medication drawn up and administered, legally has to be checked by two nurses to reduce medication errors which does not occur in adult nursing. Due to the complexity associated with treating children, specialist

children's hospitals will often have a higher ratio of nurse practitioner roles compared to other nursing positions and thus incur higher costs.

- Nursing ratios on paediatric critical care units are the same as for adult critical care units and governed by the Australian College of Critical Care Nurses (ACCCN) workforce documents.
- Paediatric services and paediatric critical care units require staff (medical and nursing) with appropriate paediatric skills. For many practitioners in mixed hospitals, skills also need to be maintained in adult healthcare – requiring dual training which is an added cost; for example, life support training, emergency medicine.
- Paediatric services require specialised allied health professionals with appropriate paediatric (as well as adult) skills, again often this is dual training. It is a quality requirement of paediatric critical care units that Paediatric ICU (PICU) trained pharmacists are present during rounds to minimise medication errors.
- Paediatric services require a full range of equipment to manage immediate paediatric resuscitation as well as ongoing care according to their level of expertise. The requirements to cover the full range of ages results in the need for stock covering all sizes which is costly in outlay. This can be as simple as paediatric resuscitation trolleys available in all areas with equipment suitable for zero to 16 years which will contain approximately five times the equipment of an adult trolley; to paediatric critical care units stocking specialised incubators, cots, and beds for all ages of critically unwell patients. Critical care areas and theatres will require a range of equipment to manage all ages for example multiple bronchoscope sizes and other surgical instruments.
- Centralised paediatric specialist services require the transport and the retrieval of critically unwell children to central services which is costly (particularly air transport). Retrievals build in delay to treatment. Moving families far away from their home for treatment has enormous impacts on family life and their financial well-being. If services could be provided in a more appropriately funded paediatric regional centre this would reduce the retrieval costs as well as taking patients and family away from their home towns.
- The governance of paediatric services requires the support of paediatric specific measures; for example, a paediatric medication safety board, paediatric specific policies and procedures.
- Mature paediatric services will have appropriate paediatric specific governance, appropriate paediatric skilled staff and appropriately equipped areas in the facility to manage children – all of which will require an uplift in cost as compared to standard adult services.

QH recommends IHACPA consider the following additional or alternative measures for inclusion in the eligibility criteria for a specialised children's hospital.

QH supports the review of the Paediatric Loading / Adjustment. Queensland is the most regionalised state in Australia. The majority of Queenslanders reside outside the State's capital city of Brisbane. The population is also widely dispersed with high concentrations in South East Queensland, populous provincial cities and towns along the coast.

To provide healthcare needs across the state, regional hubs like Townsville HHS play a key role in providing access to advanced paediatric care for a large regional population, supported by highly specialised centres like Queensland Children's Hospital (QCH) that provide a vast array of tertiary and quaternary services and manage the most complex patients for the State's population (and northern NSW).

Given the different nature of specialised children's hospitals, IHACPA should give consideration to consider the establishment of a tiered loading methodology. This would provide suitable cost support

for hospitals providing what is considered to be specialist paediatric services (such as the Gold Coast University Hospital and Townsville University Hospital) and then a differential loading for the dedicated tertiary and quaternary paediatric centres that provide the most advanced paediatric services within their respective States (such as QCH).

The recognition of a second tier of specialist children's hospital would be preferable to a tightening of the threshold for a single tier which may see some existing designated specialist children's hospitals be removed from the list.

Regarding the criteria for thresholds, using the two-tiered approach mentioned above, differentiation between the tiers may be achieved as:

- a service of which > 20 per cent of the separations for the zero to 17 age group are in the 'A' code of complexity; and at least one of the following:
    - >100,000 PICU hours per annum on a rolling average
    - >90 per cent of their separations are for the age range of zero to 17 years

The establishment of a second tier for dedicated paediatric centres would allow for paediatric adjustments to better reflect the highly advanced services provided by dedicated paediatric sites around Australia.

Regarding the existing eligibility criteria for a specialist children's hospital, the requirement to undertake a substantial number of mechanical ventilation procedures on paediatric patients is not considered consistent with current best practice and does not reflect the complexity of care provided at a facility. As a part of the review, IHACPA should consider the following criteria:

- The facility:
    - has a PICU or Paediatric Critical Care (PCCU) which is a referral centre with transfers / retrievals from outside of the hospital service catchment area.
    - has a Paediatric Surgery service (not just surgery in children but Paediatric Surgeons on call).
    - has at least five or more subspecialist services from the following specialties; paediatric cardiology, paediatric respiratory medicine, paediatric rheumatology, paediatric infectious diseases, paediatric endocrinology, paediatric neurology, paediatric gastroenterology, paediatric metabolic medicine, paediatric rehabilitation, paediatric oncology, paediatric palliative care, paediatric nephrology, paediatric immunology, adolescent health, child protection, child development, paediatric ophthalmology, paediatric neurosurgery, paediatric Ear, Nose and Throat (ENT), paediatric orthopaedics.
    - has a 24 x 7 Paediatric Emergency Department.
    - has a specialist paediatric allied health and paediatric allied health multi-disciplinary teams separate to and distinct from adult services.
    - has specialist paediatric diagnostic and radiology services.
    - has accreditation with non-Paediatric Colleges for paediatric training within that college specialty e.g. ACEM, CICM, RACP (paediatrics), ANZCA.
    - has separate Paediatric Hospital in the Home (HITH) services from Adult HITH services.
    - is an accredited primary teaching site for a medical school.

- has designated ambulatory and inpatient Child and Adolescent medical and surgical services.
- has designated ambulatory and inpatient Child and Adolescent Mental Health service.
- has a Nurse Navigation service for complex medical needs.
- provides ambulatory and inpatient eating disorder services.

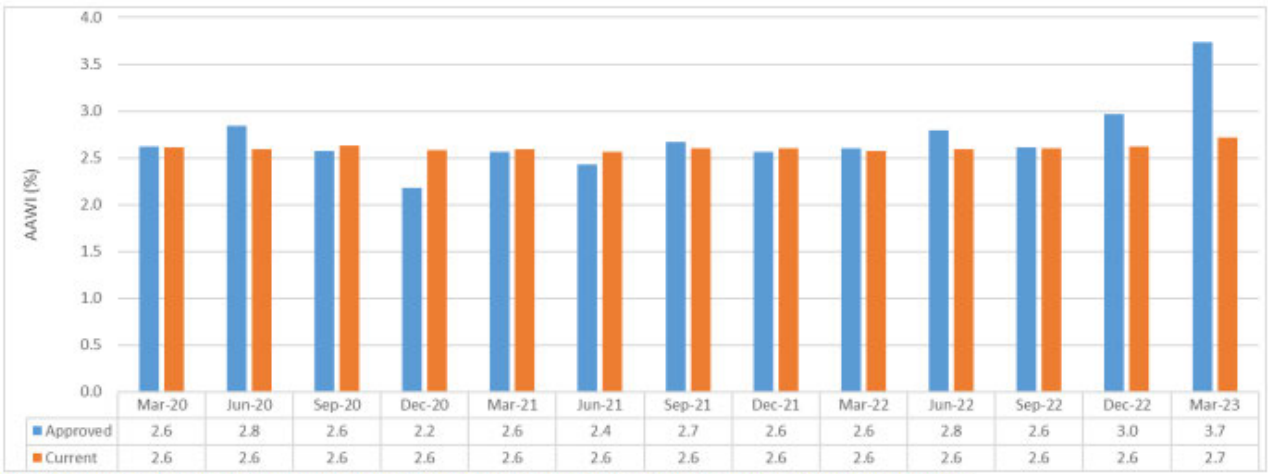
To ensure the list of specialised children's hospitals remain valid, Queensland supports regular reviews of the list.

11. To inform the NEP indexation methodology review, what alternative indices or metrics are publicly available and applicable at a national level, that demonstrate an evidence-based correlation between price inflation and cost increases in the delivery of Australian public hospital services? Additionally, what are the underlying drivers of cost growth contributing to these cost increases?

QH welcomes the review of the NEP indexation methodology. The current methodology works well in a stable inflation environment where past inflation is a reasonable predictor of future inflation. However, recently there has been a strong increase in consumer price inflation which is driving strong growth in wages, so a methodology which utilises currently available information is warranted. In QH, wages account for around 70 per cent of total expenditure, so it would be appropriate to consider wage inflation as a determinant of hospital costs. The latest Wage Price Index data to March 2023 reports an annual increase in Health care and social assistance of 3.2 per cent against total wage growth of 3.7 per cent. Wage inflation can take time to respond to overall inflationary pressures, particularly in the public sector as enterprise bargaining (EB) agreements need to be negotiated. For the purpose of indexing the NEP, IHACPA could consider the use of projected wage inflation as a determinant of future hospital costs in combination with actual wage outcomes. Both the Reserve Bank of Australia and the Commonwealth Treasury publish projections.

Another alternative is to consider the outcome of EB agreements in the healthcare sector to determine whether there has been a change in the trend of these outcomes. The Department of Employment and Workplace Relations publishes a quarterly report Trends in Federal Enterprise Bargaining. The March 2023 report shows evidence of a strong increase in wages growth in recently negotiated EB agreements.

Chart 2 - Approved and current agreements AAWI by quarter - March quarter 2020 to March quarter 2023



	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21	Jun-21	Sep-21	Dec-21	Mar-22	Jun-22	Sep-22	Dec-22	Mar-23
Approved	2.6	2.8	2.6	2.2	2.6	2.4	2.7	2.6	2.6	2.8	2.6	3.0	3.7
Current	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.7

Source: Department of Employment and Workplace Relations, Workplace Agreements Database.

12. What potential risks should IHACPA consider in progressing price harmonisation of chemotherapy and dialysis for future NEP Determinations?

QH has previously highlighted to IHACPA concerns around proposals to harmonise prices for dialysis and chemotherapy. QH considers there to be differences between chemotherapy services delivered to admitted and non-admitted patients. Each reflecting differences in resource inputs and patient pathways.

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.

Any progression of harmonisation of price weights for chemotherapy would require IHACPA to provide further information to jurisdictions to enable clear differentiation between resources across settings, various types of chemotherapy administration routes, and the duration that the patient is undergoing active treatment.

Additionally, the changes to the same day coding for chemotherapy introduced in July 2022 introduce the risk of not being able to clearly identify the inpatient episodes where the patient received a chemotherapy procedure. Specifically, the procedure code used does not specify if a prophylactic is being administered for active treatment. As such any attempts to identify relevant episodes would require additional identifying variables such as principal diagnoses, or pharmaceutical records associated with the admission.

It is recommended that these two areas be considered as a focus for new classification(s) or innovative funding models rather than price harmonisation. Additionally, given the inherent instability in activity and cost data as a result of COVID-19 for the years 2019–20, 2020–21 and 2021–22, there are risks associated with progressing harmonisation in any of the specialty areas at this time.

13. Are there any other public hospital services that are potential candidates for price weight harmonisation across settings?

QH remains supportive of price harmonisation where there is strong evidence that costs, resources and model of care are comparable across admitted and non-admitted settings, at both a local and national level.

QH suggests that price harmonisation may be considered for some surgical procedures where there are limited variations for clinical practice and no other ongoing care is required, such as colonoscopy or nasendoscopy.

14. To inform the NEC indexation methodology review, what alternative indices or metrics are publicly available and applicable at a national level, that demonstrate an evidence-based correlation between price inflation and cost increases in the expenditure of small rural hospitals, specialist metropolitan hospitals or block-funded services? Additionally, what are the underlying drivers of cost growth unique to these services?

IHACPA should investigate the same data as for the NEP indexation review. The biggest driver of cost increases in small rural hospitals has been the cost of agency staff and medical locums which have increased significantly.

The underlying drivers of cost growth unique to these services include:

- To provide safe clinical rosters 24/7 requires a higher number of staff per patient / significantly higher staff cost per weighted activity unit (WAU)
- Distance increases complexity of management of patient care which results in more time per patient
- Lack of appropriate GP services make patient care, discharges, etc. more difficult / more expensive
- Retrieval of patients leads to extended stays in ward or ED without appropriate WAU funding
- Patients present later for various reasons – more advance disease needs more time / effort to treat, often despite recording the same diagnosis code (Cellulitis can be beginning or extensive for example, an abscess can be 3 cm or 8 cm)
- Patient's health literacy and understanding of health is generally quite low, which requires more time to manage care

15. What assurance approaches should IHACPA consider, to ensure NHCDC data is prepared in line with the AHPCS, and that would reduce duplication of data reporting for states and territories?

QH supports the jurisdictional review process that IHACPA is establishing with each jurisdiction which will include a per review component at that review meeting.

QH has already recommended to IHACPA through the National Hospital Cost Data Collection (NHCDC) Advisory Committee that the following components of the old Independent Financial Review can be revised to show:

- The reconciliation of final cost data to the general ledger at summary level.
- To include the cost of submitted activity and the cost of unsubmitted activity (where either not available at patient level or out of scope for the National Health Reform Agreement) as a subset of that reconciliation process.
- An identification of activity volumes and matching of cost data to the submitted activity dataset across each of the classification groups (Acute, sub-acute etc).
- There is already a checklist of key costing processes which are completed as part of the Data Quality Statement that identifies compliance with the Australian Hospital Patient Costing Standards (AHPCS).

QH has recommended the inclusion of the above items to expand the data quality statement to meet this assurance request.

16. Given virtual care is a broad and evolving space, what specific areas and care streams where virtual care is being delivered should IHACPA prioritise for further investigation to inform future data collection, classification and pricing refinement?

QH recommends that IHACPA investigate the collection and pricing of activity for the "eConsult", a form of virtual care that allows healthcare workers (internal and external to Queensland Health, such as GPs) across Queensland to ask a clinical question of a more senior or specialised clinician about their patient. It is performed through a secure, asynchronous process of providing patient details, background information, the clinical question, and any supporting information such as test results, photos, or videos.

A key potential benefit is reduced pressure on hospitals and outpatient departments by reducing unnecessary referrals, and enhancing information included in necessary referrals. eConsult services are provided by QH hospitals for over 20 clinic types, with around 10,000 service events being delivered in 2022-23.

Ontario Health has a mature eConsult program, which is described in the following link:

https://econsultontario.ca/about-us/

Queensland is also developing a number of virtual programs that focus on hospital avoidance. These are outlined below and QH welcomes any opportunity to clearly articulate the inclusion of such services under the ABF model including:

- A Queensland Virtual Hospital that will support care initially in Emergency Care and Outpatient Care, but will eventually expand to provide inpatient models of care virtually also.
- Rapid Access Clinics (services allow primary care clinicians to receive phone advice from Queensland hospital specialists in relation to a patient).
- Queensland TeleStroke service.
- Queensland Virtual Acute Care Service (provides access to Queensland hospital acute care clinicians virtually, to divert patients from physical EDs).

With the expansion of virtual care, it is imperative that data collections are designed to support differentiation of virtual care from traditional delivery mechanisms such as face to face appointments delivered in a specialist outpatient setting. Appropriate data elements must be developed, and data collections updated, to enable jurisdictions to report all virtual care activity because virtual care initiatives such as eConsults (described above), have a significant impact on hospital avoidance however are currently not considered in the national collections.

17. *Do jurisdictions have the capacity to submit cost data for activity reported under the emergency care virtual care data specifications?*

Virtual activity for emergency care is collected and can be supplied to IHACPA as per the virtual care data specifications.

QH is heavily invested in providing innovate models of care for emergency services, of which virtual care is a key component. The Virtual Emergency Department is a key initiative operating out of the Metro North HHS. The model provides:

- Patients with a telehealth consultation with a Triage Nurse and, where appropriate, placed in queue to see the ED for a telehealth consultation.
- GPs and other primary healthcare clinicians with access to specialist emergency medicine assessment, by telephone or video conferencing.
- Queensland Ambulance Service (QAS) clinicians with access to specialist emergency medicine assessment, by telephone or video conferencing to extend the options available to patients who access healthcare through the QAS but may not require assessment or admission at an emergency department.

18. *Do you have any further comments to inform the development of the NEP and NEC Determinations for 2024–25?*

- QH has recently introduced separate funding for unqualified neonates in its jurisdictional model. The methodology involves using NHCDC data to apportion the costs of mothers and neonates and discounting the mother's DRG (for liveborns) accordingly. The mother's proportion of total cost varies between 80 and 90 per cent, depending on the DRG. The unqualified neonates are then assigned a proportion of the qualified neonate price weight. This was calculated at 52 per cent to be cost neutral at the statewide level.
- QH stakeholder have raised concern about the sustainability of providing ECMO service to patients in an environment where there is an inherent 'gap' between the funding received and the cost incurred in delivering the care. This gap many be created by the large variation in hospital costs, relatively low volume of cases nationwide and the diversity within the single DRG available to this patient cohort. QH requests that IHACPA investigatee the DRG A40Z EMCO to further develop the DRG using subgroups in diagnosis categories to provide recognition of the different cost per indication to support for health services providing ECMO services.