Government of **Western Australia**
Department of **Health**

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Via email: submissions.ihacpa@ihacpa.gov.au

Dear Professor Pervan Michael

CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR PUBLIC HOSPITAL SERVICES 2024-25 – WA SUBMISSION

Thank you for the opportunity to provide a submission to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25.*

Western Australia's consolidated feedback is provided in Attachment A.

The State's response to the COVID-19 pandemic is continuing to have substantial changes to service delivery, models of care and activity levels across all areas of the Western Australia (WA) health system. Some of the costs were not reflected in the 2021-22 cost data, which will be used for the development of the pricing model for 2023-24. The impact of these changes will be continually evident for several years and needs to be considered over time.

WA has reservations about the pricing of community mental health services using the Australian Mental Health Care Classification V1.0 from 1 July 2024 due to data quality issues and potential financial risks. Whilst some States have costed data, currently there is no costed information available for WA community mental health service provision. In the coming months, WA will for the first time, attempt to cost service contact level activity data for 2022-23, which will be submitted via National Hospital Cost Data Collection (NHCDC) in early 2024. It is envisaged that the results (available late in Quarter 3 Financial Year 2023-24) will further assist in understanding the gap between costs and block funding amounts from a local perspective.

WA would like to have a clear understanding of any potential financial implications and will continue to work with IHACPA regarding the transition from a block funded model to an ABF funded model, noting that this has not been undertaken before and there may be unforeseen impacts and consequences associated with this change. The lack of costed data is making it challenging to assess the risk and formulate transition/mitigation strategies to ensure mental health service delivery is not compromised.

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WA is supportive of IHACPA's plans regarding classification refinements including implementation of AN-SNAP V5.0 to price admitted subacute and non-acute services, review of adjustments to the National Efficient Price, review of indexation methodologies, and continuing work on virtual care and innovative funding models.

Please note that further comments will be provided during the statutory 45-day ministerial consultation period when the Draft Pricing Framework 2024-25 is released.

If you have any queries, please contact Michael Moltoni, Director Analytics and Performance Reporting on (08) 9222 0309 or at Michael.Moltoni@health.wa.gov.au

Yours sincerely

Rob Anderson
ASSISTANT DIRECTOR GENERAL
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18 July 2023

Att: WA submission

ATTACHMENT A
WESTERN AUSTRALIA’S SUBMISSION TO THE CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2024-25

Introduction

Western Australia (WA) welcomes the opportunity to provide feedback to the Independent Health and Aged Care Pricing Authority (IHACPA) on the *Consultation Paper for the Pricing Framework for Australian Public Hospital Services 2024-25*.

Classifications used to describe and price public hospital services

1. ***Are there any significant barriers to pricing admitted subacute and nonacute (SANA) care using AN-SNAP Version 5.0 for NEP24?***

   There are no barriers to the use of AN-SNAP V5 to price SANA services from a data collection and reporting perspective. WA suggests that the calculation methodology of the frailty index should be reviewed regularly as being fit for purpose.

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

   WA has no additional suggestions at this stage.

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

   WA has no additional suggestions at this stage.

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

   WA will continue to engage in discussions with the IHACPA Non-Admitted Care Working Group to inform classification refinement and costing work, and any refinements to the Indigenous adjustment applied as part of the national pricing model, particularly in the area of recognition of Aboriginal Health Practitioners, Aboriginal Health Care Workers and Liaison Officers as clinicians working autonomously and as part of a multidisciplinary team model of care to provide and facilitate access to essential services particularly for vulnerable and high-risk patients.

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?***

   Whilst some States have costed data, currently there is no costed information available for WA community mental health service provision. In the coming months, WA will for the first time, attempt to cost service contact level activity data for 2022-23, which will be submitted via NHCDC in early 2024. It is envisaged that the results (available late in Q3 FY 2023-24) will further assist in understanding the gap between costs and block funding amounts from a local perspective.

   WA's costing profile for community mental health activity may not be representative of other states and will be seeking assurance that there be safeguards to ensure WA is not adversely affected when pricing the community mental health activity and any subsequent implementation.

   WA continues to focus on the education and training of Health Service Provider staff to support the collection of timely, accurate community mental health activity, this includes compliance to clinical complexity measures (such as HoNOS and LSP-16) and the assignment of the mental health phase of care (MHPoC).

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

   WA would like to have a clear and agreed understanding of any financial implications and pathway regarding the transition from a block funded model to an ABF funded model, ensuring that no state is worse off. WA will continue to work with IHACPA and participate in discussions via the respective national committees, noting that a change like this has not been undertaken before and there may be unforeseen impacts and consequences associated with this change. Any significant funding implications may impact on the provision and delivery of services.

   WA suggests there be consideration of this activity being exempt from the calculation of the funding cap and for this to be factored into any transitional arrangement.

Setting the national efficient price

Impact of COVID-19

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?***

   WA has recently provided information to IHACPA in relation to significant events that impacted the provision and delivery of hospital services such as lockdowns

and restrictions to elective surgery during 2021-22, evidenced by available media releases.

In addition to the changes in state and Commonwealth policy that led to the lockdowns and mandated elective surgery restrictions, the COVID-19 pandemic impacted activity and expenditure in 2021-22 as follows:

- Mandatory staff furlough and resource re-allocation to COVID-19 related activities increased on-costs for leave liability and an associated increase in agency costs to replace furloughed staff.
- COVID-19 forced hospitals to structurally re-adapt services to support the management of COVID-19 pathways for patients. Some of these changes to services, which were expected to be short-term arrangements, have now become enduring changes to service delivery.
- Changes related to infection control and compliance led to increased expenditure and resource utilisation in Personal Protective Equipment, mask fit testing, cleaning, patient transport, equipment and changed clinical care models like aerosolised procedures, visitor restrictions requiring access management, and the associated training and education on new protocols.
- There was an increase in patients that were not able to be discharged in a timely manner due to non-availability of resources to manage these patients in a community setting.
- There was an increase in the ALOS of patients, which increased costs, however this did not translate to a corresponding increase in WAUs as the separations remained within the lower and upper LOS bounds of the DRG.
- Insurance costs including medical treatment liability, worker's compensation, and re-insurance markets have increased.
- Increases in relation to inflationary pressures on all expenditure and costs.
- An increase of virtual care service delivery modes has required the hospital system to provide, improve and make changes to IT systems and devices to support the delivery of these services.

As a result of the lockdown and restrictions, there was an increase in the backlog of care that has been deferred/delayed and increase in complexity which the public hospitals have been seeking to clear. To address this activity then necessitated above normal costs, such as more staff overtime.

Noting that all States have been impacted by COVID-19 differently in terms of timing, type/s and length/s of restrictions and that each state will likely incur above normal costs associated with this, it will be very challenging for IHACPA to model and account for this fluctuation across all jurisdictions consistently.

WA would suggest that IHACPA consider the scale (or threshold) and significance of any impacts and to not include changes such as activity normalisation or adjustments that make the model more complicated without clear and obvious benefits to all states. Whilst there has been an impact/s on activity and associated costs of hospital services, mostly related to COVID-19, each and every year there are other factors that impact on hospital activity and costs that may not be so

easily attributable to a single factor and are not addressed in the NEP model. For example, in WA, it is not unusual to have factors such as increased use of agency staff in rural and remote areas, challenges with specialist clinicians availability impacting elective surgery, and infrastructure related changes such as operating theatre refurbishment. Like COVID-19, these factors are largely temporary and do impact on the delivery of hospital services – however, we do not seek changes/adjustments to the model each year to account for these.

8. ***For NEP24, what evidence is available regarding the clinical management of patients with a COVID-19 diagnosis, including patients in an Intensive Care Unit (ICU), to support retention of the:***

   - ***COVID-19 treatment adjustment***

     - There was an increased number of ICU hours of approximately 8%, increased use of extracorporeal membrane oxygenation (ECMO) and ventilation support for patients with a COVID-19 diagnosis compared to those without a COVID-19 diagnosis.

   - ***temporary ICU measure for COVID-19 patients***

     WA does not apply the Intensive Care Unit (ICU) loading for COVID-19 patients to any hospital that is not included on the NEP23 eligible ICU list.

   - ***temporary HAC and AHR measures for COVID-19 patients?***

     WA does not exempt COVID-19 episodes from HAC and AHR requirements.

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?***

WA is supportive of the review of the ICU adjustment and in particular the eligibility criteria, noting that WA do not have an issue with utilising mechanical ventilation hours as a component of the eligibility criteria.

However, WA suggests that irrespective of the level of ICU hours and CMV hours, the ICU inherently requires resourcing by specialists and suitably trained staff who need to be rostered on a 24 by 7 basis regardless of the patient load.

WA suggests specific consideration where the delivery of ICU services occurs in regional areas which are required to provide an adequate level of safety for other services such as specialised surgery, which cannot operate without a dedicated ICU support service. This may mean that an individual regional ICU operates at

low volume, however, it does not make this capability any less important to the health facility than those delivered in a tertiary or metropolitan location.

In some instances, ICU services in regional areas operating an ICU at lower volumes does not reduce cost, with the fixed costs associated with a say 20,000-hour ICU not varying significantly from an ICU exceeding the 24,000-hour threshold. Bunbury Regional Hospital (BRH) is currently on the specified ICU list, but sometimes struggles to meet the eligibility criteria. It operates as an integrated health service, with the ICU providing a critical support capability that enables more complex services to be provided closer to home. This benefits patients both within the hospital and the greater Southwest region. The ICU has the capacity to support complex surgical procedures conducted at the co-located private hospital. Without this capability, many patients would have to travel to metropolitan areas, since it would be deemed unsafe to continue these services without an ICU.

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?***

As per last year's submission, WA suggests investigation of a paediatric adjustment incorporating a sliding scale model, dependent on patient age as opposed to the current model which is determined at site specialist level.

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?***

The current indexation approach has not kept pace with true service costs. In recent years, there have been unique inflationary pressures across the country, with the pandemic, enterprise bargaining agreement changes, and dramatic workforce shortages placing significant pressure on the cost of provisioning health services in country areas (e.g., nursing agency costs, utilities, and transport costs).

It is suggested that IHACPA investigate a more responsive approach to indexation, where options are available to utilise more up-to-date and targeted measures when required. The Australian Bureau of Statistics (ABS) maintains and regularly publishes producer price indices (akin to CPI but are producer-focused). These indices are available for various industries including health and hospital services. Additionally, IHACPA could consult with the ABS to further investigate observed differences between health and hospital sub-groups, with specific consideration given for regional differences. Or perhaps a composite index that incorporates multiple indices could be developed that better represents costs in the hospital system that leverages for example the ABS wage price index and information from

the Reserve Bank of Australia who also provide statistics on Australian inflation, unit labour costs growth, commodity prices and the like.

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

- There needs to be a clear understanding of the potential differences between inpatient and outpatient chemotherapy and dialysis. It is not appropriate to harmonise pricing at the lowest modality cost, but rather setting a price that would incentivise the lower cost modality.
- There may be other factors that IHACPA should consider for example, whether services are able to move to the lower cost modality and any potential supply issues depending on size, resources, and geographic location.
- Analysis to address the significant difference between radiotherapy weights in the Tier 2 non-admitted model and funding reimbursement under the Medical Benefits Schedule, creating a disincentive to use ABF funding mechanisms.
- Recognition of additional costs incurred for these services in remote areas. For example, water for dialysis is often significantly more expensive in remote areas and can be up to five times or more in WA between locations.
- Price harmonisation should be carefully considered for paediatric chemotherapy services. There are distinct requirements of paediatric chemotherapy which requires specialised care and attention, as their physiology, response to treatment, treatment protocols, treatment intensities, and clinical risks differ significantly from adults. This will ensure that funding models adequately support the specialised care these patients require. While cost-effectiveness is important, it should not come at the expense of compromising the safety and well-being of paediatric patients.
- Here are some specific scenarios in which paediatric patients would face a significantly higher risk of harm or death if chemotherapy were administered in an outpatient setting per examples below.
  - Infants with malignant brain tumours receive very intensive multi-agent chemotherapy regimens which include high dose methotrexate and require high level monitoring.
  - Anti-GD2 antibodies (e.g., Unituxin) used to treat patients with high risk neuroblastomas are associated with significant pain and require parenteral opioid analgesia during treatment administration. These patients may experience sudden changes in their condition, such as respiratory depression or an acute increase in pain, that require a rapid response. In an outpatient setting, such emergencies may not be promptly addressed, potentially leading to harm or even life-threatening situations.
  - Ifosfamide and cisplatin-containing chemotherapy regimens are associated with risk of severe and potentially life-threatening side effects, including nephrotoxicity, ototoxicity, and neurotoxicity. Close monitoring, prompt intervention, and access to specialised medical resources, such as paediatric oncology expertise and emergency care, are crucial in

managing and mitigating these risks, which may be compromised in an outpatient setting.

- That the level of care will continue to be provided in the same way, so it is important that a price weight for the activity is representative of the cost of the service. Results from a recent WA renal dialysis audit have demonstrated that same-day dialysis patient acuity is increasing however there is only one DRG to represent haemodialysis so different or increased levels of care for patients are not being accurately represented in the current recording methodology. Further, there are cohorts of patients, where age is a significant driver, that are more suitable for home based dialysis versus satellite provider versus in-hospital dialysis – all of which have a different cost profile, although on a DRG basis fall into the same DRG.

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

WA has no other potential candidates for price weight harmonisation across settings.

Setting the national efficient cost

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?

WA is supportive of the NEC indexation methodology review. The ABS maintains and regularly publishes producer price indexes (akin to the consumer price index, but producer focused) for various industries including health and hospital services.

WA further suggests that IHACPA should consult with the ABS to further investigate differences between health and hospital sub-groups available within these measures, with a consideration for regional differences. It may be possible for the ABS to make available more specific and targeted producer price indexes specific to these services, and different locations (e.g., regional vs metro) as the underlying data is likely already collected under various groupings, such as hospitals. Such price indices would better reflect major cost drivers for these services such as staffing costs, which have been heavily impacted in recent years by nursing availability and subsequently reliance on agency nursing.

Noting that transport costs have increased, and this will have a significant impact on WA patients due to the distances required to travel for hospital related services and care.

Data Collection

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?

The criticism on the independent financial review (IFR) is the review doesn't specifically test the self-assessment responses, is mostly focused on reconciliation of the general ledger (which is part of the current submission package – hence duplication) and the IFR sampling size is very small.

IHACPA need to firstly define what level of assurance they require and identify the gaps between the current self-assessment and data quality statements.

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?

- Virtual emergency department care
- Telehealth services continue to expand into mental health, maternity and obstetrics, and palliative care.
- Aged care service delivery to residential aged care facilities, care homes with nursing or other support present.
- Acute Patient Transport

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

Currently, in WA Health Service Providers' costing teams are not resourced to provide costed information more frequently than the annual NHCDC process. All HSP's are actively recruiting staff or reviewing alternative arrangements, so this ability may change in the future.

WA suggests requesting complete NHCDC submissions more frequently (i.e. quarterly) on a best endeavours approach and matching this data to specific datasets, rather than cost information only for a specific cohort of patients.

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

WA has the additional comments for consideration overleaf.

Other comments

1 Classification development

1.1 Superficial partial thickness and deep partial thickness burns

- There is a need for increased specificity within ICD-11-AM for superficial partial thickness (SPT) and deep partial thickness (DPT) burns, which are currently grouped together under the broad category of partial thickness burns.
- There are clinically significant differences between SPT and DPT burns in terms of burn depth, care complexity and cost.
- For example, SPT burns usually heal within 7-10 days, while DPT burns require 3-6 weeks to heal, and surgical intervention is often required to reduce healing time and minimise infection risk.
- These differences are not reflected in the current grouping of these patients together under the broad definition of partial thickness burns in the ICD-11-AM.
- The current ICD-11-AM code for these patients is too general and requires increased specificity.
- WA requests review and modification of the current classification of patients with partial thickness burns to be separated into two distinct AR-DRGs: SPT or DPT burns.

1.2 AMHCC refinements

WA suggests that consideration be given to aligning the AMHCC and AMHOCN data requirements. Standardisation and alignment would be of benefit and assist with data reporting, capture and quality standards.

2 Adjustments to the NEP

WA notes the deferred refinements to the Indigenous adjustment and investigation of socioeconomic factors, which will be included in future work program.

3 Costing guidance to inform the NEP and indexation

WA suggests that IHACPA and jurisdictions work collaboratively to explore the capture and use of early indicator/s of cost from the NHCDC process. Is it possible for jurisdictions to provide a view of costed activity that aligns with the September data submissions process. This information could then be used to test/inform indexation in the most recent year of activity. This does not preclude any current investigation into change and review of the current indexation approach. Similarly, what options are available such that the NHCDC process and timeline would facilitate provision of costed information in a more timely manner.