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Dear Professor Pervan

Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25

Thank you for the opportunity to provide comment on the Independent Health and Aged Care Pricing Authority's *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25*.

Tasmania's comments are provided in Attachment A.

Yours sincerely

Shane Gregory
Associate Secretary

21 July 2023

Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024–25

Question	
1	Are there any significant barriers to pricing admitted subacute and non-acute care using AN-SNAP Version 5.0 for NEP24? Comments from Tasmania: While relevant assessment data for subacute and non-acute episodes is being recorded by a large portion of clinical staff in the Tasmanian Health Service, extracting this data from source systems is problematic. Tasmania is working through this issue however any assessment Tasmania needs to undertake regarding this cohort of patients that requires this data is limited due to this problem. Despite the issues noted above, Tasmania supports the implementation of AN-SNAP version 5.0 for NEP 24, which introduces a new variable to recognise frailty as a cost driver for geriatric evaluation and management, and non-acute episodes of care.

2	Are there any other areas in the AECC that IHACPA should consider as part of the classification refinement work program? Comments from Tasmania: Tasmania considers the AECC a vast improvement over the previous URG system however feels that it remains insufficient to meet the current ABF and Casemix Classification needs. The major issues Tasmania would like to highlight include: 1) Lack of coding infrastructure and guidance • Clinicians are the primary coding staff and are not trained as coders nor are systems in place to facilitate coding • Very often instead of the most useful code being selected, symptoms codes are used or very basic codes • The codes are often selected in IT systems from a search process based on the code description. These descriptions are not based on normal clinical language but more based on classification terms for example Cancer is not mentioned but neoplasia as a term is used. This adds time and difficulty to clinicians searching for appropriate codes. 2) For patients who are subsequently admitted, previously activities undertaken and conditions noted in the Emergency department were coded as part of the episode as the episode was considered as having continuity of care from the point of entry to the Hospital, this is no longer the case and coding of events in the ED no longer occurs in the record of the admitted episode. 3) Increasingly, more of the admitted episode occurs in the ED over time and the ED LOS for subsequently admitted case is getting longer with greater care provided in the ED which includes interventions such as initiating and maintenance of ventilation, insertion of chest drains, Investigations such as CT scanning and MRI. Additionally Invasive and complex non-invasive monitoring is often very significant and "Point of Care" investigations such as ultrasound and PoC Blood testing are common. For example, tPA or clot busting for strokes occurs in the ED as it is time critical and care subsequently continues into the Intensive Care unit due to the high risk of very severe complications. Much of the investigation and initial management of episode admitted care is occurring in the ED with a "front end loading" effect, particularly for emergency and complex care of admitted patients. It is also notable that older patients with complex medical conditions are spending longer in the ED (perhaps a greater proportion of their episode) prior to getting to a ward or even instead of entry to an admitted ward. Patients even die in the Emergency department after a long stay with no admitted coding occurring and often with a symptom code. 4) There is a further change in the ED admitted boundary away from the point of a clinical decision to admit to a situation where the admission commences at the point of the patient transferring from the ED. Due to the above, an increasingly large part of complex care between the decision to admit and the episode coding commencement is leading to a deterioration in the coverage of coded information for admitted episodes. Tasmania believes that the AECC in its current form does not adequately and completely reflect the care for patients in the ED or those patients who become subsequently admitted via the ED in the time from entry to the ED until leaving the ED for an admitted ward. Tasmania request that IHACPA explore ways in which the noted issues be addressed, such as coding guidance/rules around the issue of the AECC and patients who are subsequently admitted from an ED.
3	What clinical areas and/or structural features should IHACPA consider in the development of the EPD Short List Thirteenth Edition? Comments from Tasmania: Tasmania has no comment at this time.
4	Are there any other proposed refinement areas for the Tier 2 Non-Admitted Services Classification for 2024–25? Comments from Tasmania: Tasmania suggests that age be investigated as a driver of cost outside of the paediatric adjustment for paediatric hospitals. Further comments in regard to this are provided at item 10 below.

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? Comments from Tasmania: Tasmania has no comment specifically related to AMHCC Version 1.0 at this time.
6	Are there any other measures that will assist in transitioning community mental health care from block funding to ABF for NEP24? Comments from Tasmania: While Tasmania currently only reports one entity for these services, community mental health care is provided across the State from a large number of small satellite sites, and this may potentially influence what transitioning arrangements may be appropriate for the State. Due to the lack of comparable high-quality cost data it is unclear as what may be an appropriate transitioning arrangement, however Tasmania suggests that models similar to that which are in place for the small rural hospitals under the current NEC arrangement may be appropriate. Until Tasmania can benchmark its cost structures against other Jurisdiction's services it is difficult to identify where cost variations are occurring and what is the composition of that variance. Tasmania will continue to develop its cost data for community non admitted mental health care however due to the lag in this process it does not expect to have better data available until the 2022-23 year is costed. Tasmania will work with IHACPA to identify suitable transitioning arrangements.
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? Comments from Tasmania: Tasmania is not yet clear on the full impact of the COVID-19 pandemic response on its health service provision. A number of specific changes have been incorporated into the Tasmanian Health Service funding model regarding cost increases which have been estimated and considered to be not accounted for in the National Efficient Price. Tasmania has experienced a permanent uplift in PPE and cleaning costs. These have been excluded from the NEP to date as they have been claimable under the NPCR. These costs will not be fully recognised in the NEP until NEP26, unless and adjustment is made, due to the exclusion of NPCR data from the NEP calculations. A large number of changes to the health system in Tasmania have been undertaken over recent years and separating the impact of these from the COVID-19 pandemic response itself is difficult. One example of this is the opening of K Block at the Royal Hobart Hospital in April of 2020 which was also followed by a number of other service changes which form the Royal Hobart Redevelopment Project, this fundamentally changed the cost structure of Tasmania's major tertiary hospital and the full impact of this is still washing through the system. Tasmania will continue to work with IHACPA to identify the impact of COVID-19 on the health system.
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? Comments from Tasmania: Tasmania continues to experience high volumes of COVID-19 patients. Tasmania will continue to work with IHACPA to identify the impact of COVID-19 on the health system and any adjustments that may be required.

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? Comments from Tasmania: As with the paediatric adjustment, Tasmania supports the review of the ICU adjustment and will provide evidence to IHACPA where it can regarding this item.
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? Comments from Tasmania: While Tasmania does not have a designated paediatric hospital it does provide specialist Paediatric services which are distinct from other services. The Royal Hobart Hospital have a Neonatal and Paediatric Intensive Care Unit which is a referral centre for the State. It provides: • eight neonatal intensive care unit bays • four paediatric intensive care unit bays • 13 special care nursery bays. The Royal Hobart Hospital also provides specialist paediatric outpatient services in a number of specialties such as: • Eating Disorders • Developmental/behavioural • Neurology • Paediatric Specialist Immunisation • Cystic Fibrosis Some highly specialised services are supported at the Royal Hobart Hospital by visiting clinicians from the Royal Children's Hospital in Victoria, referrals for visiting clinicians can only be made from a local pediatrician, these specialist services include: • Cardiology • Endocrinology • Rheumatology • Gastroenterology • Hepatology • Respiratory Tasmania supports IHACPA investigating the paediatric adjustment and suggests that the adjustment may be appropriate in settings other than dedicated children's hospitals. Tasmania will seek further clinical advice regarding this item and will provide further evidence to IHACPA where it can.
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? Comments from Tasmania: See comments in item 7 above. CPI or health CPI would be potentially more accurate an indicator of NEP growth than the current indexation methodology. There is a three year gap between the reference year and the year the NEP is applied to. At the time the NEP is published, the actual CPI for 18 months of the three year gap is known. Forecast CPI from the RBA could be used to predict the remaining 18 months of growth.

12	What potential risks should IHACPA consider in progressing price harmonisation of chemotherapy and dialysis for future NEP Determinations? Comments from Tasmania: Due to additional administration, such as the patient election process, regarding admitted services and variation in chemotherapy treatments, Tasmania will seek further advice regarding any potential clinical impact this item may have and will provide further evidence to IHACPA where it can.
13	Are there any other public hospital services that are potential candidates for price weight harmonisation across settings? Comments from Tasmania: Tasmania has no comment at this time.
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? Comments from Tasmania: Tasmania cannot comment in regard to national changes regarding cost increases, as mentioned at item 11 above, it did note local price increases that were accounted for in its most recent Tasmanian Health service funding model.
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? Comments from Tasmania: Previous Independent Financial Reviews and Data quality Statements were at a very high level and did not go into the detail required to ensure compliance. Similarly, the current Self Evaluation which is part of the National Health Cost data Collection is also at a high level, although it does require jurisdictions to respond as to their level of compliance with the standards. Noting this, Tasmania feel that ensuring compliance with the AHPCS without duplicating data is difficult, some alternative approaches to this may be: • Education in relation to the application of the standards by costing practitioners potentially this could be facilitated via working groups. • IHACPA increase their QA reports to test for specific variables, for example Emergency Departments that have ward costs, Tier 2 medical consultations that don't have appropriate salary & wages etc. While this may not necessarily ensure compliance with the Standards it may highlight data issues.
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? Comments from Tasmania: Tasmania is expanding our highly successful COVID@ Home program to include, in the first instance, broader respiratory diseases. The expectation after that is to expand further to include other chronic diseases and people with multiple chronic conditions. We are undertaking work to further develop what this might look like from the perspective of integrated care across care settings and care types. For example, intermediate care.
17	Do jurisdictions have the capacity to submit cost data for activity reported under the emergency care virtual care data specifications? Comments from Tasmania: Tasmania does not currently provide virtual emergency care.
18	Do you have any further comments to inform the development of the NEP and NEC Determinations for 2024–25? Comments from Tasmania: Tasmania believes that the current remoteness adjustments in the National Pricing Model do not adequately reflect the legitimate and unavoidable costs of health care provision in smaller jurisdictions. Tasmania request that IHACPA investigate cost variations in regional and remote areas with a view to determining if the National Model adequately accounts for the provision of health care in these areas.