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Professor Michael Pervan
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Email: submissions.ihacpa@ihacpa.gov.au

Dear Professor Pervan

Thank you for the opportunity to comment on the Independent Health and Aged Care Pricing Authority's (IHACPA) 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. We look forward to engaging with IHACPA to ensure that the Pricing Framework for 2024-25 supports a fit-for-purpose funding model that promotes sustainability, stability and innovation in alignment with the principles outlined in the Addendum to the National Health Reform Agreement.

Should you wish to discuss this matter further, please contact Lucy Solier, Director, Funding Policy and Accountability, at the Department of Health on 03 9821 6006 or lucy.solier@health.vic.gov.au.

Yours sincerely

Andrew Haywood
Executive Director, Funding Policy, Accountability and Data Insights Branch
Commissioning and System Improvement

12 / 07 / 2023

Encl. *Response to the Independent Health and Aged Care Pricing Authority's (IHACPA) Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25*

VICTORIA State Government

Victorian Department of Health

Response to the Independent Health and Aged Care Pricing Authority's (IHACPA) Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024–25

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Introduction

Victoria welcomes the opportunity to comment on the Independent Health and Aged Care Pricing Authority's (IHACPA) *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25* (the framework). The framework forms part of IHACPA'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 supports continuous improvement of the framework and looks forward to working with IHACPA to ensure that the objectives of the Addendum to the NHRA are achieved.

Mental Health Care (Section 3.5)

Consultation Question: 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?

Victoria considers the most significant barriers to be:

- Australian Mental Health Care Classification (AMHCC) Version 1.0's requirement that only allows up to one missing Health of the Nation Outcome Scales (HoNOS) score to classify activity to the appropriate end class. Victoria follows the National Outcomes and Casemix Collection (NOCC) protocol which allows up to two missing HoNOS scores. AMHCC Version 1.0 will lead to a significant portion of community mental health activity being not appropriately classified for Victoria.
- That existing shadow price weights for community mental health services have been developed based on relatively small samples. Victoria notes that although the introduction of pricing for other funding models by IHACPA has at times been based on small sample sizes, doing so for community mental health services will result in significant financial risk to some jurisdictions, including Victoria, as the draft price weights do not reflect the true cost of delivering community mental health services.

IHACPA's Activity Based Funding Mental Health Care National Best Endeavours Data Set (ABF MHC NBEDS) 2023–24 – Technical Specifications for Reporting (Technical Specifications) limits the ability of the model to sufficiently address the complex nature of mental health services. The Technical Specifications state that 'a consumer receiving episodes of ambulatory mental health care from different ambulatory teams within an organisation cannot have two ambulatory episodes reported. If more than one service unit from the same setting provided service in one episode, only report the service unit that is primarily responsible for the care'.

Further clarification is sought from IHACPA on how this technical advice supports reporting in instances where clients being case managed by their primary community based mental health care team experience a crisis and require input from the organisation's crisis outreach team, or specialist intervention (e.g. by family violence or eating disorder specialists). For example, ambulatory crisis teams are specialist services with different functions and costs compared to other community based mental health care teams. Victoria wishes to ensure that the reporting of ambulatory mental health services supports the capture of high-quality health service data which is essential for health service research and planning.

Additionally, clients who refuse to disclose their date of birth are not classifiable, and therefore cannot be funded. Although date of birth is mandatory when registering a consumer, a number of consumers who contact mental health triage services may be in crisis and do not provide their name or date of birth. Clients who do not disclose their date of birth are not classifiable, and therefore cannot be funded. Although collection of date of birth is mandatory when registering a consumer, in Victoria there is a subset of consumers who contact mental health triage services and may choose not to provide their name or date of birth.

Consultation Question: Are there any other measures that will assist in transitioning community mental health care from block funding to ABF for NEP24?

Victoria considers it critical that AMHCC Version 1.1 is used rather than AMHCC Version 1.0 should pricing of community mental health care be implemented for NEP24, as this allows for up to two missing HoNOS to classify community mental health activity to the appropriate end class.

Victoria notes that as per clause A3 of the Addendum to the National Health Reform Agreement 2020–25 (the Addendum), Commonwealth funding is to be provided on the basis of ABF except where it is neither practicable nor appropriate. Noting the complex nature of mental health services, it is likely that not all activity will be captured by AMHCC Version 1.0 or AMHCC Version 1.1 and therefore, a portion of activity should remain block funded.

Additionally, Victoria notes that it will take some time to transition from block funding to ABF for community mental health services - noting the need for change management, communication strategies, and workforce capability uplift at the health service level. Victoria would welcome the opportunity to work with IHACPA on considered transitional arrangements such as provision of the gap between current and future funding yielded under the ABF model being provided as block funding for two to three years, until health services are able to adequately report activity at the required level.

Victoria also suggests that IHACPA provide jurisdictions with IHACPA's version of their phase of care and contact level community mental health activity and cost data with error flags (as was provided for Admitted Mental Health activity in 2019-20). This will assist jurisdictions with understanding how their data is treated and any issues with reporting.

Additional Comments

Victoria welcomes the opportunity to continue working with IHACPA on version 2.0 of the AMHCC to inform the ongoing pricing of community mental health.

Victoria has concerns that both AMHCC Version 1.0 and AMHCC Version 1.1 are not sensitive to the complex nature of mental health clients, particularly in the admitted setting. Victoria suggests that AMHCC Version 2.0 incorporates a defined number of diagnosis and intervention codes to the admitted arm of the classification to better differentiate the cost and complexity of providing care to different consumers (for example, treatment resistant consumers who require specialling of 1:1 ratio, a consumer who is behaviourally disturbed and requires seclusion or de-escalation with a number of staff involved).

Victoria also recommends IHACPA investigate introducing a multiple health-care provider indicator to the ABF MHC NBEDS, and an adjustment for multidisciplinary case conferences to the funding model, much like the non-admitted service stream, to recognise the additional costs for this type of activity.

Additionally, Victoria suggests that consideration is given by IHACPA and other jurisdictions to the recommendations of the Royal Commission into Victoria's Mental Health System (the Royal Commission). A key recommendation of the Royal Commission was implementation of a new age-based system for mental health services. This new system design was based on the following age groups:

- ages 0–25: a single infant, child and youth mental health and wellbeing system with two separate service streams:
  - ages 0–11: infant, child and family mental health and wellbeing service stream
  - ages 12–25: youth mental health and wellbeing service stream
- ages 26 and older: adult and older adult mental health and wellbeing system with a dedicated service stream for older Victorians.

Key findings from the Royal Commission that support the new age-based system include reducing risks for young people transitioning to adult services. This followed findings that the previous transition age of 18 years was a vulnerable time and where the incidence of new mental illnesses can peak.

The Royal Commission also found many young people receiving treatment for a specific illness may not meet the criteria or have access to the same treatment in the adult mental health system. The new 0-11 and 12-25 streams suits the developmental stages of infant children and families and align with the transition from primary to secondary school. By treating these as streams rather than separate systems, clinicians and consumers will have flexibility to make decisions about young people's differing developmental and biological needs and the best time to transition to other services.

Older Victorians (including people aged 65 years or older) will be better able to access and receive mental health and wellbeing services in the same way as other adults. This follows findings that under the separate aged system, many older Victorian's did not receive the same range of mental health services as other adults and that services did not always align with their preferences or needs.

Setting the National Efficient Price (Section 4)

Victoria would like to work with IHACPA on how to increase transparency for digital and Information Communication Technology (ICT) costs in order to accurately capture the true costs of components of care by updating the cost line cost bucket matrix. Specifically, Victoria considers that the following ICT components should be split out from on-costs:

- Devices – either depreciated as assets of 3-5 years, or leased: desktop and laptop personal computers, communication devices including phones and monitors.
- Server and 'cloud' storage and processing, including failover and disaster recovery, and service contracts.
- Applications - licences – such as O365, Electronic Medical Records, Patient Administration Systems, cyber tools (this would also involves the move from purchase of applications to subscription).

Victoria notes the increasing costs associated with hospitals ICT and that device, application and service elements may exceed other costs in the near future.

Victoria considers this will support further work to identify and specify the cost components contribution to the cost of care.

Virtual Models of Care (Section 6.2)

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?

A 2022 survey of the Victorian Public Health Services revealed that there are more than 40 different virtual models of care being delivered spanning across the care continuum including emergency and chronic care management. Funding models are needed that better support virtual care delivery that demonstrate demand management, allocative efficiency gains across the public hospital sector and better patient outcomes or experiences.

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

Victoria supports the further development of pricing models for virtual care. However, in developing these models, due consideration should be given to the role of state-wide services and implications for data collection.