NSW response to 2016-17 Pricing Framework Consultation Questions

Scope of Public Hospital Services and General List of Eligible Services

Consultation question:

1. What additional evidence exists to support the inclusion or exclusion of specific services from the General List in 2016-17?

NSW Health recommends that the pricing of home ventilation services return to block funding while further work is undertaken. The current weights are insufficient and raise doubts as to whether the entirety of costs from all agencies are captured in the costing study.

NSW Health also suggests that the General List criteria should seek to support the development of integrated systems that promote patient-centred models of care and emphasise the right care being provided in the right setting.

Pricing posthumous organ procurement activities

Consultation questions:

2. Should posthumous organ procurement activities be in-scope for pricing under the National Health Reform Agreement?
3. Is posthumous organ procurement adequately accounted for in activity and cost data collections and, if not, how could it be improved?

NSW Health supports the consideration of posthumous organ procurement costs as in-scope for pricing under the National Health Reform Agreement (NHRA). NSW Health has already initiated work with key stakeholders around the principle of pricing organ donations under the NHRA. The potential inclusion of posthumous organ procurement activities will lead to a fairer and equitable distribution of funding to NSW Local Health Districts (LHD) and Specialty Health Networks (SHN).

Further work is required regarding unsuccessful retrievals, such as in the case of non-viable organs. Guidelines should accompany the decision as to whether the costs associated with the donation should be attached to that episode or the transplant episode.

Organ procurement costs are currently captured in both the Acute Care (care type 1) and Organ Procurement (care type 9) episodes. NSW Health recommends that IHPA undertake further work to develop guidelines for cost allocation and business rules through the Australian Hospital Patient Costing Standards (AHPCS). As part of this work, it should be recognised that the Admitted Patient Data Collection counting rules and the Patient Administration System pose technical challenges in identifying organ procurement costs (e.g. time and place of organ retrieval).

Classifications used by IHPA to describe public hospital services

Section 4 in the Consultation Paper refers to classifications used to describe public hospital services. While no consultation questions have been raised by IHPA, NSW Health includes the following comments for consideration.

- Australian National Subacute and Non-Acute Patient Classification (AN-SNAP)

NSW Health supports the introduction of AN-SNAP version 4 in 2016-17. However, IHPA should note the impost to the system, particularly for smaller hospitals. Small hospital throughput should continue to be measured by applying a per diem while further analysis occurs.

It is recommended that paediatric per diems in the first year of implementation are continued to maintain stability in the system and enable costing against the new classes prior to pricing in 2017-18.

- Tier 2 Non-admitted Patient Services classification

NSW Health supports the classification, counting and pricing of Multidisciplinary Case Conferences (MDCC) but does not support implementation via generic tier 2 classes. The MDCC should be linked to the parent clinic for which the MDCC has occurred, as this will enable costs and activity to be easily identified to the source activity (e.g. 20.29.1 Orthopaedic MDCC).

It is therefore suggested that IHPA undertake an impact analysis of the introduction of MDCC classes upon the parent clinic(s) to which this activity is linked.

- Emergency care classification

NSW Health supports IHPAs approach to the redevelopment of the Emergency care classification including a stronger emphasis on patient factors. NSW Health encourages IHPA to consider incorporating the following elements into the proposed ED costing study to determine their suitability as cost drivers:

- Major procedures.
- Significant co-morbidities.
- Presenting problem.
- Body Mass Index (BMI) or obesity.
- Patient function and dependency.
- Clinical pathways.

- Australian Mental Health Care Classification (AMHCC)

NSW Health is currently trialling an interim Non-Admitted Mental Health Classification and supports the continued work on the AMHCC, including the upcoming pilot study. NSW Health recommends that the impost of the new classification needs to be carefully evaluated, and a 'phasing' approach be considered. This will enable system managers to mitigate risks around the stability of the system.

NSW Health would support IHPA developing training and education material and other resources to assist jurisdictions in meeting the cost of implementing such changes, particularly with complex and cost intensive services such as Forensic Mental Health.

- Pricing Mental Health

In light of IHPAs decision to defer implementation of the AMHCC until 2017, NSW Health requests that IHPA reconsider an approach to funding the component of admitted Mental Health care that is not acute. NSW Health remains concerned with the changes imposed from 1 July 2015 and the likelihood that introduction of the AMHCC will result in a change back to something similar in respect to sub and non-acute mental health.

NSW Health recommends that IHPA consider reinstating sub-acute mental health per diem price weights, especially if there is any further delay in implementation of the AMHCC.

National Hospital Cost Data Collection (NHCDC) – Costing and Counting Rules

Section 5 in the Consultation Paper refers to costing and counting rules. While no consultation questions have been raised by IHPA, NSW Health includes the following comments for consideration.

The NHCDC is used to guide rather than "...develop the National Efficient Cost (NEC) for block funded hospitals" (as stated on pg. 16). NSW NHCDC data is not used to inform the NEC. To ensure that all data underpinning the NEC model is as robust as possible, NSW Health recommends that IHPA apply improvements to the Public Health Establishments data for 2016-17.

NSW Health is concerned that the timeline for release of the AHPCS Version 4 is too ambitious. There are certain technical difficulties with implementing the AHPCS for Round 20 of the NHCDC, as Version 4 will not be released until November 2015.

NSW Health agrees that clearly articulated costing standards are essential to delivering greater consistency and improved comparability of NHCDC data. Effective data quality frameworks and audit processes are equally important to ensure that the standards have been applied. NSW Health has developed an extensive audit process for the data submitted to the NHCDC.

It is also recommended that counting, costing and classification of consultation liaison activity become a priority focus area. This work is essential to ensure consultation liaison activity is adequately recognised and addressed in the funding model.

The National Efficient Price for Activity Based Funded Public Hospital Services Technical improvements to the National Efficient Price (NEP)

Consultation questions:

4. Should IHPA consider any further technical improvements to the NEP pricing model for 2016-17?
5. What are the advantages and disadvantages of changing the geographical classification system used by IHPA?

NSW Health reiterates the position that material changes which reflect volatility should be addressed in terms of materiality, stability, transition processes and future impact prior to adoption within the Determinations. For example, to manage potential volatility associated with the specified ICU list, NSW Health suggests the criteria to determine eligibility should include ICUs within one standard deviation range for ICU hours and Mechanical Ventilation.

NSW Health requests that IHPA undertake a further review of the unbundled Intensive Care Unit (ICU) pricing approach taken in NEP15, as the current methodology does not support the service delivery model in NSW. NSW Health has implemented a decentralised ICU Model compared to

centralised models in other jurisdictions. NSW Health also recommends IHPA undertake an analysis of the distribution of ICU hours/beds in regional areas.

In the absence of a further review, it is recommended that IHPA approach the Australian and New Zealand Intensive Care Society to assist with determining the inclusion of non-invasive ventilation in the eligibility criteria. This would go some way to alleviating concerns that the current approach incentivises invasive ventilation.

NSW Health supports a review of the current geographical classification system used by IHPA. The continued refinement of rural and remote classifications is important. Any alternative model must result in significantly improved cost ratios for rural LHDs, and reflect a strong evidence base for patient cost drivers, such as socio-economic status.

Adjustments to the National Efficient Price (NEP)

Consultation questions:

6. What are the priority areas for IHPA to consider when evaluating adjustments to NEP16?
7. What patient-based factors provide the basis for these or other adjustments? Please provide supporting evidence, where available.

NSW Health requests that IHPA review the following priorities:

- *Classification and pricing of trauma patients* – internal analysis suggests that there are cost variances.
- *Intellectual disability co-morbidity* – internal analysis of patients with a secondary diagnosis of intellectual disability ('F70', 'F71', 'F72', 'F73', 'F78', 'F79') demonstrates high cost ratios and relative stay index for this cohort.
- *Dialysis adjustment* – should be expanded to include sub and non-acute episodes of care.
- *Culturally and Linguistically Diverse (CALD) patients* – propose that the ABF Data Set Specification is amended to include the introduction of an 'interpreter services flag' to assist in identifying and costing CALD patients. For example, within Western Sydney LHD, 65 per cent of the population is born overseas – as patients, many require interpreter services.
- *Obesity* – NSW Emergency Department (ED) clinicians consider this patient characteristic to be a significant cost driver for EDs. An obesity indicator should be a priority item for collection in the ED Costing Study so that this patient characteristic as a cost driver in EDs can be examined.

Bundled Pricing

Consultation questions:

8. Do you support IHPA's expanded policy intention for bundled pricing in future years?
9. What services or patient episodes of care would most benefit from this expanded bundled pricing approach?
10. What issues should IHPA consider prior to implementing a bundled price and how can these issues best be resolved?

NSW Health supports the bundling concept in-principle. Work should focus on reflecting best practice patient pathways underpinned by price harmonisation and price neutrality to setting of care.

Activity in this area should take place outside of the Pricing Framework process, particularly as bundled pricing options are not limited to 'in-scope public hospital services' activities. The White Paper on the Reform of the Federation process is considering a range of options that may change how health services are funded and purchased. It is important that the pursuit of innovative bundling approaches are considered in this context.

In developing a bundled approach for the future, there must be clear evidence that the level of bundling results in robust cost predictiveness and ensure that risk is balanced. One risk to LHDs is the potential for reduced funding for specific types of care which is incongruous with the cost of care being delivered. This work should be carried out in conjunction with any Best Practice Pricing work considered by the Joint Working Party of IHPA and the Australian Commission on Safety & Quality in Health Care.

As a preliminary approach, NSW Health recommends that IHPA provide jurisdictions with analysis demonstrating the impact of the non-admitted bundling implemented for NEP15 as soon as practicable.

NSW Health also recommends that IHPA initially test the feasibility of a bundling approach in the maternity, hip replacement and stroke service types, allowing sufficient time for jurisdictions to consult key stakeholders. In relation to the stroke service type, consideration must be given to the different journeys and resource patterns that occur in different types of stroke (e.g. ischaemic or haemorrhage).

IHPA should consider varying levels of complexity prior to implementing a bundled price. The facility and patient location also require consideration because patients who have to travel further to their facility are more likely to have less follow up visits i.e. antenatal clinics.

The Pricing Guideline of 'administrative ease' needs to be applied in this area because the technical challenges to overcome in implementation are significant. The relevant components of bundled care will still require reporting and costing to ensure the bundling model fits the cost of care provided. Equally, the need for jurisdictions to adapt to changes means system managers must maintain granularity in the local data to make comparisons year on year. For example, NSW Health has retained non-admitted activity reporting at an Occasions Of Service level despite IHPA pricing at a service event level.

There are a number of further key issues for consideration prior to implementing a bundled price:

- It is not currently possible to link components of the bundled journey in cases where patients receive care across multiple hospital settings, in different LHDs and between public and private services.
- Any proposed bundling model must be assessed for suitability in a range of settings, particularly in rural/remote areas.
- Broad clinical consultation and agreement is required for bundling to contribute to best practice clinical care.

NSW Health recommends that bundled pricing should be linked to an appropriate measure of outcome. For example, in maternity services, IHPA should evaluate the relationship between the number of non-admitted visits and the admitted episode Length of Stay, as well as other adjustments (e.g. remoteness and Aboriginality).

Business rules associated with the bundling approach must be clearly articulated. Criteria which would result in the care of a patient not being bundled (e.g. significant complications and co-morbidities) must be determined as these factors will impact the predictability of these journeys.

Pricing for Safety and Quality

Consultation questions:

11. If feasible, would you support a best-practice pricing approach for hip fracture care in future years?
12. What implementation issues should IHPA consider when further investigating the feasibility of applying a best-practice pricing approach in future years?

NSW Health supports a best practice approach to pricing hip fractures.

The NSW Health 2015-16 activity model incorporates purchasing adjustors that promote the efficient delivery of quality patient care. This adjustor focuses on encouraging the implementation of specific models of care, through the application of a positive percentage loading to the NWAU. In 2015-16 a focus has been placed on incentivising the implementation of the NSW Agency for Clinical Innovation's 'Minimum Standards for the Management of Hip Fracture in the Older Person'.

The NSW Health activity model also incorporates a pathway to reduce emergency readmission rates over a period of time and positive adjusters focused on improvements in hospital acquired complications (specifically for pressure injuries, DVTs and pulmonary embolism).

Implementation issues to be considered in applying a best practice pricing approach include:

- Underlying principle that clinicians are pivotal to the success of quality and safety improvements and that they identify, drive, support and effect the changes required in clinical practice.
- Availability of outcomes data to indicate delivery of quality care, and variability of data quality overall.
- Acknowledgement that a reasonable band of clinical and patient condition variation exists which influences costs and outcomes.

- Best practice is not static and care needs to be taken to ensure innovative treatments and improvements on existing best practice are not discouraged.

Evaluation of the impact of the implementation of national Activity Based Funding (ABF) for public hospital services

Consultation question:
13. When should IHPA undertake 'Phase Two' of the evaluation of the impact of the implementation of national Activity Based Funding for public hospital services?

NSW Health requests IHPA provide the outcomes of the phase one component of the evaluation to assist discussions on future hospital funding arrangements.

Phase two of the evaluation should commence as soon as possible when confidence in the data has been achieved, results and findings have been published, and feedback has been received from Phase One. NSW Health recognises that Phase Two of the evaluation should proceed in a manner that does not compromise other aspects of IHPAs work plan.

Setting the National Efficient Cost (NEC)

Section 12 in the Consultation Paper refers to setting the NEC. While no consultation questions have been raised by IHPA, NSW Health includes the following comments for consideration.

NSW Health supports IHPA maintaining the NEC model introduced for NEC15; however, it is suggested that the Gross Weighted Activity Unit concept inform the activity volumes used in the matrix. The model could be further refined by expansion of Region 1, Type C category "Other" being further split.

NSW Health is trialling an interim state based Non-Admitted Mental Health classification in 2015-16. This classification is being introduced via shadow funding arrangements in 2015-16 and further refinements will be undertaken for 2016-17.