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Tasmania's Submission in response to the Independent Hospital Pricing Authority (IHPA) Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2016-2017

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1. Overview

The Tasmanian Department of Health and Human Services has provided submissions into the previous four rounds of pricing of public hospital services, under the National Health Reform Agreement, for 2012-13, 2013-14, 2014-15 and 2015-16.

Tasmania's key issues with the initial pricing frameworks still remain and principally relate to the level of complexity applied to the national ABF and the fact that the majority of the underlying classification systems employed by the model require further development, and there continues to be variances in costing approaches between jurisdictions.

As in previous years, Tasmania will continue to incorporate the national ABF infrastructure, as appropriate alongside a Tasmanian ABF model to avoid major funding distortions at the local level. This approach has enabled Tasmania, as system manager and majority funder, to continue to set activity targets and prices according to existing Tasmanian activity and block funding arrangements. The Tasmanian ABF model translates the activity into National Weighted Activity Units (NWAUs) to enable modelling of the Commonwealth contribution.

The proposed change in geographical remoteness classification for 2016-17, has particular relevance for Tasmania as 95% of the Tasmanian population falls within inner and outer regional areas. Tasmania would like to see further analysis of the Modified Monash Model geographical remoteness classification system, to ensure that it is a valid classification system for hospital pricing and costing. This issue is discussed in more detail under Section 12 'Setting the National Efficient Cost'.

Within this submission, Tasmania has also responded to the key issues on which IHPA is seeking specific feedback.

2. Pricing Guidelines

Tasmania notes that IHPA proposes no changes to the Pricing Guidelines for 2016-17. Tasmania's comments provided in previous submissions remain valid.

Overarching Guidelines

The guidelines in relation to fairness state that there should be the same price for the same service across public, private or not for profit providers of public hospital services. Whilst this guideline is supported, the current arrangements for private patients treated in public hospitals assume that all patients are billed at full cost recovery and revenue is returned to the hospital. Due to long standing private practice arrangements in Tasmania, the amount of MBS revenue received by hospitals varies by individual doctor and by the individual scheme in operation in each region.

System Design Guidelines

The guideline in reference to patient-based adjustments is not consistent with Clause B13 of the NHRA, the guideline states that adjustments to the standard price should be, as far as practicable, based on patient related, rather than provider related characteristics. Clause B13 of the NHRA provides that, in determining adjustments to the national efficient price, the IHPA must have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery, including hospital type and size, hospital location and patient complexity.

Tasmania believes there are some provider issues that should be considered such as a need to provide a full range of services to meet community expectations (for both public and private sectors), which in some states is difficult to achieve due to market failure. By default these circumstances create a measurable difference in ability to meet a national efficient price.

Process Guidelines

Tasmania believes that the new funding arrangements have created a significant administrative burden on states and Territories which has increased exponentially. Whilst there has been much discussion about reduced burden on states and territories, this is yet to be realised.

Currently the Administrator of the National Health Funding Pool, the National Health Performance Authority and IHPA have individual roles and differing priorities each imposing a significant administrative burden on states and territories in providing state resources related to committees, working parties, data provision and reporting requirements.

The Commonwealth Government announced in its 2014-15 Budget that it intended to work with states and territories to create a new Health Productivity and Performance Commission. It is proposed that the Commission would merge the functions of the Australian Commission on Safety and Quality in Health Care, the Australian Institute of Health and Welfare, IHPA, the National Health Performance Authority, the National Health Funding Body and the Administrator of the National Health Funding Pool. Until the details are made available for the new Health Productivity and Performance Commission, it is unclear if the current administrative burden imposed on states and territories will be reduced.

3. Scope of public hospital services

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

As commented on in previous submissions, Tasmania supports a further review of the inclusion of Child and Adolescent Community Mental Health as these services not only meet the criteria of other non-admitted patient services but are also a growing component of the continuum of mental health service provision.

Should posthumous organ procurement activities be in-scope for pricing under the NHRA?

Tasmania supports the inclusion of posthumous organ procurement activities as in-scope as these costs are currently not funded by other Commonwealth programs.

Is posthumous organ procurement adequately accounted for in activity and cost data collections and, if not, how could it be improved?

Whilst currently not all jurisdictions provide cost data on organ procurement, it is important that IHPA undertake further work, ie. costing studies, to develop a standard cost that is representative of national activity.

4. Classifications used by IHPA to describe public hospital services

Tasmania has commented extensively in previous submissions in relation to the classification systems. These comments remain valid.

Non-Admitted

As previously stated, Tasmania supports the development of a more robust ambulatory classification as a major priority.

Emergency Care

Tasmania agrees that the current system has an over reliance on Triage status as a classification element. The current classification adds to the lack of clarity of the continuum of care between entry to the hospital system and ward care for patients admitted via the emergency department, together with possible perverse incentives around the use of short stay care. Tasmania is keen to support work on the development of a new emergency care classification as a priority.

Subacute Care

Tasmanian is currently working towards the capture of sub-acute designated unit activity in the current AN-SNAP Version 3 elements and reviewing patient information systems in relation to sub-acute care undertaken in non-designated units. Tasmania will most likely not be in a position to submit the elements for Version 4.0 in 2016-17 for non-designated unit activity and data elements will be available for only some of the sub-acute activity undertaken in designated units in Version 4.0.

Mental Health

Tasmania is currently working on the implementation of mental health care type in Tasmanian Public Hospitals, and the collection and reporting of the new mental health data set specification (DSS), on a best efforts basis, from 1 July 2015. As previously advised, however, Tasmania does not currently collect all the required data elements for the AMHCC DSS, in particular Tasmania does not currently collect the Mental Health Intervention Classification (MHIC). As many of the required data elements are new, it is necessary for IT systems to be adapted to collect the new data elements. There is also incomplete data coverage of mental health activity within hospital information systems and work is underway to rectify this.

Tasmania has expressed an interest in taking part in the proposed pilot of the Australian Mental Health Care Classification (AMHCC) system, scheduled to commence in September 2015.

Tasmania supports the delay of the commencement date of the AMHCC to 1 July 2017, as this will enable a better understanding of any classification issues before the actual implementation across the Tasmanian health system.

Teaching, Training and Research

Whilst Tasmania is on record as supporting the development of a classification system for Teaching, Training and Research, it is not considered a priority. The provision of data from 1 July 2015, on a best efforts basis, will be difficult for Tasmania, as this data is not currently collected uniformly in Tasmania. Tasmania's preferred position would be for this work to be deferred.

5. Costing and Counting Rules

Tasmania supports the review of the Australian Hospital Patient Costing Standards and the release of Version 4.0 in late 2015, for use in future rounds of the National Hospital Cost Data Collection (NHCDC).

Tasmania notes the proposed inclusion of the Culturally and Linguistically Diverse (CALD) costing standard in the Australian Hospital Patient Costing Standards (AHPCS) Version 4. Whilst it is agreed that the cost allocations require further improvement, this may require changes to hospital information systems and the general ledger and result in an increased administrative burden for facilities.

6. The National Efficient Price for Activity Based Funded Public Hospital Services

Should IHPA consider any further technical improvements to the NEP pricing model for 2016-17?

What are the advantages and disadvantages of changing the geographical classification system for 2016-17?

What are the priority areas for IHPA to consider when evaluating adjustments to NEP16?

What patient based factors provide the basis for these or other adjustments? Please provide supporting evidence, where available.

Intensive Care Component

Tasmania believes that the ICU component should be reviewed, as a priority, to develop a weighting if a patient is managed in a regional centre ICU or HDU (if the hospital has no ICU), and Coronary Care Unit. The current exclusion of ICU units below 4,000 hours of ICU care, of which at least 20 per cent involves mechanical ventilation, effectively reduces the Commonwealth contribution in regional centres. The costs involved in ventilating a patient are the same irrespective of location. A Coronary Care Unit is more resource intensive than a general ward area. At the moment this is not recognised in the national ABF model.

Dialysis Adjustment

Tasmania also would support the expansion of the dialysis adjustment to all admitted patients, not just acute, for example; rehabilitation and palliative care. The additional costs of providing dialysis care to care types other than acute, is currently averaged in the classification.

Emergency Department – Age Related Adjustment

Tasmania would support further work to identify potential cost drivers in emergency departments and whether aged related adjustments should be introduced in Emergency Departments. Tasmania believes that an age related adjustment should be investigated for over 65 year olds in addition to children.

Changes to the Geographical Remoteness Classification System for 2016-17 - Remoteness Area Adjustment

Tasmania has argued in previous submissions that a remoteness area adjustment should be based on the Hospital location and not a patient's residential address. Further details are provided at Section 12 'Setting the National Efficient Cost', in relation to proposed changes to the geographical remoteness classification system.

Culturally and Linguistically Diverse (CALD) patients and Intellectual Disability Patients

Tasmania believes that the cost data for these patient groups is not robust and improvements to cost allocations should be undertaken to determine whether price adjustments are warranted.

7. Setting the National Efficient Price for private patients in public hospitals

Tasmania has previously provided comments on issues related to the pricing of private patients in public hospitals. These comments remain valid.

As stated in previous submissions, Tasmania believes that the deflationary measures applied in the private patient pricing for the payments hospitals receives from other funding sources are based on an incorrect assumption that hospitals directly receive the benefits from other funding sources. In Tasmania the amount of MBS revenue received by hospitals varies by individual doctor, private practice scheme(s) in operation and region. The application of a uniform discounting of the price is not valid.

Tasmania believes there are errors in the medical costing of private patients as there is no consistent approach nationally to the identification of medical costs. The widely used current costing approach which relies on the arbitrary splitting of doctor's salary across all product streams is not reliable. This approach results in substantial distortions of medical salaries across the product streams. Compounding this problem is the issue that not all medical costs are accurately captured and there is poor adherence to the national costing standards. For these reasons Tasmania does not support the phasing out of the correction factor.

Whilst it is acknowledged that the improvements to the Australian Hospital Patient Costing Standards (AHPCS), will go some way to address issues associated with the identification of medical costs, this will be wholly reliant on improved levels of national compliance with the standards.

8. Treatment of other Commonwealth Programs

Tasmania notes that there are no proposed changes to the treatment of Commonwealth pharmaceutical programs and blood products.

Tasmania supports the work to identify how blood costs can be more accurately captured in the National Hospital Cost Data Collection (NHCDC) but raises the following questions:

- If IHPA is excluding the costs of blood products in the NEP why is there a requirement to include the costs in the public sector NHCDC?

- Why is there an expectation that the public sector includes blood product costs but there are no blood product costs in the private sector NHCDC?

9. Bundled Pricing

Do you support IHPA's expanded policy intention for bundled pricing in future years?

What services or patient episodes of care would most benefit from this expanded bundled pricing approach?

What issues should IHPA consider prior to implementing a bundled price and how can these issues be best resolved?

Tasmania supports bundled pricing for home delivered chronic disease services, as this will reduce the data burden on states and territories. Tasmania does not support an expansion of bundled pricing to a range of other conditions, as this will potentially create an environment where the provider of the service wears the risk of any variance from practice or service provision models.

For example, the bundling of admitted acute, sub-acute and non-admitted settings will move the risk of funding further from the Commonwealth and onto the state, as the variation in care and costs will be averaged.

There is also potential for compression of costs to occur. For example; stroke currently has a severity index applied to all output products other than the non-admitted event, giving a possible 24 levels of severity. Using a 'bundling' approach the level of actual severity adjustment may not be appropriately identified.

Tasmania believes that IHPA should model revenue cost and revenue at a service provision level, as a one price fits all approach fails to recognise valid variations in cost.

10. Pricing for Safety and Quality

If feasible would you support a best practice pricing approach for hip fracture care in future years?

What implementation issues should IHPA consider when further investigating the feasibility of applying a best practice pricing approach in future years?

Internationally, there has been a move in most health environments to a pay for performance model (pricing for safety and quality) whether it be a reward or penalty model, all have impacted on how health services are provided. The current national ABF system is not designed to penalise on the basis of clinical standards and performance practices.

As outlined in previous submissions, Tasmania strongly opposes any move to incorporate a safety and quality impact adjustment into the setting of the NEP.

While Tasmania, supports the work of the Australian Commission on Safety and Quality in Healthcare and the Independent Hospital Pricing Authority in endeavouring to further develop the evidence base upon which sound policy may be subsequently developed, clinical and performance management should remain a state responsibility (as the system manager), not a Commonwealth responsibility. The Commonwealth's role should be restricted to providing guidance.

11. The Evaluation of the National Implementation of Activity Based Funding

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

As previously outlined Tasmania has raised concerns with the development of a framework and evaluation program for monitoring the impact of ABF implementation. Tasmania is on record as expressing a number of serious concerns around the lack of transparent consultation and the scope of the evaluation which includes reference to the management of performance of the public hospital system and implicitly assessing the States' role as system managers.

Furthermore, with very few states actually using the National NEP model locally, ongoing changes to the national classification systems and compliance issues with the Australian Hospital Patient Costing Standards, it may be difficult for an evaluation framework to determine valid results at this time.

As the Evaluation Framework and Baseline Report has not yet been finalised and made available to jurisdictions, it is difficult to provide any further comment.

12. Setting the National Efficient Cost (NEC)

As advised in previous submissions, Tasmania has consistently expressed concerns with the National Efficient Cost (NEC) Determination in relation to the block funding of small rural hospitals as this does not reflect the actual cost of Tasmania's small rural hospitals or the community service obligation requirements of these areas.

In addition to the high fixed cost proportion, the small rural hospitals in Tasmania have an additional 'actual' cost that recognises the interdependencies of collocated hospital and residential aged care services, including the costs associated with supplementing aged care. Tasmania believes that the NEC model appears to provide a preference/positive funding effect for sites without aged care facilities.

For 2016-17, it is noted that IHPA will evaluate the impact of the Modified Monash Model (MMM) geographical remoteness classification on the NEC model, and beyond this there are no other proposed changes for NEC16.

The MMM geographical remoteness classification makes no change to Major Cities, Remote or Very Remote classifications, but combines the Inner and Outer Regional areas and then splits this combined area into four new categories based on the size of the town/city. This change will be particularly relevant for Tasmania because 95% of the Tasmanian population fall within the Inner and Outer Regional areas.

Tasmania's initial impression is that the MMM geographical remoteness classification appears to demonstrate more validity than the standard ABS remoteness classification when applied to Tasmania.

Given the linkages between the IHPA model and the Commonwealth Grants Commission work, any proposed changes to the geographical remoteness classification will present risks to Horizontal Fiscal Equalisation for Tasmania.

At this time there is insufficient information to ascertain whether it will have a positive, negative or neutral impact on the Tasmanian funding allocation under the IHPA model. The main risk for Tasmania will be any alteration to the profile of national price loadings or national efficient cost for each remoteness classification.

For these reasons, Tasmania would like to see further analysis undertaken on the cost and patient profiles for the MMM geographical remoteness classification to ensure that this classification is valid for hospital pricing and costing purposes.