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

ATTACHMENT

RESPONSE TO THE IHPA CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2016-17

The Western Australian Department of Health (WA Health) welcomes the opportunity to provide feedback to the Independent Hospital Pricing Authority (IHPA) on the Consultation Paper for the *Pricing Framework for Australian Public Hospital Services 2016-17.*

PRICING GUIDELINES

WA Health is generally supportive of the main policy intentions for the Pricing Framework. As raised in our previous submissions, Western Australia has a number of unique funding issues due to its size, geographical dispersion. These factors can result in unavoidable costs that increase the costs of delivering services in Western Australia and are not fully reflected in the current funding model.

As system manager, WA Health's budget settings continue to be adjusted to reflect each Hospital's service delivery and costs. Implementation of the national ABF without the equivalent pricing adjustments, would cause major disparities in the allocation of budgets and ultimately cause budget instability for Health Services.

SCOPE OF PUBLIC HOSPITAL SERVICES

Consultation question

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

Response

- The Community-based Child and Adolescent Mental Health Services (CAMHS) is still excluded from the general list of public hospital services eligible for Commonwealth funding under the National Health Reform Agreement (NHRA).
- WA Health is of the opinion that these services should be included in the General List in 2016-17.
- WA Health provided evidence to IHPA to support the inclusion of CAMHS as part of the finalisation of the 2014-15 WA General List.

- WA Health continues to suggest that IHPA undertakes a consolidated review of all evidence provided by jurisdictions and other stakeholders on CAMHS against the eligibility criteria and guidelines for in-scope services.

Consultation question

Should posthumous organ procurement activities be in-scope for pricing under the National Health Reform Agreement?

Response

- WA Health acknowledges the advice presented in the Pricing Framework that the Organ and Tissue Authority (OTA) contributes towards some of the costs associated with posthumous organ procurement activities.
- The inclusion of posthumous organ procurement activities as in-scope for pricing under the National Health Reform Agreement is supported.
- If it is decided that posthumous organ donation is in scope, Western Australia recommends consideration of the following aspects:
  - Donation after cardiac death (in addition to brain death).
  - Tissue donations (in addition to organ donations). The activity associated with tissue donations far outweighs that associated with organ donations; and
  - The costs of donor and recipient testing.

Consultation question

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

Response

- WA Health collects some data on organ procurement activities and this is reported via the NHCDC.

CLASSIFICATIONS USED BY IHPA TO DESCRIBE PUBLIC HOSPITAL SERVICES

WA Health supports in principle, classification refinement and development for activity based funding purposes. However, IHPA's plans for future classification development work will need to consider the establishment and future role of the new Health Productivity and Performance Commission proposed by the Commonwealth government since May 2014. Timing of the development work and resource

implications for States and Territories would need to be considered in the context of future Commonwealth funding arrangements.

Australian-Refined Diagnosis Related Groups classification

WA Health acknowledges that IHPA will use AR-DRG Version 8 in NEP16 underpinned by the ICD-10-AM and ACHI 9th edition diagnosis and procedure codes.

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

WA Health appreciates that its recommendation that cases ungroupable to AN-SNAP default to DRG pricing from 2015-16 has been implemented. It would be beneficial is this arrangement is made explicit in the Pricing Framework 2016-17. A program of work is underway in WA to collect clinical measures for palliative care and non-acute cases.

Tier 2 Non-Admitted Patient Services

WA Health acknowledges that IHPA will continue to use the Tier 2 classification for pricing non-admitted services in NEP16. The proposed review of Non Admitted Tier 2 Classifications and work on the new classification is supported as the current classification does not adequately represent the overall costs of delivering Non Admitted Services.

Australian Mental Health Care Classification

WA supports the development of a new Australian Mental Health Care Classification (AMHCC) and pricing that more adequately reflects the cost of resources used in Mental Health care. It has been noted that there has been significant volatility in both the Diagnostic Related Group (DRG) price weights for mental health activity and associated price weight adjustments related to mental health over recent years.

There are significant differences between the current DRG profiles, particularly with respect to certain mental diseases and disorders. Specifically in a Paediatric context, as an example, DRG U66Z Eating Disorders has a number of deficiencies, in that while it is initially a Medical admission to treat mild to severe malnutrition, the bulk of the Inpatient stay relates to treatment by a Mental Health Physician. The Z suffix does not allow for classification between acuity, where patients with severe medical and psychological conditions are classified the same as patients presenting with much milder symptoms and require less aggressive treatment, and therefore consuming less resources. There is also significant variability in Child and Adolescent Mental Health Services adjustments. This variability has made pricing of

mental health services very difficult, highlighting the need for an appropriate AMHCC.

Whilst the revised timeframe for the new AMHCC will allow proper testing of the classification, the implementation date coincides with the timeframe for changes to the Commonwealth funding arrangements (from ABF to population growth and Consumer Price Index) to take into effect. As a system manager, WA Health will need to assess the merits of fully investing in infrastructure/systems enhancements to comply with the requirements of the new classification, when its future use nationally maybe subject to review by the HPPC.

Emergency Care Classification

WA Health acknowledges that for NEP16 IHPA will price emergency activity using the URG Version 1.4 and UDG Version 1.3 classifications. The Emergency Care costing study and classification development work being undertaken by IHPA to replace the URG and UDG is supported.

Teaching, Training and Research

WA Heath is generally supportive of the current work program towards developing a teaching and training classification system. WA Health looks forward to the outcome of the TTR Costing Study where five WA sites are participating.

COSTING AND COUNTING RULES

National Hospital Cost Data Collection (NHCDC)

Western Australia is well represented in the NHCDC. The comprehensive review of the collection is supported. Greater transparency and accuracy of costing data by State will be very useful, especially in benchmarking performance within and between States.

THE NATIONAL EFFICIENT PRICE FOR ACTIVITY BASED FUNDED PUBLIC HOSPITAL SERVICES

Technical Improvements to the NEP

Consultation question

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

Response

- As noted in our previous submissions, WA Health would be strongly opposed to any change in the calculation of the NEP that has the potential to reduce the Commonwealth contribution to jurisdictions under ABF going forward.
- Furthermore, WA Health does not support a move away from the current process of setting a NEP based on the weighted mean cost of admitted services. This is a particularly important issue as it would result in more funding being subject to funding guarantee considerations.
- WA Health is pleased that additional costs associated with fly-in fly-out workforce is being considered for NEP16.

Alternate geographical classification system

Consultation question

What are the advantages and disadvantages of changing the geographical classification system used by IHPA?

Response

- WA Health has highlighted in previous submissions, that a fairer remoteness classification than is currently applied is warranted.
- Western Australia has many remote and very remote cost pressures that are not sufficiently recognised within the Pricing Framework, as they pertain to the structural costs associated with staffing hospitals in remote and very remote locations. WA Health welcomes the introduction of a geographical classification system that would better account for the costs of providing public hospital services in remote locations.
- WA Health supports exploring the most appropriate geographical classification system, however notes the importance of this being done in collaboration with States and Territories.
- The proposal to investigate alternatives to the ASGS, such as the Modified Monash Model is welcomed. WA Health looks forward to reviewing the benefits that alternative models may provide in future iterations of the Pricing Framework.

Adjustments to the NEP

Consultation question

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

Response

Tertiary and Non-Tertiary Hospitals

- WA Health continues to advocate the recognition of cost differentials between tertiary and non-tertiary hospitals in national pricing. IHPA's intention to consider an adjustment for hospital peer groups and location is welcomed.

Location-based costs

- Location based costs in rural and remote areas such as staff accommodation, cost of award issues / allowances and the premium cost for medical locums and other agency staff is material and not funded as part of patient based loadings.

Remoteness

- The NEC addresses some elements of these structural issues by grouping hospitals into service-based as well as remoteness categories, effectively acknowledging the structural issues that remoteness (as well as economies of scale/scope) plays in providing equitable funding outcomes for this group of public hospitals. Although larger in scale, many NEP-funded remote hospitals face the same remoteness-based structural issues attempting to be addressed through the NEC matrix of remoteness-based weight attribution.
- WA Health continues to experience a level of cost disability relating to extreme remoteness unlike that experienced in other jurisdictions. Adjustments that relate to remoteness factors should be re-examined and demonstrated as they relate to remoteness-based differences in cost variability across jurisdictions.
- Many remote areas of Western Australia, particularly the Pilbara are impacted as a result of the resources sector. In Regional Development Australia's (RDA) 2013 report titled *The Cost of Doing Business in the Pilbara*, RDA highlighted several key findings:
    - The price indices for the Pilbara are the highest of any region in WA and impact negatively on employment costs to business and NGOs.
    - The major cost drivers in the Pilbara are the resource sector, growth in demand outstripping supply and constraints to economic development and infrastructure provision.
    - Over the 5 year period from 2007 to 2011 the gap between the Regional Price Index for the Pilbara and Perth had widened by 26 points which equates to an average increase in costs of nearly 5% per year.
    - In 2012, data showed that in the Pilbara the level of remuneration for employees would need to be 37% higher than that in Perth and there is

often a need to provide subsidised or free accommodation to attract or retain employees.

- In consideration of these significant factors, a funding framework that provides adjustment based on patient-based factors does not adequately address the experienced cost issues that arise from providing health services in rural and remote locations, particularly when a proportion of treated patients have metropolitan-based postcodes and attract no adjustment to the NEP. Across Pilbara-based NEP funded public hospitals, this can comprise between 10 and 30% of the patients treated in a given year, without any adjustment to NEP in recognition of those factors stated above.

Consultation question

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

Response

WA Local Characteristics

- WA Health has consistently argued that the NEP is a national average and is not sufficiently reflective of the significant cost disabilities or 'legitimate and unavoidable costs' which may be unique or specific to the delivery of health services in individual States.
- As highlighted in our previous submission, WA hospitals face some unique geographic and demographic challenges in the delivery of its health services which give rise to a range of unavoidable cost disabilities.
- It is essential that local needs and circumstances are not overlooked in the structuring of the NEP. Some of the factors experienced by WA include:
    - High wages for health system workforce flowing from the resource sector.
    - The level of remuneration for employees in remote areas are significantly higher (including a range of allowances and incentives) and there is often a need to provide subsidised or free accommodation to attract or retain employees.
    - Aged care bed shortages.
    - High indigenous population.
    - Growing population particularly in the regions.
    - Extreme remoteness.
    - High socioeconomic disadvantages particularly in the regions.
    - High reliance of Emergency Departments due to shortfalls in primary care.

   - Health workforce shortages and reliance on high cost locums and agency staff.
   - Lack of private sector alternatives.

Cultural and Linguistic Diversity in WA

- WA Health acknowledges that IHPA has identified CALD patients as a priority area for AHPCS Version 4. Western Australia has one of the most culturally and linguistically diverse States in Australia, with migrants from more than 190 countries, speaking close to 300 languages and dialects (ABS Census, 2011).
- The WA Government Language Services Policy 2014 and the WA Health Language Services Policy 2011 ensure appropriate language assistance is available when accessing government health services. WA Health Language Services annual reporting (2013-2014) identified that over 40,000 occasions of service (OOS) were provided across the WA public health system, with an approximate cost of $4 million.
- Western Australia will undertake a six-month pilot study with Curtin University at the Princess Margaret Hospital (PMH), commencing in October 2015. The pilot study will examine the impact of engaging credentialed interpreters on hospital length of stay, readmission rates, emergency presentations and health costs for PMH patients with low English proficiency (LEP). This will include an audit of hospital data and patient records at PMH and the PMH Refugee Health Service. The pilot study will be used to inform a larger study intended to inform future work on pricing of language services.
- WA Health would welcome further consideration of the costs associated with CALD Patients as part of future NEP considerations.

SETTING THE NATIONAL EFFICIENT PRICE FOR PRIVATE PATIENTS

WA Health welcomes the opportunity for IHPA to work with jurisdictions to better identify the treatment of private patient costs in the NHCDC and consideration of the existing methodology.

As noted in our previous submissions, WA Health remains concerned that not all medical costs for private patients are recorded in the general ledger of the hospitals and Local Health Networks (LHNs), and therefore not reflected in the NHCDC.

WA Health believes it is important to consider the patient journey, which crosses boundaries between funding sources, both private and public as well as State and Commonwealth. This requires attention to detail in ensuring that the patient journey to receiving optimal care and resource allocation as patients crosses these boundaries.

TREATMENT OF OTHER COMMONWEALTH PROGRAMS

WA Health acknowledges that IHPA is not proposing any changes to the treatment of Commonwealth funded programs for NEP16.

BUNDLED PRICING

Consultation question

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

Response

- WA Health supports further investigation on bundling for home delivered services. However, WA Health does not support bundled pricing beyond these services. It is noted that some data from WA sites, collected through the Costing Study for Home Delivered Services in 2014, were excluded in the 2015-16 NEP Determination process, and further analysis will be undertaken as part of the NEP16 Determination
- WA Health does not agree that stroke presentations are amenable to bundled pricing. While it is acknowledged that IHPA is considering bundled price weights which reflect the complexity of strokes, WA Health considers that strokes have a high degree of variance that would be difficult to standardise and bundle.
- WA Health does not support bundled pricing for maternity care services. While it is acknowledged that there are nationally agreed guidelines for maternity care, WA does not collect data in a way that would be amendable to bundled pricing.
- Conditions such as Dementia, COPD, and NIDDM would require integration and co-ordination of care between multiple agencies.

Consultation question

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

Response

- WA Health supports bundled pricing for Home Delivered Services, including Home Eternal Nutrition, Total Parenteral Nutrition (TPN), Home Ventilation (HV) and Renal Dialysis.

Consultation question

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

Response

- In implementing bundled pricing, IHPA should consider the administrative burden that would be imposed on jurisdictions through changes in the way that services need to be recorded in order to accommodate changes in pricing arrangements.
- Bundled pricing should only be considered for areas where there are:
    - Clear guidelines or protocols;
    - Clinical consensus on the characteristics of best practice;
    - Consistent opportunities to intervene; and
    - Good quality data available, or able to be collected.

PRICING FOR SAFETY AND QUALITY

WA Health notes the collaborative work undertaken by the IHPA and the Australian Commission on Safety and Quality in Health (the Commission) to explore options for incorporating quality and safety in the NEP.

Given the significant impact that improving safety and quality activity of patient care has on driving improved efficiency in hospitals, the inclusion of a safety and quality model in the NEP is needed to ensure adequate prioritisation and funding by jurisdictions and health service managers.

Consultation question

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

Response

- WA continues to support a cautious approach to Best Practice Pricing as the evidence for the efficacy of such programs is still currently limited. WA looks forward to reviewing any evidence produced from the trial of national high priority complications.
- WA Health reiterates a previously-raised position; that the IHPA and Commission consider a model for safety and quality activity that is similar to current work aimed at quantifying teaching, training and research activity. This new model could reflect activity related to a broad category of "Innovation and Improvement" and include activity specifically related to improving the quality and safety of health care services. Given the significant impact that safety and quality activity has on improving efficiency, unless such an activity model is

included for development in the NEP, the activities related to these essential functions may be at considerable risk.

- WA Health continues to support in principle pricing of best care pathways for patient with specific conditions. WA Health cautions that, while a specific condition pricing framework has been identified as a reasonable place to start pricing for quality, the specific conditions included in the framework at any one time may suffer from a focusing, or attentional, bias, unless a method is identified that recognises the importance and existence of local safety and quality improvement activity.
- As stated in previous consultation responses the best care pathway approach aligns with the Premium Payments Program that the Western Australian Department of Health implemented under the auspices of the Activity Based Funding and Management Program since 2012-2013.
- In financial year 2014-2015 the Premium Payment Program has continued to apply to:
  - Fragility Hip Fracture Premium Payment – aiming to ensure appropriate involvement of orthogeriatric medicine and prompt surgery (based on a successful best practice tariff in operation within the NHS);
  - Stroke Care Premium Payment – aiming to ensure appropriate admission to a designated stroke unit for all stroke patients (also based on the UK system); and
  - Acute Myocardial Infarction Premium Payment - best evidence-based care for AMI patients aligned with the WA Health AMI care pathways.
- WA Health believes that this option is best suited to targeting specific areas where strong, best practice evidence is well established and supports that hip fracture care meets this criteria. The success of these technical solutions will depend on the context in which they are introduced. Critical success factors are:
  - Clinician engagement & participation;
  - Consumer/patient empowerment; and
  - Leadership & Change (System transformation).

Consultation question

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

Response

- WA supports a cautious approach to Best Practice Pricing as the evidence for the efficacy of such programs is currently limited.

- Before this option on pricing for quality can be implemented nationally under the IHPA pricing framework Western Australia believes that further work is still required to implement a suite of nationally agreed clinical care standards, nationally agreed evidence-based clinical practice guidelines and to map the evidence-based clinical practice guidelines to classification systems such as AR-DRGs and AN-SNAP.
- Further work is also required by IHPA and State/Territory jurisdictions to augment their administrative data collection systems to ensure that compliance/non-compliance with patient care pathways are captured and any variation in clinical activity, patient outcomes and clinical costs is able to be reported.
- WA Health notes that there can be significant cost variations for best practice pricing between jurisdictions. These variances are currently not well explained. WA Health does not support a move away from the median price where such variances exist.

EVALUATION OF THE IMPACT OF THE NATIONAL ABF FOR PUBLIC HOSPITAL SERVICES

Consultation question

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

Response

- WA Health reiterates its in-principle support to the ABF evaluation and is waiting for the release of the Evaluation Framework and Baseline Report. A review of the Report will assist us in determining whether 'Phase Two' of the evaluation should proceed.

SETTING THE NATIONAL EFFICIENT COST

WA Health recognises the complexity of the work that underpins the development of the NEC Framework. It is important that the IHPA in coordination with the jurisdictions continues to refine the model and address factors that may be contributing to the variability in NEC funding allocation.

WA Health acknowledges that IHPA has undertaken considerable work to improve the methodology for the block funding model in NEC15. However, the alteration of the eligibility criteria for block funded hospitals in the NEC15 has affected several WA hospitals, such as Derby, Kununurra, Nickol Bay, Esperance, Northam and Narrogin. Four of these sites are remote or very remote and experience extreme cost pressures associated with their remoteness. This change has simply transitioned

their funding issues to a different pricing framework, rather than address the challenges currently faced under the NEC.

WA Health is generally supportive of the NEC model principles, however in its current form will not deliver appropriate or adequate funding at individual hospital level in many instances. At an individual hospital level there are instances of significant variation between NEC funding and the current operating expense / funding allocation. The NEC model, similar to the NEP framework, struggles to deal with the extreme cost pressures of the North West of WA. Many of the facilities that fall within the NEC framework are characterised by high fixed costs, which are inflexible to any change in funding levels. Funding stability is paramount for facilities that are typically funded from within the NEC framework.

WA Health supports the IHPA continuing to block fund TTR activity in ABF hospitals, including in NEC16, until the classification is developed. WA Health acknowledges that TTR block funding amounts will be determined with advice from jurisdictions and consistent with the Block Funding Guidelines developed for NEC15.

WA Health acknowledges that IHPA will continue to determine block funding amounts for non-admitted mental health activities in ABF hospitals based on jurisdictional advice in NEC16.