Consultation paper for the Pricing Framework for Australian Public Hospital Services 2013-14

31 August 2012

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1. Introduction

In June 2012, the Independent Hospital Pricing Authority (IHPA) published the *National Efficient Price Determination for 2012-13*, and the *Pricing Framework for Australian Public Hospital Services 2012-2013* that underpinned the determination.

The Pricing Framework was developed over the preceding six months, and included the publication of a discussion paper, an extensive consultation period with key stakeholder groups around the country, and a call for public submissions, which resulted in over 90 responses from a wide range of stakeholders across the country.

IHPA has committed to provide the draft National Efficient Price Determination and draft Pricing Framework to Health Ministers by 30 November 2012 for the 2013-14 financial year, and will again take public submissions in the lead up to this, as required under the *National Health Reform Act 2011* (the Act).

This document aims to provide some background as to the questions that IHPA considers pertinent in 2013-14, and should be read in conjunction with the *Pricing Framework for Australian Public Hospital Services 2012-13*and the *National Efficient Price Determination for 2012-13*, both of which are available on IHPA website www.ihpa.gov.au

Submissions should be sent to submissions.ihpa@ihpa.gov.au or posted to "Submissions" PO BOX 483 Darlinghurst NSW 1300. Submissions close at 5pm on Wednesday 10 October 2012.

All submissions will be published on the IHPA website www.ihpa.gov.au unless respondents specifically identify any sections that they believe should be kept confidential due to commercial or other reasons.

2. Context

The introduction of a national Activity Based Funding (ABF) system is intended to improve efficiency, as well as improving the transparency of funding contributions of the Commonwealth, state and territory governments for each local hospital network across Australia. To achieve this, IHPA is required to determine the National Efficient Price (NEP) that will be used to calculate Commonwealth payments for in-scope public hospital services that are funded on an activity basis. The determination of the NEP for public hospital services that are funded on an activity basis is the primary function of IHPA.

In accordance with the NHRA, the national implementation of ABF will be staged as follows:

- In 2013-14 the quantum of Commonwealth funding for public hospital services for each State and Territory will be fixed at the level specified in the National Healthcare specific purpose payment. This means that in 2013-14:
    - Total Commonwealth funding for public hospital services will not vary according to the volume of services provided; but instead;
    - Commonwealth funding will be expressed as a share of the NEP.
    - The Commonwealth's share of the NEP will vary across states and territories (it will not be a fixed share such as 40%) because there are different rates of, and expenditure on, utilisation of public hospital services across Australia.
- From 2014-15 onwards, the Commonwealth's funding for public hospital services funded on an activity basis moves from a 'capped' basis (a known quantum of funding) to an 'uncapped' basis

(funding will vary in response to changes in activity and the cost of public hospital services as represented through the NEP). The approach and formulae used to calculate Commonwealth funding from 2014-15 onwards are specified in the Agreement (Clauses A3, A5, A34-A40, and A67-A79). In simple terms:

- In 2014-15 to 2016-17 the Commonwealth will pay 45% of the NEP for 'growth' in the volume of services relative to the previous year.
- In 2014-15 to 2016-17 the Commonwealth will also recognise changes in the NEP. It will pay a price adjustment calculated by multiplying the previous year's volume of services by the change in the NEP relative to the previous year multiplied by 45%.
- From 2017-18 onwards, the growth in volume and price adjustments will use a rate of 50%, rather than 45%.

While the NEP determines Commonwealth funding for public hospital services, it does not require the states and territories to fund at the NEP. Under the Agreement (Clauses A59-A66), states and territories have autonomy as to the level of funding they choose to invest in public hospital services. States and territories "meet the balance of the cost of delivering public hospital services and functions over and above the Commonwealth contribution". States and territories may choose to provide a higher or lower share of the NEP.

3. Pricing guidelines

Understanding this element of the Pricing Framework

In the inaugural *Pricing Framework for Australian Public Hospital Services 2012-13* (the Pricing Framework), IHPA articulated the guidelines it would follow in making decisions and determining the National Efficient Price (NEP) (see Box 1). In 2013-14, IHPA is not proposing to vary these guidelines.

In the Pricing Framework, IHPA signalled that it will actively monitor the impact of the implementation of Activity Based Funding (ABF). This will include monitoring changes in the mix, distribution and location of public hospital services, consistent with its responsibilities under the National Health Reform Agreement (NHRA).

At this time, it has not been possible for IHPA to discern any impacts from the introduction of a national approach to ABF on 1 July 2012. However, IHPA is seeking feedback regarding the pricing guidelines, and especially of any unintended consequences that may be apparent to those in the public hospital system.

Consultation questions:

- **Are any amendments required to the pricing guidelines in Box 1?**
- **What have been the consequences of the introduction of ABF on 1 July 2012?**

Box 1: Pricing Guidelines

The pricing guidelines comprise the following overarching, process and system design guidelines.

Overarching guidelines that articulate the policy intent behind the introduction of funding reform for public hospital services comprising Activity Based Funding (ABF) and block grant funding:

- **Timely–quality care:** Funding should support timely access to quality health services.
- **Efficiency**: ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.
- **Fairness:** ABF payments should be fair and equitable, including being based on the same price for the same service across public, private or not-for-profit providers of public hospital services.
- **Maintaining agreed roles and responsibilities of Governments determined by the NHRA:** Funding design should recognise the complementary responsibilities of each level of government in funding health services.

Process guidelines to guide the implementation of ABF and block grant funding arrangements:

- **Transparency:** All steps in the determination of ABF and block grant funding should be clear and transparent.
- **Administrative ease:** Funding arrangements should not unduly increase the administrative burden on hospitals.
- **Stability:** The payment relativities for ABF are consistent over time.
- **Evidence based:** Funding should be based on best available information.

System design guidelines to inform the options for design of ABF and block grant funding arrangements:

- **Fostering clinical innovation:** Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the model of care that improve patient outcomes.
- **Price harmonisation:** Pricing should facilitate best practice provision of appropriate site of care.
- **Minimising undesirable and inadvertent consequences:** Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.
- **ABF pre-eminence:** ABF should be used for funding public hospital services wherever practicable.
- **Single unit of measure and price equivalence:** ABF pricing should support dynamic efficiency and changes to models of care with the ready transferability of funding between different care types and service streams through a single unit of measure and relative weights.
- **Patient-based:** Adjustments to the standard price should be, as far as is practicable, based on patient-related rather than provider-related characteristics.
- **Public-private neutrality:** ABF pricing should not disrupt current incentives for a person to elect to be treated as a private or a public patient in a public hospital.

4. In-scope public hospital services

Determining what is a "public hospital service"

Making decisions about what is, or is not, a public hospital service for funding purposes is one of the important tasks of IHPA.

In August 2011, Governments agreed to be jointly responsible for funding growth in 'public hospital services'. But, as there is no standard definition or listing of public hospital services, Governments gave IHPA the task of deciding which services will be ruled 'in scope' as public hospital services, and so eligible for Commonwealth funding under the NHRA.

IHPA's decision

IHPA determined that, from 1 July 2013, the scope of public hospital services eligible for Commonwealth funding will be:

- All admitted programs, including hospital in the home programs.
- All emergency department services.
- Non-admitted services that meet the criteria for inclusion on the General List, with further specification in Box 2 at the end of this chapter.

Since the Pricing Framework was published in June 2012, IHPA has worked with all jurisdictions on finalising the scope of public hospital services:

- In June 2012, the criteria in Box 2 were published in the Pricing Framework.
- In late June 2012, as required under the NHRA, IHPA's criteria were reviewed by the Standing Council on Health, which did not amend the criteria published by IHPA.
- IHPA asked states and territories to submit the services that they proposed for inclusion in the scope of public hospital services, in June 2012.
- IHPA will review these submissions of the states and territories against the criteria in Box 2, and seek to achieve maximum possible national consistency in defining the scope of public hospital services.
- IHPA has agreed that the Commonwealth will have an opportunity to review the proposed general list and highlight any services which they would like IHPA to further review.
- IHPA expects to finalise the general list of services eligible for Commonwealth funding under the NHRA by April 2013.

Consultation questions:

- **Have there been any recent clinical developments that IHPA should be taken into account when examining the scope of public hospital services in 2013-14?**
- **Are there any particular areas of concern that IHPA should consider in reviewing State/Territory Government submissions on the scope of public hospital services?**

Box 2: Scope of public hospital services and general list of eligible services

In accordance with Section 131(f) of the *National Health Reform Act 2011* and Clauses A9–A17 of the NHRA, the scope of "public hospital services" eligible for Commonwealth funding under the NHRA are:

- All admitted programs, including hospital in the home programs. Forensic mental health inpatient services are included as recorded in the 2010 Public Hospitals Establishment Collection.
- All emergency department services.
- Non-admitted services as defined below.

Non-admitted services

This listing of in-scope, non-admitted services is independent of the service setting in which they are provided (e.g. at a hospital, in the community, in a person's home). This means that in-scope services can be provided on an outreach basis.

To be included as an in-scope, non-admitted service, the service must meet the definition of a service event which is:

- An interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record.

Consistent with Clause A25 of the NHRA, IHPA will conduct analysis to determine if services are transferred from the community to public hospitals for the dominant purpose of making those services eligible for Commonwealth funding.

There are two broad categories of in-scope, public hospital non-admitted services:

A. Specialist outpatient clinic services

B. Other non-admitted patient services

Box 2: Scope of public hospital services and general list of eligible services (ctd)

A. Specialist outpatient clinic services

This comprises all clinics on the Tier 2 list (see Appendix 1) that were reported as a public hospital service in the 2010 public hospital establishments collection in terms of their activity, expenditure or staffing.

The following clinics are considered by IHPA to be unlikely to be considered eligible for Commonwealth funding as a public hospital service under Category A: specialist outpatient clinic services:

- Commonwealth Funded Aged Care Assessment (40.02)
- Family Planning (40.27)
- General Counselling (40.33)
- General Practice and Primary Care (20.06)
- Primary Health Care (40.08)

Jurisdictions that consider that there are exceptions where the above services should be included as eligible for Commonwealth funding as a public hospital service will be asked to provide evidence to support their inclusion based on whether the clinic was reported as a public hospital service in the 2010 public hospitals establishment collection.

B. Other non-admitted patient services

To be eligible, this service must be:

1) Directly related to an inpatient admission or an emergency department attendance; OR

2) Intended to substitute directly for an inpatient admission or emergency department attendance; OR

3) Expected to improve the health or better manage the symptoms of persons with physical or mental health conditions who have a history of frequent hospital attendance or admission; OR

4) Reported as a public hospital service in the Public Hospitals Establishment Collection 2010.

Jurisdictions will be invited to propose programs that will be included or excluded from Category B "other non-admitted services". Jurisdictions will be required to provide evidence to support the case for the inclusion or exclusion of services based on the four criteria above, and may draw on the examples listed in Box 3.

For the purposes of clarification, relevant subacute and mental health services may be included under either the specialist outpatient clinic services category or the other non-admitted patient services category.

The full list of specialist outpatient clinic services and other non-admitted patient services clinics eligible for Commonwealth funding is provided at Appendix 1.

Box 2: Scope of public hospital services and general list of eligible services (ctd)

Appendix 1

Category A – in-scope Tier 2 clinics list

10.01 Hyperbaric Medicine
10.02 Interventional Imaging
10.03 Minor Surgical
10.04 Dental
10.05 Angioplasty/Angiography
10.06 Endoscopy - Gastrointestinal
10.07 Endoscopy- Urological/Gynaecological
10.08 Endoscopy- Orthopaedic
10.09 Endoscopy - Respiratory/ENT
10.10 Renal Dialysis
10.11 Medical Oncology (Treatment)
10.12 Radiation Oncology (Treatment)
10.13 Minor Medical Procedures
10.14 Pain Management Interventions
20.01 Transplants
20.02 Anaesthetics
20.03 Pain Management
20.04 Developmental Disabilities
20.05 General Medicine
20.07 General Surgery
20.08 Genetics
20.09 Geriatric Medicine
20.10 Haematology
20.11 Paediatric Medicine
20.12 Paediatric Surgery
20.13 Palliative Care
20.14 Epilepsy
20.15 Neurology
20.16 Neurosurgery
20.17 Ophthalmology
20.18 Ear, Nose and Throat (ENT)
20.19 Respiratory
20.20 Respiratory - Cystic Fibrosis
20.21 Anti coagulant Screening and Management
20.22 Cardiology
20.23 Cardiothoracic
20.24 Vascular Surgery
20.25 Gastroenterology
20.26 Hepatobiliary
20.27 Craniofacial
20.28 Metabolic Bone
20.29 Orthopaedics
20.30 Rheumatology

Box 2: Scope of public hospital services and general list of eligible services (ctd)

Category A – in-scope Tier 2 clinics list (ctd)

20.31 Spinal
20.32 Breast
20.33 Dermatology
20.34 Endocrinology
20.35 Nephrology
20.36 Urology
20.37 Assisted Reproductive Technology
20.38 Gynaecology
20.39 Gynaecology Oncology
20.40 Obstetrics
20.41 Immunology
20.42 Medical Oncology (Consultation)
20.43 Radiation Oncology (Consultation)
20.44 Infectious Diseases
20.45 Psychiatry
20.46 Plastic and Reconstructive Surgery
20.47 Rehabilitation
20.48 Multidisciplinary Burns Clinic
20.49 Geriatric Evaluation and Management (GEM)
20.50 Psychogeriatric
20.51 Sleep Disorders
30.01 General Imaging
30.02 Medical Resonance Imaging (MRI)
30.03 Computerised Tomography (CT)
30.04 Nuclear Medicine
30.05 Pathology (Microbiology, Haematology, Biochemistry)
30.06 Positron Emission Tomography (PET)
30.07 Mammography Screening
30.08 Clinical Measurement
40.01 Aboriginal and Torres Strait Islander Health Clinic
40.03 Aids and Appliances
40.04 Clinical Pharmacy
40.05 Hydrotherapy
40.06 Occupational Therapy
40.07 Pre-Admission and Pre-Anaesthesia
40.09 Physiotherapy
40.10 Sexual Health
40.11 Social Work
40.12 Rehabilitation
40.13 Wound Management
40.14 Neuropsychology
40.15 Optometry
40.16 Orthoptics
40.17 Audiology
40.18 Speech Pathology

Box 2: Scope of public hospital services and general list of eligible services (ctd)

Category A – in-scope Tier 2 clinic list (ctd)

40.19 Asthma
40.20 Chronic Obstructive Pulmonary (Disease)
40.21 Cardiac Rehabilitation
40.22 Stomal Therapy
40.23 Nutrition/Dietetics
40.24 Orthotics
40.25 Podiatry
40.26 Diabetes
40.28 Midwifery
40.29 Psychology
40.30 Alcohol and Other Drugs
40.31 Burns
40.32 Continence
40.34 Specialist Mental Health

Box 3: Scope of public hospital services and general list of eligible services

Category B – Examples of In scope services which are Other Non-admitted Patient Services

Lymphoedema services
Post acute care services
Mental health crisis assessment services
Mental health step down services
Mental health hospital avoidance programs
Chronic disease hospital avoidance programs
Early discharge program services
Falls services
Home Parenteral/Enteral Nutrition services
Community Palliative Care
Other hospital avoidance programs

5. The national efficient price for activity based funded public hospital services

5.1 Overview

Setting the National Efficient Price (NEP)

The major areas of work informing the determination of the NEP comprise:

- **Developing and refining classifications:** For 2012-13, the major work to be carried out on classification systems includes:
  - Foundational work for the development of a mental health classification system, including the definition of eligible services, identification of the cost drivers for service delivery and refinements to the current Australian Refined Diagnosis Related Groups (AR-DRGs).
  - Refinement of the existing classification systems for non-admitted, subacute and emergency patients.
  - Initial work on the efficient cost of small rural hospitals not suitable for ABF.
  - Initial work on a classification system for Teaching Training and Research (TTR), which will inform IHPA's advice to the Council of Australian Governments (COAG), due in 2017-18.

- **Improving and verifying the robustness of costing data**: This has included:
  - Engaging a third party to carry out a reconciliation of cost data against audited financial returns, to ensure that all relevant costs have been included.
  - The development of an "all product costing methodology" to ensure that costs are appropriately assigned to all areas of activity within hospitals and avoid the over or understating of costs in a particular area.
  - Efforts by jurisdictions to improve the quality of data for the new classifications, particularly outpatients and emergency services.
- **Developing the funding model**: This has included:
  - Further refinement of the inpatient, outpatient and emergency department costing and pricing models.
  - An initial approach to the funding of subacute and mental health services.
  - Development of an understanding of the efficient cost of block funded community based mental health hospital services.
  - Review and refinement of the adjustments to the NEP to be applied for various groups of patients or hospitals. This has included more detailed work on identifying and quantifying unavoidable cost variations, as required by the NHRA.

5.2 Classifications, counting and costing inputs

In determining the NEP for ABF services, IHPA must first specify the classifications, counting rules, data and coding standards, and the methods and standards for costing data.

IHPA undertakes the data functions delegated to it under the NHRA in accordance with nationally agreed standards for the collection and management of data. IHPA will use existing data standards and definitions contained in METeOR (the repository for national metadata standards for the health, community

services and housing assistance sectors that is maintained by the Australian Institute of Health and Welfare (AIHW)). IHPA has been established as a METeOR registering authority. To the extent that IHPA develops new dataset specifications, these will be available through METeOR.

IHPA's position

IHPA proposes that the following classifications, counting unit and costing data will be used in setting the national efficient price in 2013-14.

The classifications are:

- Admitted patient services: ICD-10-Am 8th Edition And Australian Refined Diagnosis Related Groups Version 6.X;
- Emergency department services: urgency related groups (for recognised emergency departments at Levels 3B-6) and urgency disposition groups (for recognised emergency departments at Levels 1-3A);
- Non-admitted patient services: Tier 2 outpatient clinics definitions;
- Sub-acute patients: AN-SNAP Version 2 (in designated units where AN-SNAP data is collected) and AR-DRG Version 6.X (where AN-SNAP data is not collected); and
- Specialist mental health patient services: AR-DRG Version 6.X (with possible enhancements to improve the explanatory power of mental health DRGs – see below).

The counting unit (that is used to express the price weights) is the National Weighted Activity Unit (version 2013-14), described as NWAU (13).

The costing data used in setting the 2013-14 National Efficient Price (NEP) is the National Hospital Cost Data Collection (NHCDC) Round 15 (2010-11 data). Public hospital expenditure data is also used to give additional confidence in the NHCDC data where possible. The 2010-11 cost data will be indexed to calculate the 2013-14 price.

The costing of public hospital services that are delivered in 2013-14 (NHCDC Round 18) will use the Australian Hospital Patient Costing Standards Version 3.0.

Further information and explanation is provided on each of these three elements.

Classifications

Admitted acute patients

For 2012-13, IHPA adopted ICD-10-AM 7th Edition and AR-DRG Version 6.x as the classification system for admitted acute patients. This built on the AR-DRG Version 6.0, and addressed a number of concerns with that version.

The University of Wollongong (UOW) was contracted by the Commonwealth Department of Health and Ageing to develop ICD-10-AM 8th Edition and AR-DRG Version 7.0, for use from 1 July 2013. In developing these new versions of the classification systems, UOW has consulted heavily with jurisdictions, clinicians and other stakeholders to ensure that they best represent the current clinical practice in Australian hospitals. A summary of modelled impacts of moving to AR-DRG V7.0 is included at Attachment A.

IHPA has considered the question of whether to adopt the newest version of the classification for 2013-14 carefully. As a result, IHPA is proposing to remain with AR-DRG V6.x in 2013-14.

IHPA will adopt AR-DRG V7.0 in 2014-15 and encourages hospitals to make preparations to implement to this time frame.

IHPA will adopt ICD-10-AM 8th edition from 1 July 2013.

Emergency department patients

For 2012-13, Urgency Related Groups (URGs) and Urgency Disposition Groups (UDGs) were used to classify patient in emergency departments, depending on their size and ability to collect diagnosis.

In 2013-14, IHPA is proposing to retain these classification systems. The following amendments have been proposed in 2013-14:

- Separate URG/UDG classes for:
  - Patients who are subsequently transferred (visit end status 3).
  - Pre-planned visits (type of visit 2).

Non-admitted patients

In 2012-13, Tier 2 clinics (Version 1.2) were used to classify visits for outpatient services.

As a result of further work by the non-admitted advisory working group, the following changes are proposed for 2013-14:

- Additional clinics for home based services:
  - Home Based Haemodialysis.
  - Home Based Peritoneal Dialysis.
  - Home Enteral Nutrition (HEN).
  - Total Parental Nutrition (TPN).
- A potential review of the business rules for Tier 2, to enable the counting of services delivered to the patient's family and carers in the case of palliative care and mental health services.

Sub-acute patients

For 2012-13, sub-acute and mental health patients were predominately funded via block funding. The quantum of Commonwealth funding directed to these block payments was subject to bilateral agreements between the Commonwealth and States and Territories. The NHRA requires ABF to commence for sub-acute and mental health patients from 1 July 2013.

It was previously agreed by all jurisdictions that AN-SNAP would be used as the starting point for the classification of sub-acute patients. To support this agreement, all states and territories agreed to implement a new data set specification for sub-acute patients. From 1 July 2011 this is on a best efforts basis and will only cover designated sub-acute units.

IHPA proposes to use AN-SNAP Version 2 in 2013-14, subject to a sufficient quantity of data of adequate quality being available to cost and price AN-SNAP patient classes.

In the event that sufficient data is not available, IHPA proposes to default to Australian Refined Diagnosis Related Groups (AR-DRGs) for pricing of sub-acute services.

Non-admitted sub-acute services will be classified using the Tier 2 classification system.

Mental health services

As described earlier in this document, IHPA has commenced the work required to establish a new classification system for mental health patients. It is anticipated that this new classification will be available from 2014-15 at the earliest. In 2013-14, IHPA will utilise existing classification systems, with enhancements as required.

For admitted patients IHPA proposes to use AR-DRGs in 2013-14, albeit with an enhanced approach. These enhancements will focus on factors that should be introduced into the mental health classification system that will improve the accuracy of pricing these services, and increase the clinical relevance of the classification.

The mental health DRGs in major diagnostic category (MDC) 19 are the poorest performing in the AR-DRGs, explaining only 16% of the variation in the length of stay of these patients.

IHPA is proposing to identify mental health patients who have received treatment in a specialist facility (using the 'days in a specialist psychiatric facility' field of the national minimum dataset). IHPA will also consult with the Mental Health Working Group to identify other fields that could be used to further refine the grouping of mental health patients, such as:

- Homelessness
- Age
- Socioeconomic factors

In 2013-14, for in-scope admitted and community services, IHPA will examine improvements in classification costing and pricing whilst avoiding distortions to existing models of care. This work will be carried out in conjunction with the Mental Health Working Group.

Teaching, training and research

IHPA is required to provide advice to Health Ministers on the feasibility of transitioning funding for TTR from a block grant to ABF or another method that reflects activity volumes by no later than 30 June 2018 (Clause A49, NHRA).

In early 2013, IHPA will commence the work on designing appropriate classification systems and costing standards in order for this work to progress.

Consultation questions:

- **What unavoidable costs do you think IHPA should examine, which may lead to loadings on the NEP?**
- **Do you support IHPA's proposal to not adopt AR-DRG V7.0 in 2013-14?**
- **What, if any, modifications should be made to the classification systems for 2013-14?**
- **What factors should IHPA investigate for incorporation into DRGs to better explain the variance in mental health patients' resource consumption?**
- **What are the key factors that IHPA should examine that influence the efficient cost of providing community based public hospital mental health services for different patient groups?**
- **What factors should IHPA consider when designing an approach to classifying and pricing TTR?**

Counting unit (the national weighted activity unit)

The 2012-13 National Efficient Price (NEP) was defined using the National Weighted Activity Unit (NWAU) as its basis. It is the 'currency' that is used to express the price weights for all services that are funded on an activity basis and allows local hospital networks to understand the price relativities of different types of public hospital services such as inpatients, emergency departments and non-admitted services. Box 3 provides further information on the construction of the NWAU.

IHPA does not propose change its approach to the NWAU in 2013-14.

Costing data

The primary data used to calculate the price weights (the relativities between various hospital services) and the NEP, is the cost data from the NHCDC. IHPA also uses the Public Hospital Establishments Collection to provide a further reference point in the calculation of the NEP.

5.3 Setting the level of the national efficient price for public patients

A detailed description of the technical aspects of the 2012-13 National Pricing Model is available on IHPA's website: http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/NEP-tech-spec.

IHPA's position

The decision to set the 2012-13 NEP on the basis of the average cost per weighted separation was underpinned by an analysis of the distribution of public hospital costs. This analysis indicated that the median cost/weighted separation was approximately 80% of the mean cost per weighted separation. This wide variation between the median and the mean cost per weighted separation is a function of the skewed distribution of public hospital costs and, in particular, the very high costs associated with small numbers of patients. The costs of the patients are often not due to inefficiency, but reflect the cost of providing care to the sickest and most complex patients in the public hospital system. Due to this skewed distribution of public hospital costs, the mean is preferred over the median as it provides a fairer representation of the actual costs experienced by most hospitals.

Consistent with the approach outlined in the 2012-13 Pricing Framework, in the second year of a national Activity Based Funding (ABF) system, IHPA is not proposing to vary its approach to setting the price. During 2013, IHPA will undertake detailed analysis of hospital costing data to better understand the differences in efficiency of different Australian public hospitals. In undertaking this work IHPA will also need to better identify efficiency differences, and the unexplained variations in patient complexity.

Consultation questions:

- **Do you agree with IHPA's intention to again set the NEP at the average cost in 2013-14?**
- **Are there any other factors that IHPA should consider in setting the level of the NEP in 2013-14?**

5.4 Indexation and projections of the national efficient price

The 2013-14 National Efficient Price (NEP) will be calculated using cost data for 2010-11 activity. As in 2012-13, IHPA will need to apply an indexation factor to this cost data to arrive at the 2013-14 price.

IHPA's position

In 2012-13 in association with independent advice, IHPA developed an index using cost data from the NHCDC. This was further validated against a number of other sources, including Australian Institute of Health and Welfare expenditure information and State and Territory budget paper growth over the past five years. For 2012-13, an annual indexation factor of 5.1% was applied to the 2009-10 cost data.

Following this decision, IHPA received a variety of feedback. The primary concern expressed was that the decision to base future price growth on the historic patterns of growth ran the risk of overstating growth in the period 2010-11 to 2012-13, especially given the significant change in government budgetary positions over that time.

In 2013-14, IHPA proposes to again use the actual growth in the NHCDC unit costs over the previous five years as the basis of indexing 2010-11 costs to 2013-14 prices. However, it will undertake further analysis of published data on the growth in hospital expenditure to ensure that the NEP is not overstated or understated by adopting this approach.

Consultation questions:

- **What factors should IHPA consider in the escalation of 2010-11 costs to 2013-14 prices?**
- **If IHPA continues to rely on the NHCDC cost data to carry out this indexation, what moderating factors should it consider to ensure it does not overstate or understate the NEP?**

5.5 Incorporating new technology in the national efficient price

IHPA recognises that there are parallel national and State/Territory-based processes for the evaluation of new technology. Some State and Territory Governments fund new technology outside existing activity based funding arrangements, as part of piloting and evaluating the more widespread introduction of new technology into their public hospitals. IHPA expects that these existing technology evaluation and supplementary funding mechanisms will continue. IHPA's core function is the pricing of public hospital services and it was not established to take on a major technology evaluation role.

However, when significant changes in technology or service delivery models take place in the period between the collection of the costing data (in this case 2010-11) and the period for which IHPA is pricing, it is important that these are understood, and if need be, accounted for in the National Pricing Model.

IHPA's position

IHPA, through its Clinical Advisory Committee, will monitor the potential impact of new technology and innovations in the model of care that have not yet been incorporated in the costing of public hospital services. This will be informed by existing national and State-based approaches for technology evaluation.

Consultation questions:

- **Have there been any significant changes in technology or service delivery models that impact on costs in the period between the last round of the NHCDC (2010-11) and the period for which IHPA is currently pricing (2013-14)?**

5.6 Setting the level of the national efficient price for private patients in public hospitals

IHPA's position

IHPA will calculate the National Efficient Price (NEP) for private patients in public hospitals so that the total revenue (including Activity Based Funding (ABF), Medicare Benefits Scheme (MBS) and private health insurance payments) available to a hospital is equivalent to the NEP for public patients.

IHPA has decided that the determination of the NEP for private patients in public hospitals will incorporate State-specific default benefits.

IHPA does not consider private non-admitted services (privately referred clinics) to be eligible for ABF as public hospital services, when there is a payment under the MBS, the PBS, private health insurance or any other Commonwealth program. However, IHPA has decided that other services for these patients (that constitute separate service events such as allied health services) are public hospital services that will be funded under ABF as these services are not able to be funded privately.

Further technical information on the calculation of the NEP for private patients in public hospitals is available on IHPA website.

The calculation is based on the National Hospital Cost Data Collection (NHCDC). There are three major categories of private patient revenue that are factored into the calculation of the NEP for private patients in public hospitals:

- *Prostheses, pathology and imaging costs*: the actual costs of these services are removed, on the basis that the costs associated with these services are met by the MBS and private insurance funds.
- *Medical costs*: some of the costs of medical services are retained in the calculation of the NEP for private patients. This recognises that the costs of junior medical staff are not funded through the MBS and therefore need to be included in the ABF payments.
- *Default benefits payable by private health insurers*: the NEP is calculated through deducting State-specific default benefits. This recognises that there is considerable variation across states and territories in the level of default benefit payable by private health insurers. The deduction is undertaken on the basis of actual length of stay for each patient. A deduction based on the average length of stay would penalise local hospital networks that had a lower than average length of stay.

The outcome of these steps is a set of private patient adjustments to the price weights that then determines the NEP for private patients in public hospitals. In 2012-13, IHPA calculated a different price weight for every DRG, on the basis of feedback received from some stakeholders that a uniform discount across all DRGs would unfairly discount DRGs which do not include prosthesis costs, or are less intensive users of pathology or imaging.

The approach has been to establish a separate set of price weights for private patients. IHPA has received some feedback that this creates complexities, and potential distortions, because it leads system managers to set separate NWAU targets for public and private patients. An alternative approach is to apply a negative loading consistent with the above methodology. IHPA seeks views on which technical methodology works best to achieve a neutral incentive to treat public and private patients in public hospitals.

Non-admitted private patients

Whilst IHPA has received significant levels of feedback regarding its interpretation of Clauses A6 and A7 of the , there is no intention to change the current position on this issue, subject to any further advice from the Heads of Treasury working party.

In reaching this decision, IHPA has considered the wording and the intent of Clauses A6, A7 and A41 of the NHRA. IHPA recognises that Clauses A6 and A7 provide specific directions for IHPA to exclude privately referred non-admitted services that receive an Commonwealth payment from eligibility for Commonwealth funding under the NHRA. IHPA has also carefully taken into account Clause A41 which is less specific than Clauses A6 and A7 prior to reaching its conclusion as to the interpretation of Clauses A6 and A7.

Next steps and future work

IHPA has engaged an external consultancy to conduct a review of its approach to calculating private patient prices for 2013-14. It is expected that this work will review the existing approach, consult with a range of stakeholders to understand what, if any, impact the current approach has had on practice at a Local Hospital Network (LHN) level, and explore what other data sets (for example, the Hospital Casemix Protocol (HCP) dataset) could be utilised in calculating the price for private patients.

Consultation questions:

- **Do you support IHPA's approach to calculate separate price weights for each DRG? Could this approach be simplified? Is a negative loading preferable to a separate set of price weights?**
- **Are there any distorted incentives in the approach used by IHPA, such that public hospitals are either encouraged or discouraged from treating public patients and private patients equally?**

5.7 Adjustments to the national efficient price

The NHRA requires IHPA to take into account legitimate and unavoidable cost variations in the costs of service delivery, including for the following factors:

1. "hospital type and size;
2. hospital location, including regional and remote status; and
3. patient complexity, including Indigenous status" (Clause B13).

IHPA's position

IHPA first examined patient-based characteristics in the cost of providing public hospital services, before considering hospital or provider-based characteristics.

IHPA determined that in 2012-13, there would be:

- An adjustment for patients who are treated in an Intensive Care Unit (ICU). This applies only to patients in DRGs that do not normally have ICU treatment AND are admitted to a level 3 ICU.
- A specialist paediatric services adjustment that will take the form of DRG-specific adjustments to the price weights in relevant hospitals.
- An adjustment of +5.0% to the National Efficient Price (NEP) for Indigenous patients.
- An adjustment of +8.7% to the NEP for public hospital services provided to patients from outer regional locations, payable wherever these patients are treated.
- An adjustment of +15.3% to the NEP for public hospital services provided to patients from remote locations, payable wherever these patients are treated; and
- An adjustment of +19.4% to the NEP for public hospital services provided to patients from very remote locations, payable wherever these patients are treated.

IHPA has determined that these adjustments to the NEP will apply across relevant in-scope public hospital services in all settings.

Next steps and future work

For the 2013-14 NEP, IHPA will review the adjustments calculated in 2012-13. In particular, IHPA will examine:

- *Specialist paediatric adjustment*: IHPA has received a range of feedback on the specialist paediatric adjustment. In 2013-14, IHPA will review the adjustment to examine:
    - The case to expand the adjustment to a wider range of hospitals, or to all paediatric patients (those aged 16 and under).
    - Simplification of the application of the adjustment.
    - The possible impacts that negative DRG adjustments may have on the incentives for specialist paediatric hospitals to treat patients in these DRGs.

- *ICU adjustment*: IHPA will examine:
    - The basis of eligibility for the ICU adjustments, including widening the eligibility of facilities, to include Level 2 ICUs and defining how IHPA will define eligible ICUs into the future.

- The feasibility and impact of using mechanical ventilation as the primary driver for ICU adjustments.

- *Highly specialised services delivered in hospitals with low economies of scale*: IHPA will examine the proposition that the provision of highly specialised services (e.g. neurosurgery, cardiothoracic surgery etc) in isolated cities (Perth, Hobart, Townsville, Darwin and Canberra) leads to unavoidable cost variations, as these services are not able to achieve the throughput that is achievable in other major centres.
- *Unavoidable input costs in remote and very remote ABF hospitals*: There is anecdotal evidence that the costs of attracting and retaining staff in remote locations is significantly higher than the adjustment for remote and very remote patients outlined above. IHPA will examine what the impact of these apparent unavoidable input costs is on the cost of providing treatment to patients in these locations.

Consultation questions:

- **Should the paediatric adjustment be widened to include more hospitals, or all paediatric patients?**
- **How could the application of the adjustment be simplified?**
- **Do you have views about the basis for adjusting for the costs of delivering highly specialised services in hospitals with low economies of scale, and the unavoidable costs of remote and very remote ABF hospitals?**

6. Pricing for safety and quality

IHPA has adopted a definition of the National Efficient Price (NEP) that states, in part, that a public hospital service operating at the NEP will "be able to provide services at a quality level consistent with national standards, and to minimise negative consequences that fall on patients (including those attributable to poor quality and safety) or on other parts of the service system". Accordingly, this section begins to explore how IHPA might incorporate quality considerations in its setting of the NEP in the future. It also considers the related concepts of best practice pricing and normative pricing.

The NHRA also requires IHPA in setting the NEP to "have regard to ensuring reasonable access to public hospital services, clinical safety and quality, efficiency and effectiveness and financial sustainability of the public hospital system" (Clause B12(a)). The NHRA does not specify, nor does it constrain, how IHPA might seek to give effect to this broad set of responsibilities. Clause B12(a) indicates that IHPA should not only be guided by the efficiency of the public hospital system, but it must also have regard to other important policy objectives such as quality and access as it undertakes its price-setting role.

IHPA's position

As a consequence of submissions received regarding the Pricing Framework in early 2011, IHPA is aware that the public health system is presently participating in many significant reforms, over and above the implementation of ABF nationally. Any adjustment of price for quality must be supported by research and occur at a manageable pace.

With this is mind, IHPA has agreed to work in partnership with the Commission during 2012 to explore options for addressing quality and safety in determining the NEP for 2013-14. Both agencies have resolved to work together to provide options to their respective governing bodies on the most appropriate methodological approach within the National Pricing Framework to ensure safety and quality in the provision of health care services.

To support the Commission and IHPA in its work, a Joint Working Party for Safety and Quality (JWPSQ), chaired by the CEO of the Commission, is being established to provide advice on the options for the consideration of safety and quality in the pricing of public hospital services in Australia.

The role of the JWPSQ is to provide advice to the Commission and IHPA on the following:

- The intended outcomes of a methodological approach to ensuring the consideration of safety and quality within the National Pricing Framework and the likely benefits to the Australian community.
- Mechanisms in operation in jurisdictions or health systems (public or private) both within and outside of Australia.
- The advantages and disadvantages of these systems already in operation.
- The need for any unique features that may be desirable in any National Pricing Framework in Australia.
- The options for the implementation and implementation strategies that will need to be considered prior to any implementation including any requirements to obtain the support of all jurisdictions.

To support the JWPSQ in this role, IHPA and the Commission will undertake a systematic literature review on options for integrating quality and safety into the pricing or funding arrangements for health care. The literature review will also consider the potential impact of implementing these mechanisms on the current Australian health care system, and whether the mechanisms could be applied to pricing quality across the various health care delivery settings (such as acute inpatient, sub-acute, non-acute, emergency department, outpatients and block funded facilities etc).

Following endorsement by the Commission's Board and the Pricing Authority, a discussion paper summarising the key options and issues with regard to pricing for safety and quality will be released for public consultation in 2013.

This work should also involve the Clinical Advisory Committee, the Australian Government, state and territory governments and other key stakeholders such as the National Health Performance Authority.

Consultation questions:

- **What other considerations should IHPA, the Commission and JWPSQ have with regard to incorporating safety and quality considerations in the setting of the NEP?**
- **What mechanisms for pricing safety and quality are in operation in jurisdictions or health systems (public or private) both within and outside of Australia across the various health care delivery settings (such as acute inpatient, sub-acute, non-acute, emergency department, outpatients, block funded facilities, etc.)? What are the advantages and disadvantages of these systems already in operation?**

7. Block funding of public hospital services

The NHRA requires IHPA to define criteria for block funded services, and to then calculate the efficient cost for these services.

IHPA's decision in 2012-13

Consistent with the requirements of the NHRA, IHPA has submitted draft block funding criteria to COAG for endorsement. The NHRA allows COAG to either endorse the criteria or request IHPA to refine the criteria and resubmit them to COAG for endorsement.

Next steps and future work

IHPA has convened a small rural hospital working group to provide advice to IHPA to assist in determining the efficient cost for these services. The working group consists of representatives from a range of organisations, as well as the Commonwealth and , state and territory governments.

The objective of the working group is to provide advice to IHPA on:

- The development of an understanding of the cost drivers for small rural hospitals.
- The appropriate methods of comparison of these cost drivers across small rural hospitals in Australia.
- The appropriate categories, to enable grouping of small rural hospitals for comparison purposes.
- The key parameters that should be taken into account by IHPA in determining the "efficient" cost of these services; and
- The interaction with other funding arrangements for small rural hospitals including aged care and MBS funding.

Consultation questions:

- **What issues does IHPA need to consider in determining the efficient cost of block funded services?**