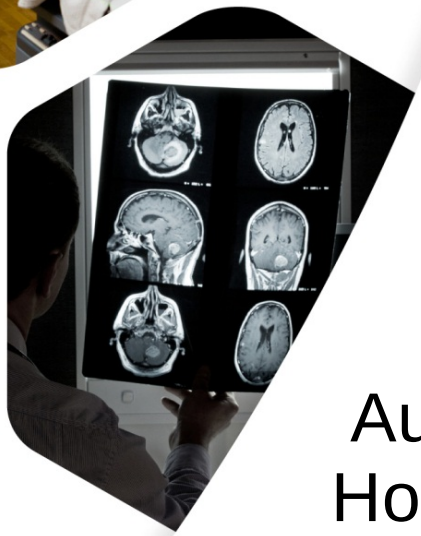
Independent Hospital Pricing Authority

IHPA



The Pricing Framework for Australian Public Hospital Services 2014-15

Independent Hospital Pricing Authority
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The Hon Jillian Skinner MP
Chair, Standing Council on Health
Level 31, Governor Macquarie Tower
1 Farrer Place
SYDNEY NSW 2000

Dear Minister

On behalf of the Independent Hospital Pricing Authority (IHPA), I am pleased to present the *Pricing Framework for Australian Public Hospital Services 2014-15* (Pricing Framework).

This is the third Pricing Framework issued by IHPA. The Pricing Framework emphasises IHPA's commitment to transparency and accountability, and it is the key strategic document underpinning the National Efficient Price (NEP) and National Efficient Cost (NEC) Determinations for the financial year 2014-15. The NEP Determination will be used to calculate Commonwealth payments for in-scope public hospital services that are funded on an activity basis, whilst the NEC Determination covers those services which are block funded.

The national implementation of activity based funding for Australian public hospitals is one of the most significant reforms impacting on public hospitals in recent history. The implementation of activity based funding creates new transparency and strengthened incentives for efficiency in the delivery of public hospital services.

Looking forward, IHPA is committed to continuing to improve the key foundations of activity based funding. IHPA is focused on making improvements to support the implementation of activity based funding, including the revision and development of classification systems; focusing on the quality, accuracy and timeliness of activity, cost and expenditure data from jurisdictions; and the consistency of cost allocation methods applied across the states and territories.

The role of states and territories as system managers of public hospitals is vitally important. IHPA also works in partnership with other national agencies, including the Australian Commission on Safety and Quality in Health Care and the National Health Performance Authority. These collaborations ensure that pricing, quality and performance measures for public hospitals are complementary and, together, create a strong national framework for the delivery of public hospital services.

Finally, I would like to affirm the commitment of IHPA to transparency and continuous improvement in how it undertakes its delegated functions, grounded in an open and consultative approach to working with the health sector in the implementation of funding reform for public hospital services.

Yours sincerely

Shane Solomon
Chair
Independent Hospital Pricing Authority

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Glossary

ABF	Activity Based Funding
AIHW	Australian Institute of Health and Welfare
AN-SNAP	Australian National Subacute and Non-acute Patient classification
ARCBS	Australian Red Cross Blood Service
AR-DRG	Australian-Refined Diagnosis Related Groups
CAC	Clinical Advisory Committee
CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
DRG	Diagnosis Related Group
DSS	Data Set Specification
ED	Emergency Department
HCP	Hospital Casemix Protocol
ICU	Intensive Care Unit
IHPA	Independent Hospital Pricing Authority
JWP	Joint Working Party for Safety and Quality
LHN(s)	Local Hospital Network(s)
MBS	Medicare Benefits Schedule
MDCCs	Multi-disciplinary case conferences
MTAA	Medical Technology Association of Australia
NBA	National Blood Authority
NEC	National Efficient Cost
NEP	National Efficient Price
NHCDC	National Hospital Cost Data Collection
NHISSC	National Health Information Standards and Statistics Committee
NMDS	National Minimum Data Set
NPHED	National Public Hospital Establishment Database
NWAU	National Weighted Activity Unit
PBS	Pharmaceutical Benefits Scheme
PCCL	Patient Complexity and Comorbidity Level

PPSA	Private Patient Service Adjustment
Pricing Authority	The governing body of IHPA established under the *National Health Reform Act 2011*
RACP	The Royal Australasian College of Physicians
RANZCP	The Royal Australian and New Zealand College of Psychiatrists
SCoH	Standing Council on Health
SPF	Special Purpose Fund
The Act	The *National Health Reform Act 2011*
The Agreement	The National Health Reform Agreement
TTR	Teaching, Training and Research
UDGs	Urgency Disposition Groups
URGs	Urgency Related Groups
VHA	Victorian Healthcare Association

1. Introduction

The Independent Hospital Pricing Authority (IHPA) has previously completed two rounds of pricing public hospital services under the National Health Reform Agreement (the Agreement), for the 2012–13 and 2013–14 financial years.

In February 2013, IHPA released the *Pricing Framework for Australian Public Hospital Services 2013–14* as well as the *National Efficient Price (NEP) 2013–14 Determination*, and for the first time, the *National Efficient Cost 2013–14 (NEC) Determination*.

The NEP Determination lays out pricing for services funded on an activity basis, whilst the NEC Determination covers those services which are block funded. In 2013–14 the NEP covered subacute and admitted mental health services for the first time. The NEC covered block funded hospitals (predominately small rural hospitals), and services for which the technical requirements for Activity Based Funding (ABF) do not currently exist. This includes teaching, training and research, as well as non-admitted mental health services.

In June 2013, IHPA released a consultation paper on key issues that IHPA would consider in the preparation of the *Pricing Framework for Australian Public Hospital Services 2014-2015*. Submissions were received from over 40 organisations, including all state and territory governments and the Commonwealth. These submissions are available on the IHPA website except where submissions have been provided in confidence.

These submissions have been carefully considered by the Pricing Authority, and incorporated into the Pricing Framework where appropriate.

The *Pricing Framework for Australian Public Hospital Services 2014-2015* builds on the two previous Pricing Frameworks (*2012-2013 Pricing Framework* and *2013-2014 Pricing Framework*). For simplicity, where IHPA has reaffirmed a previous principle, the supporting argument has not been restated in this year's paper.

In a departure from previous years, IHPA has issued the *Pricing Framework for Australian Public Hospital Services 2014-2015* prior to releasing the NEP and NEC Determinations, which will be publicly available in February 2014. Through this change in timing, IHPA is providing an additional layer of transparency and accountability by making available the key principles, scope and approach adopted by IHPA to inform the NEP and NEC Determinations.

2. Context

The introduction of a national ABF system is intended to improve the efficiency of public hospitals as well as improving the transparency of funding contributions of the Commonwealth, state and territory governments for each Local Hospital Network (LHN) across Australia. To achieve this, IHPA is required to determine the 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 Agreement, the first two years (2012-13 and 2013-14) of the introduction of ABF have been phased, including a number of funding guarantees. At a state level, the total amount of Commonwealth funding was set at the level that would have been received under the pre-existing arrangements (i.e. through the Specific Purpose Payments), and has not fluctuated with the level of activity delivered by public hospital services.

- However, this is not the case in 2014–15, as Commonwealth 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 those services 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

Governments agreed to establish IHPA to provide independent advice about the efficient cost of public hospital services. This advice is evidence-based, drawing on technical knowledge and expertise about the classification, costing and funding of public hospital services. Nonetheless, IHPA must also balance a range of national policy objectives including improving the efficiency and accessibility of public hospital services. This role requires IHPA to exercise judgement on the weight to be given to different policy objectives.

In order to be transparent about how it makes decisions that involve policy choices, IHPA has developed a set of Pricing Guidelines. These Pricing Guidelines are used to explain the key decisions made by IHPA in this Pricing Framework. The Pricing Guidelines may also be used by governments and other stakeholders to evaluate whether IHPA is undertaking its work in accordance with the explicit policy objectives included in the Pricing Guidelines.

The Pricing Guidelines signal IHPA's commitment to transparency and accountability in how it undertakes its work.

Feedback received

Submissions were generally supportive of the current set of Pricing Guidelines. Some submissions questioned the implementation of the Pricing Guidelines (for example, Victoria recommended consistent application of the pricing guidelines in the development of the Pricing Framework, NEP Determination and calculation of price weight adjustments). In this document, such issues are addressed in the specific part of the Pricing Framework that deals with the implementation of that specific pricing guideline.

Most submissions welcomed the work undertaken by IHPA to evaluate the impacts of the implementation of ABF on a national basis. However, Victoria noted the evaluation would be restricted as some state hospital funding systems continue to maintain significant elements of pre-Agreement funding arrangements in order to offset the distributional impacts of IHPA's Pricing Framework. Queensland argued for an expansion of the 'administrative ease' guideline to cover health departments as well as Local Hospital Networks (LHNs). IHPA has amended the Pricing Guidelines to reflect Queensland's request.

IHPA's decision

IHPA has developed, and will use, a set of Pricing Guidelines (specified in Box 1) to guide its decision-making where it is required to exercise policy judgement in undertaking its legislated functions. IHPA has updated the 'administrative ease' guideline to explicitly refer to system managers.

Next steps and future work

IHPA will actively monitor the impact of the implementation of ABF. This will include monitoring changes in the mix, distribution and location of public hospital services, consistent with its responsibilities under Clause A25 of the Agreement. In 2013, IHPA will develop a monitoring framework for this purpose in conjunction with the Clinical Advisory Committee and the Jurisdictional Advisory Committee.

IHPA is also undertaking an evaluation of the national implementation of ABF to monitor any impacts that the introduction of a national ABF system may have on the delivery of public hospital services.

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 Agreement:** 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 and system managers.
- **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 models 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 the purpose of determining eligibility for Commonwealth funding 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 Government funding.

The reformed funding arrangements agreed by governments apply to 'public hospital services', not public hospitals. Many public hospitals provide some services, such as residential aged care services, that are not generally regarded as public hospital services. In addition, organisations other than public hospitals may provide 'public hospital services'. This happens, for example, if governments or public hospitals contract out the provision of some public hospital services to private hospitals and non-government organisations.

IHPA published the 'General List' which, in accordance with Section 131(f) of the *National Health Reform Act 2011* (the Act) and Clauses A9–A17 of the Agreement, defines public hospital services eligible for Commonwealth funding to be:

- 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 (ED) services
- non-admitted services (see Box 2 below).

IHPA also published the 'A17 List' of public hospital services that are eligible for Commonwealth funding under the Agreement as part of the NEP Determination in February 2013. The 'A17 List' is based on Clause A17 of the Agreement which provides a form of grandparenting in that a service not already captured within the General List and which is not eligible for Commonwealth funding under Clause A10 of the Agreement will be eligible for Commonwealth funding for a specific hospital if that service was purchased or provided by that hospital during 2010.

In 2013, IHPA developed a framework for the Annual Review of the General List which provides guidance to jurisdictions which request IHPA to consider services to be included or excluded from the General List. Jurisdictions will be required to provide evidence to support the case for the inclusion or exclusion of services based on the eligibility criteria detailed in Box 2.

Policy drivers underpinning IHPA's decision

The way in which public hospital services are delivered is evolving, with many services now being provided in different settings. For example, dialysis is now frequently provided in a person's home or in satellite clinics located outside public hospitals. Hospital-in-the-home programs allow people to receive chemotherapy, intravenous antibiotics and antiviral therapy in their homes under the supervision of hospital outreach staff. In order to provide these new approaches to patient care, funding has to follow the patient outside the hospital.

Clause A23 of the Agreement states that if services move outside hospitals in response to changes in clinical practice, these services will still be funded as if they were provided in hospitals. To do otherwise when funding is based on activity could create incentives to admit more patients into public hospitals, rather than treat them in the community when it is safe to do so.

The implementation of ABF for public hospital services does not change the existing responsibilities of governments for funding other health services. The ongoing responsibilities of each level of government are specified in the Agreement. One of IHPA's Pricing Guidelines states it will "recognise the complementary responsibilities of each level of government in funding health services". This includes subsidisation of General Practitioners, private medical specialist services, pharmaceuticals and aged care by the Commonwealth Government, and the provision and funding of a range of public health, community health and other specialised services by the states and territories.

Similarly, IHPA's responsibility for making decisions on the scope and pricing of public hospital services is intended to complement (not to replace) the ongoing autonomy of states and territories, LHNs and clinicians to make decisions about desirable models of care to meet the needs of their local communities. IHPA will price public hospital services, recognising that they may be provided in different settings and be based on different models of care.

Submissions received

Chronic disease services (including mental health)

In establishing which chronic disease programs (including community mental health services) were eligible for inclusion on the General List, IHPA considered the links that these services had with hospitals, consistent with the intent of the Agreement. Whilst a significant range of community-based hospital services were determined to be in scope by IHPA, as a result of applying the criteria and interpretive guidelines contained in Box 2, a number of community-based mental health services were determined not to be eligible for Commonwealth funding. This includes:

- Psychosocial rehabilitation programs (including long term supported accommodation, vocational training programs, community care units) where the primary purpose is to meet the social needs of consumers living in the community rather than hospital avoidance
- Prevention and early intervention services, which are in many cases funded by the Commonwealth Government
- Older Persons Community Mental Health Services; and
- Child and Adolescent Community Mental Health Services.

These services were not included on the basis that, according to the information provided by states and territories, these services were aimed at patient cohorts with lower rates of admission or admission avoidance interventions than adult community mental health services.

However, IHPA subsequently received additional information that suggests that the admission rates for older persons community mental health services are comparable to general adult community mental health services (see Table 1).

Submissions received from most jurisdictions, the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the Victorian Healthcare Association (VHA), and Health Services Union, were supportive of the proposal to include older persons and child and adolescent community mental health services on the General List.

Evidence provided by the Australian Capital Territory shows that older persons enrolled in community mental health programs have a hospital admission rate that is comparable to the adult patient cohort.

Table 1: Number of patients enrolled in the community mental health programs (ACT)

Community Mental Health Service Categories by Age Group	**FY 2011-12**		
	Number of patients	**Number of admissions**	**Admission rate**
Child and Adolescent (0-17 years)	1301	50	4%
Adult (18-64 years)	6199	1347	22%
Older Persons (65+ years)	889	169	19%
Total	**8389**	**1566**	**19%**

Furthermore, the RANZCP provided strong evidence that the acuity of these patients was similar or higher than for comparable under 65 years adult populations not enrolled in community mental health programs.

The RANZCP submission states “An analysis of the number of child and adolescent patients who had a service interaction with non-hospital based (referred to in this submission as ambulatory or community care) services demonstrates that the rates of admission are, in fact, significant. This data suggests that 15% of all admissions (ambulatory and inpatient) to child and adolescent mental health services occur in hospital settings. The RANZCP considers that this is a significant rate of admission representing a high rate of inpatient care.” The RANZCP also argues that child and adolescent patients in non-admitted services have a higher complexity than adult patients in comparable services. Finally RANZCP claims that the lower observed admission rates for child and adolescent services is also related to the lack of inpatient services available, which means that higher acuity patients must be treated in non-admitted settings.

Despite these arguments there is still insufficient evidence that community-based child and adolescent mental health services satisfy IHPA’s published criteria for inclusion as in scope (Box 2) on the basis that there is only a low level of interaction between this client group and hospital services. IHPA will reconsider this decision if additional supporting evidence is provided against the criteria established to determine the scope of public hospital services eligible for Commonwealth funding under the Agreement.

Inclusion in the Public Hospital Establishments Collection

According to the Agreement (Clause A17), services provided by public hospitals in 2010 are automatically considered to be in scope for IHPA pricing, and therefore eligible for Commonwealth funding, under the Agreement whether they comply with the General List inclusion criteria or not.

In establishing whether services were provided by public hospitals in 2010, IHPA chose to rely on the *National Public Hospital Establishments Database* (NPHED). The NPHED is a national minimum data set reported to the Australian Institute of Health and Welfare (AIHW) on an annual basis. This was particularly relevant to outpatient clinics as classified by the Tier 2 non-admitted services classification system.

Whilst this has generally been a useful reference point in determining which services should be eligible for Commonwealth funding, it has resulted in some unexpected outcomes in some LHNs which, for a variety of reasons, had not reported services to the NPHED in the past. For example, it resulted in services being determined out of scope in some LHNs whilst in scope in other LHNs due to reporting differences. The Commonwealth recommended keeping the A17 list anchored in the NPHED 2010. Submissions were generally supportive of removing the criterion relating to services having been reported on the 2010 NPHED.

IHPA considers that it is no longer necessary to retain this requirement as the General List criteria and Tier 2 clinic descriptions provide a reasonable basis to determine the range of public hospital services which are in scope. The A17 list is now finalised and the services listed on the A17 list are in scope.

Multi-disciplinary case conferences (MDCCs)

Multi-disciplinary case conferences (MDCCs), otherwise referred to as multi-disciplinary team meetings or multi-disciplinary meetings, are an important, and rapidly developing, feature of evidence-based care and treatment. Across a number of service areas, and particularly in cancer care, there is evidence to show that patients who have their case discussed at an MDCC experience better outcomes than patients who do not. IHPA's Clinical Advisory Committee (CAC) has recognised this value, and presented a view that MDCCs should be encouraged as good clinical practice and represent a significant cost of care, and therefore should be considered as a service event for the purposes of ABF.

IHPA acknowledges the current definition of a patient service event, whereby the patient must be present for a valid service event to be recorded would preclude MDCCs from being eligible for funding under the Agreement.

New South Wales was supportive of IHPA moving to appropriately classify and price MDCCs. The Commonwealth, Victoria, South Australia and Western Australia all expressed some concerns with the proposal to count, cost and price these services.

In 2013, IHPA engaged a consultancy to undertake a review into the feasibility of counting, costing and classifying these services. The conclusion was that this would be possible. In 2013-14, IHPA will work with jurisdictions and the CAC to develop an approach to pricing these services.

Addiction medicine and alcohol and other drugs

New South Wales suggested adding a medical consultation class (20 series) for Addiction Medicine and The Royal Australasian College of Physicians (RACP) added there is currently no suitable classification for drug and alcohol work by an addiction medicine specialist in the General List.

IHPA's decision

IHPA has determined that, from 1 July 2014, the scope of public hospital services eligible for Commonwealth funding will be:

- All admitted programs, including hospital in the home programs
- All emergency department (ED) 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.

Community-based older persons mental health services will be included as in-scope.

Addiction Medicine clinics will be included as in-scope

Community-based child and adolescent mental health services will continue to be out-of-scope.

The criterion relating to services having been reported on the 2010 NPHED will be removed from 2014-15 as the requirement for a range of non-admitted services to meet strict inclusion criteria negates the need for the requirement of hospital services to have been reported in the 2010 NPHED. This does not affect the existing 'A17' list.

Full details of the public hospital services determined to be in scope for Commonwealth funding will be provided in the 2014-15 NEP Determination.

Next steps and future work

The Annual Review of the General List Framework provides a mechanism for jurisdictions to apply to IHPA for additional services to be included or excluded from the General List. IHPA will monitor and review the eligibility of services to remain on the General List during the annual Pricing Framework and NEP and NEC Determination processes.

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* (the Act) and Clauses A9–A17 of the Agreement, the scope of "Public Hospital Services" eligible for Commonwealth funding under the Agreement are:

- All admitted programs, including hospital in the home programs and forensic mental health inpatient services.
- 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 Agreement, the Independent Hospital Pricing Authority 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)

Category A: Specialist outpatient clinic services – Tier 2 Non-admitted Services Classification – Classes 10, 20 and 30

This comprises all clinics in the Tier 2 Non-Admitted Services classification, classes 10, 20 and 30, with the exception of the General Practice and Primary Care (20.06) clinic, which is considered by the Pricing Authority as not to be eligible for Commonwealth funding as a public hospital service.

Category B: Other non-admitted patient services and non-medical specialist outpatient clinics (Tier 2 Non-Admitted Services Class 40)

To be eligible for Commonwealth funding as an Other Non-admitted Patient Service or a Class 40 Tier 2 Non-Admitted Service, a service must be:

- directly related to an inpatient admission or an emergency department (ED) attendance; or
- intended to substitute directly for an inpatient admission or emergency department attendance; or
- 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.

Jurisdictions have been invited to propose services that will be included or excluded from Category B "Other Non-Admitted Patient Services". Jurisdictions will be required to provide evidence to support the case for the inclusion or exclusion of services based on the three criteria above.

The following clinics are considered by the Pricing Authority as not to be eligible for Commonwealth funding as a public hospital service under this category:

- Commonwealth funded Aged Care Assessment (40.02)
- Family Planning (40.27)
- General Counselling (40.33)
- Primary Health Care (40.08).

Interpretive guidelines for use

In line with the criteria for Category B, community mental health, physical chronic disease management and community based allied health programs considered in-scope will have all or most of the following attributes:

- Be closely linked to the clinical services and clinical governance structures of a public hospital (for example integrated area mental health services, step-up/step-down mental health services and crisis assessment teams);
- Target patients with severe disease profiles;
- Demonstrate regular and intensive contact with the target group (an average of eight or more service events per patient per annum);
- Demonstrate the operation of formal discharge protocols within the program;
- Demonstrate either regular enrolled patient admission to hospital or regular active interventions which have the primary purpose to prevent hospital admission.

Home ventilation

- A number of jurisdictions have submitted home ventilation programs for inclusion on the General List. The Pricing Authority has included these services on the General List for 2014-15 in recognition that they meet the criteria for inclusion, but will review this decision in the future once the full scope of the National Disability Insurance Scheme is known.

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

5.1 Overview

Setting the National Efficient Price

The national introduction of ABF is intended to improve efficiency, as well as making the funding contributions of the Commonwealth, state and territory governments for each Local Hospital Network across Australia transparent. 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.

One of IHPA's primary functions is to determine the NEP each year. The NEP represents the price that will form the basis for Commonwealth payments to LHNs for each episode of care under the ABF system. In accordance with the Agreement, IHPA will consider the actual cost of delivery of public hospital services in as wide a range of hospitals as practicable. It will also take into account any legitimate and unavoidable variations in costs due to hospital characteristics (e.g. size, type and location) and patient complexity (e.g. indigenous status and demographic profile).

Provisions of the Act and/or the Agreement

The Act (Section 131(1)) identifies several of IHPA's functions that are particularly relevant to determining the NEP including:

- To develop and specify classification systems for health care and other services provided by public hospitals
- To determine data requirements and data standards to support uniform provision of data, including standards relating to patient demographic characteristics and other information relevant to classifying, costing and paying for public hospital functions
- To determine adjustments to the NEP to reflect legitimate and unavoidable variations in the costs of delivering health care services.

The Agreement provides further specifications on the approach to be used by IHPA in determining the NEP. In particular, the Agreement states that IHPA will:

- Undertake "empirical analysis of data on actual activity and costs in public hospitals, taking account of any time lag and the cost weights to be applied to specific types of services" (Clause B3(d));
- 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)) and "to the need for continuity and predictability in prices" (Clause B12(d));
- "Have regard to any input costs funded through other Commonwealth programs, such as pharmaceuticals supplied under arrangements pursuant to Section 100 of the *National Health Act 1953* and magnetic resonance imaging services funded through Medicare Benefits Schedule (MBS) bulk-billing arrangements" (Clause B12(e));

- Determine "the national efficient price that will apply to eligible private patients receiving public hospital services (Clause B3(l)), with the methodology to be based on excluding or reducing the components of the service for private patients which are covered through other funding sources (Clause A41);

- Determine adjustments to the national efficient price that "have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery including: a) hospital type and size; b) hospital location, including regional and remote status; and c) patient complexity, including Indigenous status" (Clause B13); and

- Develop "projections of the national efficient price for a four year period, updated on an annual basis and providing confidential reports on these projections to the Commonwealth and States" (Clause B3 (h)).

5.2 Purpose and use of the National Efficient Price

IHPA reaffirms that the NEP has two important purposes:

1. The NEP is one of the major determinants of the level of Commonwealth funding of public hospital services; the other factor determining Commonwealth expenditure is the volume of public hospital services provided.

2. The NEP provides a price signal or benchmark about the efficient cost of providing public hospital services. This price signal is an important driver of change:

- It allows states and territories in their capacity as system managers to determine the level of state or territory funding provided, and the approaches that will be implemented to support public hospitals in improving efficiency.

- It encourages Local Hospital Networks (LHNs) and public hospitals to benchmark their cost structure against the efficient cost of providing public hospital services and so identify options for improvement.

- It promotes transparency so that states and territories, LHNs and public hospitals can make choices (within the context of state or territory health plans and service agreements) about the range of public hospital services they provide, the models of care and the settings in which care is provided that are consistent with accessible, equitable and high quality public hospital services provided on an efficient basis.

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.

The outcome of these different funding approaches by the Commonwealth, state and territory governments is that LHNs will not necessarily be paid at the NEP. The 'price' or payment that LHNs receive will be the sum of:

- The Commonwealth share of the NEP (which varies depending upon whether activity is 'baseline' or 'growth' activity); and

- The state and territory contribution towards funding public hospital services.

IHPA's decision

Within this context of the important role of the NEP as a price signal, IHPA has developed a definition of the NEP.

IHPA reaffirms the following definition that sets out its expectations about the operation of the NEP:

A public hospital service operating at the NEP will:

- be able to provide episodes of patient care (on average, across all types of care, as measured using agreed classifications) and other services (including teaching, training and research) at or below the national benchmark price
- be able to respond to evidence based initiatives to improve patient care including new technologies
- 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
- be able to make choices about how best to deliver services to ensure that people receive the 'right care at the right time in the right setting'.

In adopting this definition, IHPA is seeking to convey that:

- The NEP is a benchmark of efficiency. It is not the price at which public hospital services can be provided most cheaply or at the lowest price.
- The NEP is the price that allows for the provision of public hospital services at a quality level consistent with national standards. It is not the price at which public hospital services can be provided with no regard for the quality and safety with which those services are delivered.
- The NEP will move in response to changes in how care is delivered. The 'value' of the NEP will not be eroded over time; instead it will move in response to changes in the costs of delivering public hospital services.
- The NEP will provide a price signal that will allow choices to be made by governments, by LHNs, and by public hospitals about how best to provide public hospital services.

5.3 Classifications, counting and costing inputs

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

Feedback received

Classifications

Classification systems are a critical element of any ABF system. They group patients who are clinically relevant (i.e. have similar conditions) and resource homogenous (i.e. cost similar amounts per episode) together.

Acute admitted

The issue of pricing services in 2014-15 using ICD-10-AM 8th Edition and Australian Refined Diagnosis Related Groups (AR-DRGs) V7.0, and the proposed pace of change to AR-DRG V8.0, (including a review of the Patient Complexity and Comorbidity Levels (PCCLs)), for pricing in 2015-16, resulted in a wide range of responses. PCCLs are a measure of the cumulative effect of a patient's complications and comorbidities, and is calculated for each episode.

Medical technology manufacturers, such as Medtronic and the Medical Technology Association of Australia (MTAA), agreed with moving to price services using AR-DRG V7.0 in 2014-15 for pricing, and advocated for more rapid classification development processes to better reflect the uptake of new technologies.

Tasmania identified developing AR-DRG V8.0 as a high priority and supported the PCCL review and improvements to the measure of paediatric complexity, citing these as two key issues with the current classification system. The Commonwealth encouraged the implementation of AR-DRG V8.0 from 1 July 2015 for pricing acute admitted services in order to reflect evolving clinical practice. Victoria argued that the proposed AR-DRG V8.0 development timeframes are too short and recommended deferring adoption until 2015-16.

IHPA has carefully reviewed the work program associated with developing AR-DRG V8.0 and confirmed it is not feasible to have the update completed in time to allow it to be used for pricing from 1 July 2015. The timeframes allowed ensure a comprehensive review of the PCCL mechanism. The PCCL has not been substantially reviewed since the late 1990s and this is a major piece of work, which should deliver real improvements to the classification.

IHPA's approach is to balance timely and regular updates to the AR-DRG classification system and provide a stable and predictable pricing regime.

IHPA's decision

IHPA has determined that ICD-10-AM 8th Edition and Australian Refined Diagnosis Related Groups (AR-DRG) V7.0 will be used in setting the NEP in 2014-15 for acute admitted services.

IHPA will develop AR-DRG V8.0 with the intention of using this version for pricing from 1 July 2016.

Emergency services

In the current ABF system, payments for ED are unbundled. This means that patients who attend ED and are subsequently admitted will receive two payments – one for the ED component of their episode ((using the Urgency Related Groups (URGs) or Urgency Disposition Groups (UDGs) classifications)), and one for the inpatient portion of their episode using the admitted patient care AR-DRG classification.

IHPA is currently undertaking an extensive review of the URGs/UDGs classifications. The purpose of the review is to improve the clinical meaningfulness of the classification system, as well as the explanatory power to predict costs. This review will also assess the inclusion of additional classification variables such as age.

All jurisdictions welcomed the continued development of the emergency care classification system. Victoria argued the focus of the emergency care classification should be patient complexity and its relationship to an admitted diagnosis.

IHPA's decision

IHPA will price emergency department services in URG V1.4 for NEP14. IHPA will continue to use V1.3 of the UDG classification system.

Subacute services

IHPA has entered into a licensing agreement with an independent consultant to enable the development of Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) V4.0 in the coming 12 months. The purpose of the AN-SNAP V4.0 development will ensure that the AN-SNAP classification system remains valid; identifies key cost drivers; evaluates counting issues for subacute and non-acute patients; and reflects and incorporates changes in patient mix, medical practice and clinical assessment tools.

In its consultation paper, IHPA proposed to discontinue the default option of per diem pricing by care type for episodes which could not be classified using AN-SNAP, and only price valid AN-SNAP grouped services from 2015-16 onward.

The Commonwealth suggested ongoing funding models should use AN-SNAP where possible, and otherwise continue per diem payments. New South Wales, Victoria and the RANZCP supported discontinuing per diem payments, with the RACP arguing to retain per diem funding for palliative care services only. However, Queensland, Western Australia, Tasmania and the Australian Capital Territory did not support discontinuing per diem payments at this time due to their reservations regarding implementing AN-SNAP.

Furthermore, IHPA notes that the changes to the subacute care types in the Admitted Patient Care NMDS introduced from 1 July 2013 mean that patients without recorded functional assessments no longer meet the care type definition.

IHPA's decision

In 2014-15, IHPA will price subacute services using AN-SNAP V3.0, and per diem payments weighted by care type where AN-SNAP data is not available.

After 2014-15, IHPA will cease per diems for subacute classification payment, as foreshadowed in the 2013-14 Pricing Framework.

Next steps and future work

IHPA will continue to develop AN-SNAP V4.0 and consult with jurisdictions and other stakeholders to ensure that the revised classification provides a robust and comprehensive system for subacute and non-admitted patient services.

Mental health services

In 2013-14 IHPA priced admitted mental health services using AR-DRGs with a modified inlier boundary policy.

IHPA has been undertaking a program of work to develop a new mental health classification. This work has been guided by the Mental Health Working Group, which includes clinicians, consumers and carers as well as jurisdictional representatives.

IHPA commissioned a consultancy to recommend a definition for specialist mental health that can be used for classification purposes, and to also identify the key cost drivers in the

delivery of mental health services, which will underpin the next stage of classification development.

In May 2013, the Pricing Authority approved a new mental health care type and definition for inclusion in the *National Health Data Dictionary*, which reads as:

> "Mental health care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder. Mental health care:
>
> - is delivered under the management of, or is regularly informed by, a clinician with specialised expertise in mental health; and
>
> - is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan.
>
> - may include significant psychosocial components including family and carer support."

It is expected that a data set specification for the new mental health classification will be ready in time for data collection to commence from 1 July 2015. As part of this, IHPA is proposing the creation of a new mental health care type to identify patients who will be classified using the new classification system.

From 1 July 2014 the mental health care type will be included in the Admitted Patient Care NMDS and the Non-Admitted Patient Data Set Specification. IHPA is working with the national health information governing bodies to progress this work.

The work undertaken on the mental health definition and cost drivers has also highlighted the challenge of costing and counting consultation/liaison services that are delivered to patients who are not primarily under the care of a mental health service. Given the growing nature of this service delivery model, IHPA proposes to undertake further investigation into the challenges involved in ensuring these services are properly priced in future years.

Queensland, Victoria and the Commonwealth advocated for the implementation of a new Mental Health Care Classification system to be deferred beyond 1 July 2014. Tasmania argued to discontinue developing a new classification system, preferring refinements to the AR-DRG system. The Australian Medical Association recommended trialling the new classification system before widespread implementation.

IHPA's decision

IHPA is progressing work to include the mental health care type in the Admitted Patient Care National Minimum Data Set and the Non-Admitted Patient Data Set Specification from 1 July 2014.

IHPA's approach to pricing acute admitted mental health services in the National Pricing Model in 2014-15 remains unchanged from 2013-14.

IHPA will work towards implementation of the new Australian Mental Health Classification by 1 July 2016 with implementation trials conducted in 2015-16.

Next steps and future work

IHPA will investigate further enhancements to the data set specifications for future development and collection as well as continue the development of the new Australian Mental Health Classification.

Non-admitted services

IHPA has commenced a review of existing international non-admitted classification systems to inform the direction of future work in this area. Australia's Tier 2 Outpatient Clinic Definitions were developed in 2011-12 and modified in 2012-13. IHPA will continue to review the Tier 2 non-admitted classification based on the 2011-12 National Hospital Cost Data Collection (NHCDC) data, as well as using the patient level data available from the Non-Admitted Patient Data Set Specification (DSS). Data collected from the extensive costing study conducted in 2013 will also inform this work.

Several refinements were made to the non-admitted classification for 2014-15, Tier 2 Non-Admitted Services V3.0, with input from IHPA's Non-Admitted Care Advisory Working Group and the CAC. Full details will be provided in the 2014-15 Definitions Manual and Compendium and revised Tier 2 National Index to accompany the National Efficient Price Determination 2014-15.

Submissions from New South Wales and Tasmania raised concerns that the Tier 2 classification system is clinic based. New South Wales also identified ways to improve how all modes of dialysis are more accurately costed.

IHPA is mindful of the limitations of the current non-admitted classification system and will continue to refine the Tier 2 system, and will assess if changes are required to the classification system following the review.

IHPA's decision

It is not proposed that any major development work will be undertaken on Tier 2 for NEP14.

From 1 July 2014, jurisdictions will be required to count, cost and report in-scope community-based non-admitted activity.

Next steps and future work

IHPA will continue to review international non-admitted classification systems and consider developing an improved classification system for non-admitted services and undertake wide consultation during 2013-14.

IHPA will also consider the merit of conducting a costing study in time for NEP15 to better account for the costs associated with different modes of delivering dialysis across the settings.

Teaching, training and research

The Agreement requires IHPA to advise the Standing Council on Health (SCoH) on the feasibility of transitioning funding for teaching, training and research (TTR) to ABF by 30 June 2018.

IHPA created a TTR Working Group to advise IHPA on establishing the building blocks of a future pricing model. IHPA also engaged an independent consultant to define TTR and identify associated cost drivers for ABF purposes.

The consultant has delivered a systematic literature review that focuses on how TTR is defined, funded and delivered; identifies relevant cost drivers; and examines the current availability of cost and activity data that could support a national analysis of these cost drivers. Additionally, an environmental scan, involving extensive stakeholder consultation and site visits (with jurisdictional health authorities, hospitals, health services and interest groups), will also be undertaken.

Key ABF technical requirements, such as a classification system, counting rules and costing and activity data, are not yet in place for TTR activity and, as such, substantial work is required to inform IHPA's advice to SCoH.

Experience from other service categories has demonstrated that the infrastructure and processes underpinning national data collection take time to develop and mature. Furthermore, as collections mature and data definitions become more widely accepted and understood, the data becomes more reliable and robust. Consequently, the earlier a standard, integrated national collection of TTR activity data can commence, the more straightforward any ABF implementation would be. IHPA is therefore developing a TTR activity DSS during 2013, with a best efforts collection of national activity data from 1 July 2014.

The DSS will be developed in accordance with national health data standards and will follow normal National Health Information Standards and Statistics Committee processes and timelines.

Feedback received regarding TTR highlighted the importance of continuing to progressively examine and develop TTR. The Commonwealth expressed the need to separately distinguish teaching and training from research. Victoria was concerned that timeframes to develop the building blocks of a future TTR pricing model were proceeding too rapidly and advocated for data collection to be deferred until 2015-16 rather than 2014-15.

IHPA's decision

IHPA will progressively work on developing the TTR pricing model over the next few years, commencing with a first-stage data collection from 1 July 2014. IHPA will progress work in order to advise SCoH on the feasibility of moving to ABF by 30 June 2018.

Costing

As advised in the Pricing Framework consultation paper, IHPA will work with stakeholders, including all jurisdictions, to address actions from the Strategic Review of the National Hospital Cost Data Collection (Strategic Review) progressively over the coming 24 months.

As part of this, IHPA expects to release the next version (Version 3) of the Australian Hospital Patient Costing Standards in mid-2014, for use in costing Round 18 of the NHCDC.

In 2013, IHPA worked with jurisdictions to rationalise and substantially reduce the Round 17 NHCDC Data Request Specifications for public hospitals to avoid duplication and to facilitate a more streamlined submission process. For example, where possible, IHPA will source patient activity data items from the Activity Based Funding quarterly data submissions.

The Strategic Review found that through stronger governance and compliance frameworks; better communication and transparency; an agreed understanding of the key purpose of the collection; greater industry involvement and some improvements in methodology, the NHCDC will continue to serve an important role in Australia's health system. Recommended priorities include establishing an NHCDC Advisory Committee with both jurisdictional and industry members; rationalising data specifications to reduce duplication of morbidity data elements between the NHCDC and other national minimum data sets; and developing Version 3 of the Australian Hospital Patient Costing Standards.

The detailed costing feedback received during the consultation process has been referred to the NHCDC Advisory Committee for review.

The Pricing Authority is confident that the NHCDC is fit for the purpose of determining the NEP, but IHPA will continue to work with jurisdictions to continually improve the robustness of this data collection.

IHPA's decision

IHPA will work with the NHCDC Advisory Committee to develop Version 3 of the Australian Hospital Patient Costing Standards.

IHPA will continue to monitor the quality of the NHCDC data received from jurisdictions, and will develop a stronger compliance framework in conjunction with the NHCDC Advisory Committee.

Counting rules

Currently IHPA's counting rules for non-admitted services state that a service event can only be counted once for each patient. Some stakeholders have raised a concern that this may have unintended consequences for non-admitted services provided on an outreach basis usually in small block funded rural hospitals, by metropolitan hospitals. Under the 2013-14 Pricing Framework, if the service event is recorded at the hospital where the service is delivered, and the hospital is block funded, then the service event receives no additional revenue. As outlined in the 2014-15 Pricing Framework consultation paper, it was suggested to IHPA that this may lead metropolitan hospitals to reconsider providing outreach services to block funded hospitals.

Feedback received related to counting focused on the two issues of outreach and telehealth. The RACP advocated for the Pricing Framework to incentivise the continued provision of outreach services, whereas the Commonwealth, views funding services, such as outreach to block funded hospitals, as the responsibility of system managers. Tasmania and the RANZCP supported a counting rule change to record outreach services at the site, usually a metropolitan ABF hospital, from which the service originates.

New South Wales, Queensland, Victoria and Western Australia requested a rule change for telehealth services outlining that sites at both the patient and provider ends incur costs for delivering health care through this medium. In particular, New South Wales identified that the majority of costs incurred for a telehealth consultation are borne at the provider rather than the patient-end.

The Commonwealth raised concerns that this change in counting rules could lead to artificial growth in activity in the short term. IHPA will closely monitor this over the coming 12 months.

IHPA's decision

For the NEP14, IHPA has decided to:

- allocate outreach activity and cost to the originating service (usually a metropolitan ABF hospital providing the service) as this better reflects the costs incurred in providing an outreach service.
- count telehealth activity at the service provider end, but investigate the most appropriate counting arrangements for these services in future years.

Next steps and future work

IHPA will monitor the impact of the counting rule changes in 2014-15 and discuss with the Administrator and the jurisdictions whether there is a material impact on activity volume growth.

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

Having determined the classifications, counting and costing data, the critical question is the approach to setting the level of the NEP. IHPA has considered and balanced three of the Pricing Guidelines, namely:

- **Timely-quality care**: Funding should support timely access to quality health services. In other words, the NEP should support public hospital services being widely accessible, in a manner that allows care to be provided at the right time and at a quality level that meets national standards.

- **Fairness**: ABF payments should be fair and equitable. The Agreement indicates that IHPA should "consider the actual cost of delivery of public hospital services in as wide a range of hospitals as practicable" (Clause B12 (b)).

- **Efficiency**: ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.

Clause B11 of the Agreement defines the role of the NEP as being to:

a. form the basis for the calculation of the Commonwealth funding contribution; and,
b. provide a relevant price signal to States and Local Hospital Networks.

In 2012–13 and 2013–14, IHPA decided to set the NEP based on the arithmetic mean cost at the patient level. In adopting this position, IHPA was mindful of a number of issues:

- The maturity of the national ABF system (including the underpinning classification systems and activity and cost data collections).
- The arithmetic mean cost provided a significant incentive to states and LHNs to examine their underlying cost structures, particularly in the jurisdictions where LHN costs were predominantly above the average.
- There are significant efficiency benefits for the public hospital system as a whole if high-cost LHNs move their cost base towards the average.

In 2014-15, IHPA has decided to maintain this approach. However, in the coming year, IHPA will begin to explore other approaches that will "provide a relevant price signal" to states and LHN's. This work will be underpinned by rigorous examination of the existing cost data and will involve significant consultation with a range of stakeholders including all jurisdictions.

Indexation

For NEP12 and NEP13, IHPA developed an indexation methodology to account for the time lag between the costing data used and the price to be set (for example, NEP12 was based on 2009–10 cost data). The methodology is explained in a detailed technical working paper, but essentially uses the growth in the past five years' cost data to estimate the expected growth in costs over the three year time lag. In NEP13 this methodology included data from 150 hospitals across most states and territories.

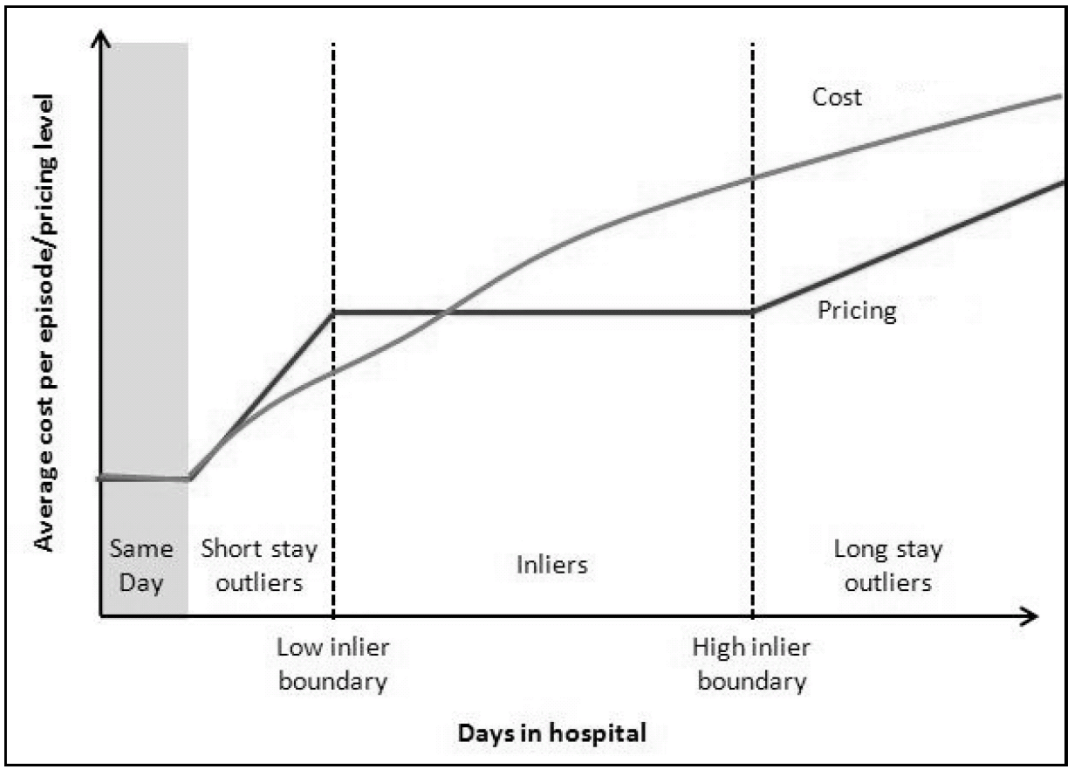
IHPA has previously reviewed a number of other possible indices that could be applied to this task, all which have significant limitations, such as a much broader scope than hospital costs, or only measuring the increases in the costs of inputs, and thus not picking up important factors such as changes in productivity.

As such, IHPA is not altering the indexation methodology to be used in NEP14 IHPA will carry out an assessment of the indexation methodology once Round 17 NHCDC data is available in mid-2014 for direct comparison of actual costs incurred in 2012-13 to those predicted by indexation in the past by IHPA.

Pricing short-stay patients

The National Pricing Model groups patients within each DRG into four different groups determined by their length of stay, and assigns different price weights accordingly as illustrated in Figure 1.

Figure 1: AR-DRGs grouped by length of stay



The use of these differing price weights ensures that prices reflect actual costs as accurately as possible, and maximise incentives to minimise length of stay where clinically appropriate.

A number of Pricing Framework submissions raised concerns about the large price differential between short-stay outlier and inlier payments for some DRGs.

Queensland argued that IHPA should review how the inlier boundaries were set, providing examples of the potential incentive to extend patient lengths of stay to achieve an inlier payment. NSW provided an example of impact for Lung/Heart Lung Transplant (DRG A03Z and A05Z), showing that the short stay base plus per diem weight is considerably lower than the inlier lower bound weight. The efficiency in the model of care for these DRGs within NSW may result in the hospital being significantly disadvantaged financially.

Currently the short stay outlier per diem rate is based on the actual costs reported for this group of patients in each DRG. IHPA has reviewed this approach, and in NEP14 will adopt an alternate approach, wherein the short stay outlier rate will be determined with closer proximity to the inlier payment to ensure that there is no incentive to keep these patients in hospital longer.

Pricing very long stay patients

IHPA's national pricing model sets prices for patients on the basis of their entire episode of care in a single setting – for example for admitted patients this is from when they are admitted to when they are discharged. At the time of discharge the NWAU associated with the patient's episode is calculated on the basis of the DRG they were assigned and any other adjustments that may have been applied. For the vast majority of patients, their stay commences and finishes within a single financial year.

However, for some patients with very long lengths of stay, the episode may span more than one financial year. These patients are predominately in subacute and psychiatric facilities, and when these facilities have large numbers of these patients as a proportion of their overall patient population it can cause significant issues in reconciling expenditure and activity figures each year.

In the consultation paper, IHPA sought feedback from stakeholders on possible mechanisms to address this issue. A number of alternatives were considered including a "statistical discharge" approach in which a patient is administratively discharged on 30 June of each year. This would have required significant changes to the National Minimum Data Set and would have been administratively burdensome on jurisdictions.

Instead, IHPA is proposing that any patient with a length of stay of more than 200 days as at 30 June each year would be assigned a provisional NWAU value. This NWAU value would be based on the average high outlier per diem rate for the care type that the patient is admitted under (i.e. acute or subacute). On discharge, the provisional NWAU value assigned to the patient in previous years would be subtracted from the actual NWAU value calculated at the time of discharge.

IHPA will work with the Administrator and jurisdictions to agree the business rules for implementing this approach to very long stay patients in the first quarter of 2014, for implementation from 1 July 2014.

IHPA's decision

IHPA has decided to set the NEP using a measure of central tendency again in 2014-15.

IHPA has determined that the NEP for 2014-15 will be set on the basis of the average cost per weighted separation (arithmetic mean).

IHPA will extensively review the setting of price signals in future years.

IHPA will change the approach to determine the pricing for short stay outliers by moving it into closer proximity to the inlier payment.

IHPA is not altering the indexation methodology from NEP13.

IHPA will determine the provisional NWAU for very long stay patients in NWAU14

IHPA will work with the Administrator of the National Health Funding Pool and jurisdictions to develop the business rules to support the calculations of provisional NWAUs in the first quarter of 2014 for implementation from 1 July 2014.

5.5 Setting the NEP for Private Patients in Public Hospitals

The Agreement requires IHPA to price private patients in public hospitals accounting for revenue received from other sources, such as health insurance funds and the Commonwealth Medicare Benefits Schedule (MBS). Specifically, Clause A41 of the Agreement requires IHPA to account for Commonwealth funding other than ABF; and patient charges including:

i. prostheses; and
ii. accommodation and nursing related components/charges related to the private health insurance default bed day rate (or other equivalent payment).

The collection of private patient medical expenses is problematic in the NHCDC. For example, there is a common practice in some jurisdictions of using Special Purpose Funds (SPFs) to collect associated revenue (e.g. MBS) and reimburse medical practitioners.

These funds generally do not appear in hospital accounts used for costing in the NHCDC, leading to an under attribution of total medical costs across all patients, as costs associated with medical staff are applied equally across public and private patients.

In NEP12 and NEP13, IHPA corrected for this issue by inflating the cost of all patients, prior to applying the Private Patient Service Adjustment (PPSA).

In NEP13, the PPSA was determined by summing the following components from the reported costs (in the NHCDC) of all private patient and self-funded episodes to estimate the non-accommodation revenue potentially received by the hospital (as recommended by an independent consultant). The summation of these removed costs was then expressed as a percentage of private patient costs at the AR-DRG level to define the adjustment:

- 100% of the pathology cost bucket (direct and indirect);
- 100% of the imaging cost bucket (direct and indirect);
- 100% of the prosthesis cost bucket (direct and indirect);
- 75% of the ward medical cost bucket (direct and indirect);
- 37.5% of the operating room cost bucket (direct and indirect);
- 37.5% of the special procedure suite cost bucket (direct and indirect); and
- 15% of the critical care cost bucket (direct and indirect).

In early 2013 IHPA engaged an independent consultant to review the approach that had been adopted in the first two NEP Determinations and highlight areas for improvement.

The review generally supported IHPA's approach, but suggested that using the Hospital Casemix Protocol (HCP) data set would increase the precision of IHPA's approach. HCP data provides detailed information on the charges levied by hospitals, and the benefits paid by private health insurers and the MBS, for all private patients.

Feedback received

The subject of private patients in public hospitals drew the greatest interest in the submissions to the 2014-15 Pricing Framework consultation paper. Most organisations noted the growth in recent years of private patients in public hospitals and examined the potential drivers, challenges and implications of this shift in private health insurance utilisation.

In examining the growth of private patients in public hospitals, the Australian Centre for Health Research highlighted that "from 2005-06 to 2010-2011 public patients in public hospitals increased by 16%, whilst over the same period private patients in public hospitals increased by 50%. In 2010-11, 10.0% of all patients in public hospitals were private patients, compared to 7.8% in 2005-2006". These figures show that the growth in private patients precedes the Agreement and introduction of a national ABF system. It may be too early to determine the detailed impact of the national ABF system on private patient utilisation rates of public hospital services.

The Commonwealth was concerned that IHPA's approach for NEP12 and NEP13 may be incentivising greater provision of private patient services in public hospitals. The Commonwealth's comments went further to suggest that IHPA's alternative approach for NEP14 may not completely adjust for Commonwealth funding.

By contrast, most states and territories argued that the current National Pricing Model over-discounted for Commonwealth revenue received from other sources.

Queensland was concerned that over-discounting created disincentives for public hospitals to treat private patients. Western Australia noted that not all private patient medical costs are recorded in hospital general ledgers and that jurisdictional variability in private patient pricing could distort the NHCDC. New South Wales and Tasmania supported calculating the private patient discount at the DRG level, whereas Victoria proposed applying a uniform discount rate across all DRGs.

Victoria raised concerns that IHPA's application of the private patient adjustment to the NWAU rather than to the NEP meant that the "model has severed the link between activity and funding, allowing health services to achieve their NWAU targets by treating fewer private patients". New South Wales proposed an alternative approach which included discounting the price paid for private patients rather than discounting the price weights.

IHPA has implemented the change in methodology to calculate The Private Patient Service Adjustments using the HCP data and the approach will be detailed in the NEP14 Determination.

IHPA's decision

The Pricing Authority has determined that for NEP14:

The Private Patient Service Adjustment will be determined using Hospital Casemix Protocol data to calculate the actual revenue received by public hospitals from private health insurers and the Medicare Benefits Schedule (MBS).

The Private Patient Accommodation Adjustment will continue to be based upon the default benefit payable for shared accommodation in each state and territory.

Next steps and future work

IHPA will regularly review the utilisation of public hospitals by private patients in order to detect any emerging trends. This will form part of its evaluation of its price determination function for private patients in public hospitals.

5.6 Treatment of other Commonwealth programs

The Agreement requires IHPA to discount funding that the Commonwealth provides to public hospitals through programs other than the Agreement payments (see Clauses A6 and A7).

Blood and blood products

In the NEP13 Determination, a total of $118.3 million was removed for blood products. State and Commonwealth contributions to blood product funding are administered under the National Blood Agreement and not under the Agreement. The $118.3 million of expenditure removed represents costs reported by states and territories for blood in the NHCDC, and does not represent Commonwealth expenditure, which is paid directly to the National Blood Authority (NBA). It should be noted that not all states report blood costs to the NHCDC as these costs are devolved to Local Hospital Networks.

IHPA has reviewed the methodology of removing blood costs, and has had preliminary discussions with the National Blood Authority over the feasibility of costing blood products in

future years. Through their submission in the consultation process, the Australian Red Cross Blood Service (ARCBS) identified a multi-stage approach to including blood and blood products in the NEP. IHPA will commence a process with the NBA and the ARCBS to progress the foundation work to support further examining blood costs, however this will not be ready in time for inclusion in 2014-15.

Commonwealth funded pharmaceutical programs

Due to data limitations in NEP12 and NEP13, Commonwealth pharmaceutical payments, such as payments for the Pharmaceutical Benefits Scheme and Highly Specialised Drugs, were removed in the derivation of the NEP, but not at the level of the individual DRGs or Tier 2 clinics. This meant that DRGs with high proportions of pharmaceutical costs associated with them (for example chemotherapy) were, in effect, overpriced, whilst other DRGs were under-priced.

In its consultation paper, IHPA advised its intention for NEP 14 to use a more targeted approach to discounting for Commonwealth pharmaceutical payments by deducting identified amounts from relevant DRGs and Tier 2 Clinics rather than from the NEP overall, and concentrate this work on the drugs that represent the highest total spend.

IHPA also advised it would engage with the IHPA Clinical Advisory Committee (CAC) to develop a mapping table of high cost drugs to DRGs and Tier 2 clinics, and consult with jurisdictions to estimate the impacts of their admission policies where necessary.

Victoria and the Commonwealth supported this approach, maintaining it is consistent with the Agreement (Clause B12e). Four other jurisdictions and two stakeholders supported the alternative approach where adjustments for Commonwealth pharmaceutical related items would be managed by the National Health Funding Pool Administrator when six-monthly reconciliations are made. However, the Commonwealth highlighted the potential complexity and uncertainty for LHNs if the Administrator made these adjustments.

The Commonwealth Department of Health has provided a detailed breakdown of their pharmaceutical payments by program and by drug name, and where possible by hospital.

The total amount of Commonwealth pharmaceutical payments to be discounted is $978.8 million across the following programs:

- Highly Specialised Drugs (HSD) (Section 100 funding) $737.6 million
- PBS – Herceptin: Early Stage Breast Cancer (Section 100 funding) $19.5 million
- Pharmaceutical Reform Agreements – PBS Access Program $115.7 million
- Pharmaceutical Reform Agreements – Efficient Funding of Chemotherapy (Section 100 funding) $106.0 million

IHPA's decision

IHPA will remove blood costs from the NHCDC data prior to determining NEP14 but will aim to introduce an improved approach in future years.

IHPA has developed a methodology to remove Commonwealth pharmaceutical program payments from the NHCDC data used to determine NEP14 which provides greater accuracy than the previous methodology used in NEP13 and NEP12. The approach adopted will be detailed in the Technical Specifications released with NEP14 in early 2014.

Next steps and future work

IHPA will continue to work on developing an improved approach to the treatment of blood products and Commonwealth pharmaceutical program funding in future years.

5.7 Adjustments to the national efficient price

Provisions of the Act and/or the Agreement

The Act gives IHPA the role of determining "adjustments to the NEP to reflect legitimate and unavoidable variations in the costs of delivering health care services" (Clause 131(1) (d)).

The Agreement provides an additional specification indicating that IHPA "must have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery including:

a. hospital type and size;

b. hospital location, including regional and remote status; and

c. patient complexity, including Indigenous status" (Clause B13).

In determining whether an adjustment should be made to the NEP, IHPA needs to pay regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery.

In 2013, IHPA established a framework to assist jurisdictions in making applications to have legitimate and unavoidable variations which affect the costs of service delivery recognised by IHPA. Jurisdictions may continue to propose potential unavoidable cost variations under this framework for IHPA to consider.

Feedback received

Much like in previous years, the subject of adjustments received significant and diverse feedback during the consultation process.

Intensive Care Unit (ICU) Adjustment

The current ICU Adjustment is based on hours spent in a Level 3 ICU (as defined by the College of Intensive Care Medicine) for some AR-DRGs. In our consultation paper, IHPA indicated the intention to use mechanical ventilation as a marker of complexity.

Victoria's submission supported the "approach to move to mechanical ventilation as an adjustment for ICU stay and recommends that this approach extend beyond Level 3 ICUs". Tasmania, Western Australia and the Commonwealth were also supportive, with Western Australia advocating the adjustment be applied in addition to the existing measure based on time spent in Level 3 ICUs. Stakeholders including the Australian Health Service Alliance and the VHA also supported the proposed change.

Conversely, IHPA received nine submissions opposed to the change. The Australian and New Zealand Intensive Care Society wrote "whilst mechanical ventilation is a marker of severe illness, of itself it does not accurately reflect the patient-mix or the complexity of modern intensive care practice. ICU admission may be required to support other organ system failures in the absence of a need for invasive mechanical ventilation". Other

submissions also outlined an international trend to non-invasive methods of ventilation therapy in ICUs and argued the move would risk creating perverse incentives.

New South Wales and the Australian Capital Territory proposed retaining the existing ICU Adjustment mechanism. New South Wales wrote: “hours in ICU should remain as the measure until other measures of intensity are defined and agreed.”

Various alternative models were proposed for the ICU Adjustment such as “blending” a number of variables (Queensland and New South Wales); proposed hourly adjustments for patients who qualify for 1:1 nursing ratios in a recognised ICU (The College of Intensive Care Medicine); or incentivising alternatives to ICU services (e.g. intermediate care unit services) (the RACP).

IHPA has explored the concept of recognising the clinical use of mechanical ventilation as the basis for determining the ICU adjustment. This analysis has shown that using mechanical ventilation did not improve the explanatory power of the model. This analysis coupled with the clear advice from clinical groups that the use of mechanical ventilation was not supported means IHPA will not be adopting this approach in NEP14. Instead, IHPA will determine a list of ICUs which will be eligible to receive an ICU adjustment based on a measure of the size of the ICU and the overall complexity mix of patients within each ICU. IHPA will publish details of the criteria used to determine the list of eligible ICUs in the 2014-15 NEP Determination.

IHPA will continue working with stakeholders and jurisdictions to explore alternative patient-based mechanisms for determining the ICU Adjustment for future years during 2014.

Adjustment for specialist paediatric hospitals

The current Specialist Paediatric Services Adjustment takes the form of DRG-specific adjustments to the price weights in relevant hospitals, for acute admitted patients. An additional paediatric adjustment is also applied for paediatric patients admitted as a subacute patient in any hospital.

IHPA acknowledges that an adjustment for specialist paediatric hospitals in some DRGs is not ideal, as it is not made on the basis of patient characteristics, which is IHPA’s stated preference for adjustments. IHPA expects that the PCCL review which will be part of the process used to develop AR-DRG V8.0 will better explain the higher costs of treating paediatric patients. Additionally, IHPA will also investigate the potential contributors to paediatric complexity which will be used to inform the work on AR-DRG V8.0. IHPA will then determine if there is any further need to provide an adjustment for specialist paediatric hospitals in some DRGs. Until this work is complete, IHPA will retain the adjustment for specialist paediatric hospitals in some DRGs.

Key paediatric patient characteristics raised through the consultation process included age and the presence of co-morbidities (e.g. cerebral palsy). Additional characteristics such as supervision, children needing more support for interventions, family support, increased medication administration costs and lower economies of scale were also noted. This feedback will be provided to the PCCL review.

Indigenous Patient Adjustment

The current Indigenous Patient Adjustment applies to public hospital services provided to persons who identify as being of Aboriginal or Torres Strait Islander descent. IHPA recognises that there are challenges in identifying Indigenous patients in existing data sets, and also in accurately costing the services provided to these patients. In recognition of this,

IHPA has applied an Indigenous Patient Adjustment to all admitted patients (acute, subacute and mental health) and to ED and non-admitted patients.

Analysis carried out by IHPA for the NEP13 Determination showed that once location of patient residence is combined with Indigeneity, the average adjustment when both adjustments are applied for Indigenous patients is 13%.

IHPA will undertake an in-depth review of the existing Indigenous Patient Adjustment, including a costing study and review of the Productivity Commission report (2012 *Indigenous Expenditure Report*) with a view to implementing any changes in NEP15.

The Northern Territory's submission to the Pricing Framework consultation paper argued for a normative loading to assist with the Council of Australian Governments (COAG) "Closing the Gap" targets, in recognition of the substantial unmet need for public hospital services in the Northern Territory, particularly for Indigenous patients and for those living in remote areas.

IHPA also received a request to analyse the relative cost of renal dialysis (AR-DRG L61Z) for Indigenous patients, who constitute about 12% of all renal dialysis patients. The analysis found that almost half the Indigenous patients are in L61Z; and almost half of the very remote patients are in L61Z. However, 2011-12 cost data from the NHCDC showed no significant cost differential between Indigenous and non-Indigenous renal dialysis patients.

Remoteness Area Adjustment

The Remoteness Area Adjustment for all admitted patients applies based on the location of the patient's residence. That is, there will be a price adjustment for patients who reside in outer regional, remote or very remote locations if they are treated in these locations, and there will also be a price adjustment when these patients receive public hospital services in other locations. This adjustment is based on the residential status of the patient (on their post code where available), not the location of the LHN. IHPA was unable to find evidence to support the application of this adjustment to ED or non-admitted patients.

Tasmania's submission argued that locality adjustments should be applied to hospital location rather than patient residence due to unavoidable costs incurred at remote hospitals that are not included after ABF adjustments.

New South Wales and the Northern Territory put forward their concerns regarding transport costs within LHNs. The Northern Territory stated that the average distance per inter-hospital transfer in the Northern Territory is significantly further, and the costs significantly greater, than the cost of inter-hospital transfers for other jurisdictions. The Northern Territory also identified that patient travel and emergency medical retrievals are not included in NHCDC.

The Remote Area Adjustment accounts for the higher costs of patients who live in remote locations, and provides the best result in the national model. Retrievals and ambulance costs are beyond the scope of the Agreement and therefore beyond the scope of IHPA pricing.

Low volume, high complexity services

IHPA did not provide an adjustment for low volume, high complexity services in NEP12 or NEP13. A number of submissions presented arguments for adjustments to be applied to support low volume, highly complex services. Many of these submissions advocate for block funding arrangements for some services – these are discussed further in Chapter 6.

New South Wales asked for costing work on 'low volume, high complexity' and specialist referral hospital services to identify and assess the unique costs of highly specialised services with a view to determining justifiable 'cost outliers' within the National Pricing Model.

IHPA does not intend to introduce an adjustment for low volume high complexity services as there is no evidence that these services incur unavoidable costs.

Hospital peer groups

As in previous years, IHPA will analyse hospital peer groups for NEP14 to see whether there are any statistically significant cost differentials between principal referral hospital (using the AIHW peer groups) and other hospitals. In previous years this has not demonstrated a significant level of cost differential.

IHPA believes that there are a number of reasons driving this outcome. Firstly, DRGs explain a significant amount of the differences in complexity between patients. This, paired with an ICU Adjustment, and separate block payments for teaching, training and research, results in there being no statistically significant residual variation between this group of hospitals and the general hospital population.

Culturally and Linguistically Diverse (CALD) background

Several submissions supported an adjustment factor for CALD patients. St Vincent's Hospital Melbourne detailed that approximately half of their patients come from a CALD background and many of these require an interpreter.

IHPA tested the evidence to ascertain whether an adjustment factor for CALD patients is warranted for the 2014–15 Pricing Framework.

An analysis of the relative costs of the CALD group was undertaken using the NHCDC and the Admitted Patient Care activity data sets. The only CALD-related attribute in the NHCDC is the country of birth. This can only be regarded as a proxy because it does not take account of how long the person has resided in Australia nor what cultural or linguistic difficulties they face. The analysis of the cost ratios shows that those patients born in non-English speaking countries:

- comprised about 22% of all patients
- cost less on average per patient (by –2.9%) than others, but
- had a slightly longer length of stay (by 2.5%) on average than other patients.

This suggests that there is insufficient evidence at this time to justify the implementation of a specific CALD Adjustment for NEP14. IHPA will work with jurisdictions to examine additional data sets to further analyse CALD patient costs.

Radiotherapy

A number of stakeholders suggested that an adjustment should be considered for radiotherapy inpatients. For example, many patients who undergo radiotherapy, a relatively expensive treatment given to a relatively small proportion of patients, do not group to a DRG where radiotherapy is a normal procedure.

IHPA engaged an independent consultant to undertake a review of radiotherapy costs in the admitted and non-admitted settings in time for consideration in the NEP14. The review made a number of recommendations, including the introduction of an adjustment for inpatients who

receive radiotherapy treatment and the introduction of an additional Tier 2 clinic to account for the high costs associated with planning sessions.

IHPA analysed the NHCDC data for admitted patients and found that the average costs for patients who received radiotherapy procedures are significantly higher than those patients who do not receive any radiotherapy treatment in equivalent hospitals. This statistically significant difference suggests that an NEP adjustment for admitted radiotherapy patients is justified.

Stability of adjustments

IHPA has reviewed the stability of adjustments applied in NEP12 and NEP13. Some adjustments such as the indigenous adjustment for admitted subacute patients are volatile due to the small number of indigenous patients reported in this caretype. To counter this, for NEP14 adjustments will be determined on a rolling average where historical data is available in order to maximise stability of these adjustments.

Mental health patients with concomitant intellectual disability

The Commonwealth asked IHPA to consider whether there are any relevant empirical differences to support the introduction of a loading for mental health patients with co-occurring intellectual disability. This potential loading was suggested by the NSW Council for Intellectual Disability at the National Roundtable on the Mental Health of People with Intellectual Disability.

IHPA will consider this proposal in the development of NEP15.

IHPA's decision

IHPA will test whether there are empirical differences in the cost of providing public hospital services in order to determine whether there are legitimate and unavoidable variations in the costs of service delivery that may warrant an adjustment to the NEP. Decisions are based on national data sources but will be informed by data held by states and territories.

IHPA will examine patient-based characteristics in the cost of providing public hospital services before considering hospital or provider-based characteristics.

IHPA will determine a list of ICUs in which patients will be eligible to receive an ICU Adjustment based on a measure of the size of the ICU and the overall complexity mix of patients within each ICU.

There will be a Radiotherapy Adjustment.

IHPA has reviewed the stability of the adjustments applied to the NEP over previous years. For NEP14 adjustments will be determined on a rolling average where historical data is available in order to maximise stability of these adjustments.

Specific detail on adjustments will be provided as part of the NEP Determination 2014-15.

Next steps and future work

IHPA is committed to a program of ongoing work to establish the factors resulting in legitimate and unavoidable variations in the costs of providing public hospital services.

IHPA will undertake an in-depth review of the Indigenous Patient Adjustment, including a costing study and review of the 2012 Productivity Commission report (*Indigenous Expenditure Report),* with a view to implementing any changes in NEP15. Also for NEP15, IHPA will explore alternative patient-based mechanisms for determining the ICU Adjustment; further examine the costs of CALD patients; and whether there is sufficient empirical data to support the introduction of a loading for mental health patients with concomitant intellectual disability.

5.8 Incorporating new technology in the national efficient price

One of the Pricing Guidelines adopted by IHPA specified that the "pricing of public hospital services should respond in a timely way to the introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes". However, there are several factors that might work against this outcome including:

- The time lag in the NHCDC collection and processing which means that the NEP will be set based on the technology and model of care that were in operation two to three years previously.

- It may take some time for new technology and innovations in care delivery to be adopted more broadly, and for their costs to be routinely captured, in national costing data. Similar issues apply to the updating of ABF classifications such as AR-DRGs.

The NEP is, however, constructed in a way that does take some account in overall terms of the continuous adoption of new technology and processes. The accounting for the cost of technology improvements is inherent in the indexation methodology used to project the three-year empirical data to the NEP year. In effect, the indexation rate includes a component reflecting the average increase in cost over the previous five years that was associated with the introduction of new technology and improvement in quality. This is an average increase to all prices rather than attributing it to the specific hospital services that benefit from the new technology.

IHPA's CAC has an important 'watching brief' on new technology. The CAC is established under the Act to "advise the Pricing Authority in relation to developing and specifying classification systems for health care and other services provided by public hospitals". Hence, IHPA has access to clinical expertise and can consider the extent to which classifications are reflective of new technology and changing models of care.

IHPA has developed the *Impact of New Health Technology* framework to outline the process by which IHPA, through the CAC, will monitor and review the impact of new technologies on the existing classifications in order to accurately account for it in the pricing of public hospital services.

Feedback received

Submissions were supportive of the current approach for incorporating new health technologies in classification development. A few submissions recommended creating a new adjustment to account for new technologies or the introduction of a mechanism for introducing supplementary payments until the DRG classification, and NHCDC, accurately reflect the costs of the new technology.

The Pricing Authority has determined that the impact of new health technologies would feed into classification development, not pricing for particular DRGs.

IHPA's decision

IHPA, through the CAC, will continue to monitor and review the impact of new health technologies on the existing classifications in order to accurately account for it in the pricing of public hospital services. To this effect, IHPA will, on advice from CAC:

- Review monitoring reports on the emergence of new health technologies
- Review the impact of the new health technology on the classification systems currently used by IHPA to determine the NEP; and
- Determine whether and how the classification systems should be adjusted in response.

Next steps and future work

IHPA and the CAC will monitor new technologies on a biannual basis, based on reports received from government agencies and advisory bodies.

6. Pricing for safety and quality

Understanding this element of the Pricing Framework

IHPA has adopted a definition of the 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 explores how IHPA will consider whether to incorporate quality considerations in its setting of the NEP in the future.

The Agreement says that in setting the NEP, IHPA must "consider the actual cost of delivery of public hospital services in as wide a range of hospitals as practicable" (Clause B12 (b)). However, this does not preclude taking quality into account in price-setting.

In the same clause, the Agreement 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 Agreement 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 and the Australian Commission on Safety and Quality in Health Care have agreed to work in partnership to explore options for addressing pricing for quality and safety. A Joint Working Party (JWP) of senior clinicians nominated by both organisations has been established, to oversee and advise on the options for consideration.

The findings of the research undertaken show that the concept of linking funding and quality is on the agenda of many countries however most of the literature to date is equivocal and weak on empirical evidence that it has material impacts on health outcomes.

In addition to the literature review, the JWP also considered further research and expert advice, including Queensland and Western Australia's learnings from the implementation of initiatives to incentivise safety and quality in the delivery of public hospital services.

Feedback received

Submissions were generally supportive of the approach undertaken by IHPA, in partnership with the Commission, acknowledging IHPA plans to release a discussion paper in late 2013 to explore options for incorporating safety and quality into pricing.

Submissions from Victoria and Tasmania were unsupportive of the Joint Working Party established with the Commission on the basis those considerations are state responsibilities as managers of public health services. The Commonwealth continues to have reservations about the merits of incorporating safety and quality in the setting of the NEP as there remains insufficient evidence that pricing for quality has material impacts on health outcomes.

Generally the other jurisdictions supported the approach and noted some key considerations for IHPA in undertaking this work, including ensuring that any adjustment of price for quality is supported by research, occurs at a manageable pace and does not compromise the states and territories in their role as system managers to make decisions related to the pricing of safety and quality.

IHPA's decision

IHPA will not make any adjustments to the NEP for safety and quality for 2014-15.

Next steps and future work

IHPA will continue to work with the Commission to consider options on pricing for safety and quality. To support the Commission and IHPA in its work, the JWP will provide advice on the options for the consideration of safety and quality in the pricing of public hospital services in Australia.

IHPA and the Commission have commissioned some research on high volume and high variation AR-DRGs to determine the cost differential (if any) of patients who develop complications once in hospital (Hospital-Acquired Diagnoses). Other work is being undertaken to better understand how patient information is currently provided to clinicians and its potential to improve patient outcomes and care pathways.

Based on the above work and on guidance from the JWP, a discussion paper on options for incorporating safety and quality into public hospital pricing will be released in early 2014 for public consultation.

7. Setting the National Efficient Cost (NEC)

The Agreement recognises that some services are better funded through block grants, including relevant services in regional and rural communities (Clause A1(c)).

The Agreement requires IHPA to establish eligibility criteria for block funding (Box 3), and submit these to the COAG for endorsement. IHPA developed these draft criteria in 2012, and provided them to COAG. Notwithstanding that COAG were yet to endorse the criteria, in late 2012, IHPA asked states and territories to nominate services which they believed should be block funded, and assessed them against the criteria.

Box 3: Draft Block Funding Criteria

These Draft Block Funding Criteria were released for further development and consultation in 2013-14, prior to submission to the Council of Australian Governments for endorsement.

The Draft Block Funding Criteria are that public hospitals, or public hospital services, will be eligible for block grant funding if:

1. The technical requirements for applying ABF are not able to be satisfied.
2. There is an absence of economies of scale that mean some services would not be financially viable under ABF.

IHPA has also determined 'low volume' thresholds that form part of the draft Block Funding Criteria. Under these thresholds, hospitals are eligible for block funding if:

- They are in a metropolitan area (defined as 'major city' in the Australian Statistical Geography Standard) and they provide ≤ 1,800 inpatient NWAU per annum; or
- They are in a rural area (defined as all remaining areas, including 'inner regional', 'outer regional', 'remote' and 'very remote' in the Australian Statistical Geography Standard) and they provide ≤ 3,500 inpatient NWAU per annum.

Teaching Training and Research (TTR)

Key ABF technical requirements, such as a classification system, counting rules and costing and activity data, are not yet in place for TTR activity and, as such, substantial work is required to inform IHPA's advice to SCoH before 30 June 2018.

Work is underway in 2013-14 to define the scope of TTR, and understand the cost drivers underpinning the delivery of these services. IHPA will also seek advice from jurisdictions on their expected expenditure on direct TTR expenses, to determine the amount of funding for each state and territory in this area. IHPA expects these amounts to be in line with amounts agreed bilaterally with the Commonwealth in 2012-13.

IHPA's TTR Working Group provides advice on the future design of an ABF model for TTR, and expects to make substantial progress on this matter in 2013-14.

Non-admitted mental health services

The NEP13 Determination advised that non-admitted mental health services were block funded for 2013-14. For 2014-15, IHPA investigated the feasibility of funding non-admitted mental health on an activity basis.

Such an approach would require appropriate classification, counting, costing and pricing of those services using the Tier 2 classification. The Commonwealth supported using the Tier 2 classification in order to increase the transparency for non-admitted mental health services receiving Commonwealth funding.

Stakeholder feedback regarding the feasibility of reporting non-admitted mental health activity data within Tier 2, however, indicated that the technical requirements have not advanced sufficiently to allow these services to be funded on an activity basis in 2014-15.

The Pricing Authority has decided to retain the current block funding approach for these services in 2014-15 whilst work continues to design appropriate classification, counting and costing systems. This arrangement is anticipated to continue until the Australian Mental Health Care classification is introduced in 2016.

Other non-admitted services

In NEP 13 IHPA determined the General List of public hospital services eligible for Commonwealth funding under the NHRA. These included a number of “other non-admitted services” additional to the existing Tier 2 classification.

In NEP13 there were a range of the “other non-admitted in-scope services” that were unable to be priced as the underlying costing and activity data were not available. These services were block funded as they met the draft Block Funding criteria proposed by IHPA.

For NEP14 IHPA has determined that most of these services are able to be priced by an appropriate near equivalent Tier 2 clinics.

There were three in-scope services that are unable to be priced in NEP14 and will be block funded. These services are:

- Home delivered ventilation
- Total parenteral nutrition – home delivered
- Total enteral nutrition – home delivered

IHPA will carry out work in the coming 12 months to ensure these services are able to be priced in NEP15.

Small hospitals where there is an absence of economy of scale

The AIHW’s National Public Hospital Establishments Database (NPHED), specified by the Public Hospital Establishments (PHE) National Minimum Data Set (NMDS), is one of the primary data sources available to IHPA to determine the National Efficient Cost for block funded services.

During 2013, IHPA worked with AIHW to review and refine the PHE NMDS to ensure it better reflects how hospitals and Local Hospital Networks deliver their services. It is intended that the scope of the collection is expanded to collect information related to all services delivered by LHNs and to specifically identify activity and expenditure that is in scope for the Agreement. IHPA will work with AIHW and the National Health Information Standards and Statistics Committee (NHISSC) to determine the timetable for implementation of the revised collection.

Feedback received

Submissions were received relating to the increased administrative burden on small rural hospitals (Victoria) as well as the difficulty to distinguish between admitted and non-admitted activity (Tasmania). Western Australia questioned the reliability of the NEC model due to high variability in reporting costs in hospitals covered by the NEC.

The VHA suggested transplant services should be block funded or an adjustment applied to recognise the complexity and costs of the procedures, and the fact that low volumes means that dependable data is unlikely to exist.

IHPA has made a number of improvements to the process for determining NEC14.

Unlike the ABF cost models which utilise relatively robust cost and activity files for the model, the input data for the NEC cost model is drawn from a variety of sources. As such, the NEC cost model has two distinct phases – data preparation and data modelling. For NEC14, IHPA has made significant improvements to the data preparation methodology.

Data preparation

Patient level activity data for admitted patients is robust and covers the vast majority of patients. Emergency department data is also widely available. Conversely, non-admitted data for block funded hospitals is not generally available at the patient level meaning that about half of these hospitals report aggregate service event information to IHPA. The remaining hospitals do not report to either collection which means that IHPA models NPHED data to determine the outstanding in-scope non-admitted NWAUs. IHPA also uses the NPHED as the primary data source with respect to expenditure data

In comparison to NEC13, there is likely to be a significant increase of the NWAU activity count and reported expenditure in NEC14. This will be confirmed in the 2014-15 NEC Determination. The implication of this increase is that service volumes were underestimated and expenditure under-reported in NEC13.

IHPA improved the transparency of the data preparation process this year by working with jurisdictions to review and validate input data, and making corrections where there were material errors, as advised by state officials.

Data modelling

The value of the NEC and the change of the NEC across years are influenced by the change in the definition of outliers. In NEC13, the outliers were handled separately as an interim measure with the intention to review this practice for NEC14. Many of the NEC13 outliers now fit into the model because the revised estimates of activity and expenditure provide a better fit.

In light of the significantly increased NWAU reported, IHPA has also explored a number of different approaches to setting the volume thresholds to allocate hospital between throughput categories.

IHPA will work with IHPA's Small Rural Hospital Working Group and with jurisdictions when finalising methods to determine the efficient cost of outlier hospitals and when conducting further analysis to determine the most appropriate volume thresholds. IHPA's approach will be detailed in the 2014-15 NEC Determination.

IHPA's decision

Pending COAG's endorsement of the Block Funding Criteria above, IHPA has determined the following parameters for the funding of small hospitals where there is an absence of economy of scale.

IHPA will use a three-year rolling average of annual acute admitted NWAU as the basis of identifying whether hospitals are above or below the low volume thresholds for block funding. Where significant changes in Service Agreements are foreshadowed by states or territories, IHPA will consult with the relevant states and territories to determine the expected volume impact to ensure that the hospital is not disadvantaged.

In 2014-15, hospitals in metropolitan areas that meet the low volume threshold will have their block funding amounts determined by IHPA in conjunction with the relevant state or territory.

Next steps and future work

IHPA acknowledges that there is significant work required on block funding approaches in coming years. This includes:

- Better identification of in-scope expenditure at a facility level.
- Improvements in the reporting of activity data, whilst limiting the data burden on these small facilities.
- Reviewing the groupings of these hospitals, both in terms of location, volume groups and any other relevant factors that may better help explain the variance between hospitals.

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