



**The Pricing
Framework for
Australian Public
Hospital Services
2016-17**

**Independent Hospital Pricing Authority
The Pricing Framework for Australian Public Hospital Services 2016-17**

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The Pricing Framework for Australian Public Hospital Services 2016-17

The Hon Jack Snelling
Chair, COAG Health Council
GPO Box 2555
ADELAIDE SA 5001

Dear Minister

On behalf of the Independent Hospital Pricing Authority (IHPA), I am pleased to present the *Pricing Framework for Australian Public Hospital Services 2016-17*.

The Pricing Framework emphasises the commitment by IHPA 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 2016-17. 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 the services which are block funded.

This is the fifth Pricing Framework issued by IHPA. The nature of the comments received in response to the Consultation Paper on the Pricing Framework for 2016-17 demonstrates that IHPA has developed a clear and stable methodology that guides the annual determination of the NEP and NEC.

IHPA will continue to develop and refine its classification systems, counting rules, data, coding and costing standards which underpin the national activity based funding system.

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 activity based funding for public hospital services.

Yours sincerely



Shane Solomon
Chair
Independent Hospital Pricing Authority

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Glossary

ABF	Activity Based Funding
AHPCS	Australian Hospital Patient Costing Standards
AMHCC	Australian Mental Health Care Classification
AN-SNAP	Australian National Subacute and Non-Acute Patient
ARCBS	Australian Red Cross Blood Service
AR-DRG	Australian Refined Diagnosis Related Groups
ASC	Australian Stroke Coalition
ASGS-RA	Australian Statistical Geography Standard Remoteness Area
ANZSGM	The Australian and New Zealand Society for Geriatric Medicine
CALD	Culturally and Linguistically Diverse
CHA	Children's Healthcare Australasia
COAG	Council of Australian Governments
ED	Emergency department
GEM	Geriatric evaluation and management
General List	General List of In-Scope Public Hospital Services
IHPA	Independent Hospital Pricing Authority
JWP	Joint Working Party
LHN	Local Hospital Network
MBS	Medicare Benefits Schedule
NBA	National Blood Agreement
NEC	National Efficient Cost
NEP	National Efficient Price
NHCDC	National Hospital Cost Data Collection
NHRA	National Health Reform Agreement
NPHEd	National Public Hospital Establishments Database
NSF	National Stroke Foundation
OTA	Organ and Tissue Authority

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PBS	Pharmaceutical Benefits Scheme
QNU	Queensland Nurses' Union
RACP	The Royal Australasian College of Physicians
RANZCO	The Royal Australian and New Zealand College of Ophthalmologists
RCPA	The Royal Australian College of Pathologists of Australasia
SMMSE	Standardised Mini-Mental State Examination
the Act	<i>National Health Reform Act 2011</i>
the Commission	Australian Commission on Safety and Quality in Health Care
TTR	Teaching, training and research
UDG	Urgency Disposition Groups
URG	Urgency Related Groups
WHA	Women's Healthcare Australasia

1. Introduction

The implementation of a national Activity Based Funding (ABF) system is intended to improve public hospital efficiency and the transparency of funding contributions by the Commonwealth, state and territory governments for each Local Hospital Network (LHN) across Australia, and is a key component of the 2011 Council of Australian Governments' National Health Reform Agreement (NHRA).

Under the NHRA, IHPA is required to determine the National Efficient Price (NEP) which is used to calculate Commonwealth ABF contributions for in-scope public hospital services and the National Efficient Cost (NEC) which covers those services which are block funded.

In June 2015, IHPA released a consultation paper on key issues that IHPA would consider in the preparation of the *Pricing Framework for Australian Public Hospital Services 2016-17* (Pricing Framework 2016-17).

Feedback received from stakeholders has informed the development of the Pricing Framework 2016-17 which sets out IHPA's key principles, scope and approach for the NEP16 and NEC16 Determinations.

Submissions for the Pricing Framework 2016-17 were received from 30 organisations, including from all state and territory governments and the Commonwealth. These submissions are available on the [IHPA website](#), except where submissions have been provided in-confidence.

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

The Pricing Framework 2016-17 builds on the Pricing Frameworks from previous years ([2012-13](#), [2013-14](#), [2014-15](#) and [2015-16](#)). For simplicity, where IHPA has reaffirmed a previous principle, the supporting argument has not been restated in this year's paper.

IHPA has issued the Pricing Framework 2016-17 prior to releasing the NEP16 and NEC16 Determinations, which will be publicly available in February 2016, with the intention of providing an additional layer of transparency and accountability.

2. Pricing Guidelines

2.1 Understanding this element of the Pricing Framework

All nine Australian governments agreed to establish IHPA to provide independent advice about the efficient cost of public hospital services and to determine the NEP and NEC of public hospital services throughout Australia. The decisions made by IHPA in pricing in-scope public hospital services are evidence-based and utilise the costing and activity data supplied to IHPA by states and territories.

In making these decisions, IHPA must balance a range of 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.

For this reason, IHPA developed a set of Pricing Guidelines to signal its commitment to transparency and accountability in how it undertakes its work ([Box 1](#)).

Whilst these Pricing Guidelines are used to guide the key decisions made by IHPA in determining the NEP and NEC, they can 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.

Feedback received

Jurisdictions and other stakeholders were broadly supportive of the Pricing Guidelines.

IHPA considers that the Pricing Guidelines remain appropriate. For this reason, IHPA has not made any changes to the Pricing Guidelines for 2016-17.

IHPA's decision

IHPA has developed, and will use, a set of Pricing Guidelines ([Box 1](#)) to guide its decision making where it is required to exercise policy judgement in undertaking its legislated functions. IHPA has not made changes to the Pricing Guidelines for 2016-17.

Next steps and future work

IHPA will actively monitor the impact of the implementation of Activity Based Funding (ABF). This will include monitoring changes in the mix, distribution and location of public hospital services, consistent with its responsibilities under Clause A25 of the National Health Reform Agreement. IHPA will continue to work with the Jurisdictional Advisory Committee and the Clinical Advisory Committee to analyse any changes evident in the data.

The first phase of the *Evaluation of the Impact of the Implementation of National Activity Based Funding for Public Hospital Services* will be completed in the first half of 2016. An independent consortium was engaged to design the evaluation framework and establish the baseline data set. The evaluation will allow IHPA to monitor any impacts that the introduction of a national ABF system has had 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 NHRA:** Funding design should recognise the complementary responsibilities of each level of government in funding health services.

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

- **Transparency:** All steps in the determination of ABF and block grant funding should be clear and transparent.
- **Administrative ease:** Funding arrangements should not unduly increase the administrative burden on hospitals 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.

3. In-scope public hospital services

3.1 Overview

In August 2011, Australian governments agreed to be jointly responsible for funding the growth in activity and cost for 'public hospital services'. However, there was no standard definition or listing of public hospital services at that time. The Council of Australian Governments (COAG) assigned IHPA the task of determining which services will be ruled 'in-scope' as public hospital services, whereby they become eligible for funding from the Commonwealth Government under the National Health Reform Agreement (NHRA).

The reformed funding arrangements agreed by COAG apply to the scope of 'public hospital services', which is broader terminology than public hospitals or hospital-based care. For example, private hospitals and non-governmental organisations may provide public hospital services under contract to health departments, Local Hospital Networks or public hospitals. However, many public hospitals provide residential aged care services, but these are not regarded as public hospital services under the NHRA.

3.2 Scope of public hospital services and general list of eligible services

Each year, IHPA publishes the 'General List of In-Scope Public Hospital Services' (General List) which defines public hospital services eligible for Commonwealth funding under the NHRA, except where funding is otherwise agreed between the Commonwealth and a state or territory.

In accordance with Section 131(f) of the *National Health Reform Act 2011* and Clauses A9-A17 of the NHRA, the General List 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 also included if they were recorded in the 2010 National Public Hospital Establishments Database (NPHEd).
- All Emergency Department (ED) services provided by a recognised ED service; and
- Other non-admitted services that meet the criteria for inclusion on the General List.

A public hospital service's eligibility for inclusion on the General List is independent of the service setting in which it is provided (e.g. at a hospital, in the community or in a person's home).

IHPA also publishes an 'A17 List' of public hospital services which would not normally be considered a public hospital service, but are eligible for Commonwealth funding under Clause A17 of the NHRA. The A17 List provides a form of "grand parenting" in that an otherwise ineligible service is eligible for Commonwealth funding in a specific hospital if the service was purchased or provided by that hospital during 2010, as reported to the NPHEd.

The Pricing Authority determines whether specific services proposed by states and territories are in-scope for Commonwealth funding based on criteria and interpretive guidelines outlined in the [Annual Review of the General List of In-Scope Public Hospital Services](#) policy (General List policy). IHPA updated the General List policy in early 2015 to clarify that an eligible service will only be added to the General List after sufficient supporting evidence is provided by jurisdictions.

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The criteria and interpretive guidelines are presented in [Box 2](#). The General List and A17 List were last published as part of the [NEP15 Determination](#) in February 2015.

Feedback received

Victoria, Western Australia, Tasmania and the Royal Australian and New Zealand College of Psychiatrists continued to advocate for the inclusion of community-based child and adolescent specialist mental health services on the General List. To date, IHPA has not received sufficient empirical evidence to support the inclusion of these services on the General List as the administrative data provided to IHPA indicates that there is a low level of interaction between people enrolled in these services and public hospitals. IHPA formed this view on the basis of the low percentage of enrolled community-based child and adolescent mental health consumers who present at an ED or are admitted in a given year. IHPA will consider any additional evidence provided by jurisdictions in future years as part of its annual review of the General List.

IHPA's decision

IHPA does not propose any changes to the criteria which it uses to determine whether in-scope public hospital services are eligible for Commonwealth funding under the National Health Reform Agreement in 2016-17.

Full details of the public hospital services determined to be in-scope for Commonwealth funding will be provided in the NEP16 Determination.

Next steps and future work

The General List policy provides a mechanism for jurisdictions to apply to IHPA for additional services to be included or excluded from the General List. IHPA periodically reviews the General List to ensure that all in-scope services continue to meet the criteria to be eligible for Commonwealth funding under the NHRA.

3.3 Pricing posthumous organ donation activity

Clause A6 of the NHRA states that the Commonwealth will not fund patient services through the NHRA if the same service, or any part of the same service, is funded through any other Commonwealth program. For this reason, IHPA has previously not priced posthumous organ donation activity on the understanding that these costs were already funded by the Commonwealth through the Organ and Tissue Authority (OTA).

Posthumous organ donation refers to activities involving the procurement of organs for the purpose of transplantation from a donor who has been declared brain dead.

In 2014, IHPA's Clinical Advisory Committee requested that IHPA clarify with the OTA whether its funding programs cover all organ donation costs. The OTA advised that it contributes towards the costs of preparing a patient for organ donation which are additional to those normally incurred for providing care for critically ill patients, and that this is not intended to cover the costs of posthumous organ retrieval or costs incurred thereafter.

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The OTA's advice means that the costs of posthumous organ donation are not funded by the Commonwealth and as such should be in-scope for pricing by IHPA under the NHRA.

For IHPA to account for all posthumous organ donation activity, it must be accurately captured in the national activity and cost data. However, IHPA and jurisdictions have identified that posthumous organ donation is not accurately captured in these data sets.

Some jurisdictions are not reporting this activity data to IHPA at all, whilst others may not be fully capturing all of the posthumous organ donation activity undertaken. There are also a variety of different costing approaches being used by jurisdictions to capture posthumous organ donation costs. For example, some jurisdictions are allocating these costs to the posthumous organ donors, whilst others attribute the costs to the organ recipient.

Feedback received

The Commonwealth, New South Wales, Western Australia, Tasmania, the Northern Territory and Catholic Health Australia considered that posthumous organ donation activity should be in-scope for pricing under the NHRA and supported the activity being priced in NEP16.

Queensland provided in-principle support for IHPA pricing posthumous organ donation activity, subject to advice on what system changes will be required to capture the activity.

New South Wales advised that it has already initiated work with key stakeholders to better understand posthumous organ donation activity and costs.

All jurisdictions recognised that there are gaps in the collection of posthumous organ donation activity and cost data and advocated for the development of cost allocation standards through the Australian Hospital Patient Costing Standards. However, Queensland and South Australia noted that the low volume of cases may not justify the cost of system changes required to accurately report posthumous organ donation activity. Victoria argued to defer the pricing of posthumous organ donation until robust data is available.

IHPA considers that posthumous organ donation services are in-scope for Commonwealth funding purposes under the NHRA and will work with jurisdictions and the OTA to ensure the costs of these services are recognised.

IHPA's decision

IHPA considers posthumous organ donation to be in-scope for pricing under the National Health Reform Agreement and will price this activity in NEP16 if sufficient data is available.

IHPA will confirm its final approach for pricing this activity in the NEP16 Determination.

Next steps and future work

As posthumous organ donation is not accurately reported in the cost data, IHPA will work with jurisdictions and the OTA to determine a nationally consistent approach to reporting this data in future years through the Australian Hospital Patient Costing Standards to ensure the costs of these services are recognised.

IHPA is also considering whether posthumous organ donation activity could be better described through the classification system for admitted patient services.

Box 2: Scope of Public Hospital Services and General List of Eligible Services

In accordance with Section 131(f) of the *National Health Reform Act 2011* (the Act) and Clauses A9–A17 of the National Health Reform Agreement (NHRA), 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 (ED) services.
- Non-admitted services as defined below.

Non-admitted services

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

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

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

Consistent with Clause A25 of the NHRA, 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

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 ED attendance; or
- intended to substitute directly for an inpatient admission or ED 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; and
- 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 submitted home ventilation programs for inclusion on the General List. The Pricing Authority has included these services on the General List 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.

4. Classifications used by IHPA to describe public hospital services

4.1 Overview

In order to determine the NEP for services funded on an activity basis, IHPA must first specify the classifications, counting rules, data and coding standards as well as the methods and standards for costing data.

4.2 Classification systems

Classification systems are a critical element of Activity Based Funding (ABF) as they group patients who are clinically relevant (i.e. have similar conditions) and resource homogenous (i.e. cost similar amounts per episode) together.

4.3 Australian-Refined Diagnosis Related Groups classification

For NEP15 IHPA used the Australian Refined Diagnosis Related Groups (AR-DRG) Version 7 classification to price admitted acute patient services with the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) and the Australian Classification of Health Interventions (ACHI) 9th edition used for the underlying diagnosis and procedure coding.

In the Pricing Framework 2015-16, IHPA foreshadowed its intention to price admitted acute patients using AR-DRG Version 8 in NEP16. This version of the classification includes a new approach to calculating case complexity which more accurately quantifies individual patient complexity and better recognises the impact of the principal diagnosis and comorbidities on overall case complexity.

Feedback received

Stakeholders supported the use of AR-DRG Version 8 for pricing admitted acute services in NEP16. The Australian and New Zealand Society for Geriatric Medicine (ANZSGM) noted that the new version better defines and reflects the complexity of the casemix in geriatric medicine.

IHPA's decision

IHPA has determined that the ICD-10-AM and ACHI 9th edition diagnosis and procedure codes and the Australian Refined Diagnosis Related Groups Version 8 classification will be used for pricing admitted acute services in NEP16.

Next steps and future work

To ensure the admitted acute classification reflects ongoing developments in clinical practice, IHPA commenced developmental work on AR-DRG Version 9 and ICD-10-AM and ACHI 10th edition during 2015.

4.4 Australian National Subacute and Non-Acute Patient classification

For NEP15 IHPA used the Australian National Subacute and Non-Acute Patient (AN-SNAP) Version 3 classification to price admitted subacute and non-acute patients. Admitted subacute patients unable to be assigned an AN-SNAP class are classified using DRGs.

In NEP15 IHPA also ceased per diem pricing for subacute services which were not classified using AN-SNAP, except for admitted paediatric subacute activity because AN-SNAP Version 3 did not include specific paediatric classes.

IHPA has since completed its development of AN-SNAP Version 4. The new version better reflects current and evolving clinical practice in subacute services such as rehabilitation, palliative care and geriatric evaluation and management (GEM) services, as well as introducing paediatric classes for palliative care and rehabilitation.

During the development of AN-SNAP Version 4, clinical input identified that cognitive impairment was a significant cost driver for geriatric evaluation and management (GEM) services. Clinicians identified that the Standardised Mini-Mental State Examination (SMMSE) best assessed this in a GEM service setting. IHPA is now undertaking a targeted study to source additional data on cognitive impairment for these patients. The study is expected to conclude in late 2015 and will enable further improvements to the GEM classification in future versions of the AN-SNAP classification.

Additionally, IHPA has purchased the rights to use the SMMSE in Australian public hospitals, and the reporting of the results of the SMMSE has been included in the relevant data sets from 2015-16.

Feedback received

Stakeholders broadly supported the use of AN-SNAP Version 4 for pricing admitted subacute and non-acute services in NEP16.

New South Wales recommended that IHPA retain paediatric per diem pricing in the first year of implementation of AN-SNAP Version 4 to enable costing of the new paediatric subacute classes prior to their use for pricing.

In the Pricing Framework 2015-16, IHPA set out its intention to price paediatric subacute activity using only AN-SNAP grouped services from 1 July 2016. However, IHPA has identified that there is insufficient data available to price subacute paediatric services using AN-SNAP Version 4. IHPA will therefore retain paediatric per diem pricing for NEP16, with the intention of ceasing per diem pricing for these services from 1 July 2017.

IHPA's decision

IHPA has determined that the Australian National Subacute and Non-Acute Patient (AN-SNAP) Version 4 classification will be used for pricing admitted subacute and non-acute services in NEP16.

IHPA will retain per diem prices for paediatric subacute and non-acute services for NEP16. Subacute and non-acute services not classified using AN-SNAP Version 4 will be classified using Diagnosis Related Groups (DRGs).

Next steps and future work

IHPA will monitor and review implementation of AN-SNAP Version 4 and will identify areas for further improvement in future versions of the classification.

The completion of the targeted GEM clinical data collection in late 2015 will enable further improvements to this care type in future versions of the AN-SNAP classification.

4.5 Tier 2 Non-admitted Services classification

IHPA acknowledges that the existing Tier 2 Non-admitted Services classification is not ideal in the longer term for pricing non-admitted patients as it is not patient centred. However, there are no non-admitted classifications in use internationally which could be suitably adapted to the Australian setting.

For this reason, IHPA is continuing its work to develop a new Australian non-admitted patient care classification that will be better able to describe patient complexity and more accurately reflect the costs of non-admitted public hospital services.

In their responses to the Consultation Papers for 2014-15 and 2015-16, most stakeholders broadly supported the counting, costing and classification of non-admitted Multidisciplinary Case Conferences (MDCCs) where the patient is not present. IHPA commenced developmental work in 2014-15 to define MDCCs where the patient is not present for inclusion in the new non-admitted patient care classification. This work is informed by the definitions already in use in the Medicare Benefits Schedule. IHPA will continue to work with jurisdictions to consider the introduction of additional data elements in the non-admitted data sets for future years. This would allow for the capture of MDCCs where the patient is not present, with a view to building an understanding of the prevalence of these events.

For NEP16 IHPA will continue to use the Tier 2 Non-admitted Services classification for pricing non-admitted services. IHPA is committed to ensuring the Tier 2 classification remains clinically relevant and suitable for ABF purposes until such time as the new non-admitted patient care classification is completed.

Feedback received

Queensland, Western Australia, Tasmania and the Royal Australian and New Zealand College of Ophthalmologists supported the development of a new non-admitted patient care classification as a major priority.

New South Wales, the Australian and New Zealand Society for Geriatric Medicine (ANZSGM), the Royal Australasian College of Physicians (RACP) and the Royal College of Pathologists of Australasia (RCPA) supported the developmental work on MDCCs where the patient is not present.

ANZSGM noted that recognition of MDCCs where the patient is not present reflects current practice for clinicians treating memory and cognitive disorders, as they often collate and discuss a number of assessments in a case conference setting. The RCPA saw benefit in recognising MDCCs where the patient is not present as to allow for better comparisons of pathology costs between settings through factoring in the number of case reviews.

Victoria and South Australia did not support the introduction of additional data elements in the non-admitted data sets to account for MDCCs where the patient is not present. They contend this will result in an additional administrative burden for jurisdictions, is inconsistent with IHPA's Pricing Guidelines principle of 'administrative ease' and the costs of MDCCs are already taken into account in the costing process at a hospital level and hence influence the relevant non-admitted price weight.

IHPA considers that its developmental work to count, cost and classify non-admitted MDCCs where the patient is not present is important as coordinated care reflects contemporary clinical practice for many non-admitted services. IHPA will continue this work, given the strong support from its Clinical Advisory Committee. Nonetheless, IHPA will work with jurisdictions through the Non-Admitted Care Advisory Working Group to address their technical and other concerns.

IHPA's decision

IHPA has determined that the Tier 2 Non-admitted Services classification Version 4.1 will be used for pricing non-admitted services in NEP16.

Next steps and future work

IHPA will continue developmental work on a new Australian non-admitted patient care classification for implementation in future years, including MDCCs where the patient is not present.

4.6 Emergency care classification

IHPA currently uses the Urgency Related Groups (URG) and Urgency Disposition Groups (UDG) classifications to describe presentations to Emergency Departments (EDs) and emergency services for ABF purposes.

IHPA acknowledges that the URG and UDG classification systems require improvement for classifying emergency care in the medium to long term. There is a need for an emergency care classification with a stronger emphasis on patient factors, such as diagnosis, compared to the current focus on triage status in the existing classification. IHPA commenced work on the redevelopment of the emergency care classification systems in 2015.

IHPA is committed to ongoing maintenance work to ensure the relevancy of the existing emergency care classifications for clinical and ABF purposes until such time as the new emergency care classification is completed.

Feedback received

Western Australia and Tasmania supported the development of a new emergency care classification as a priority.

Queensland noted that the national data sets used for the URG classification system do not capture clinician time per patient which would allow for accurate cost allocation. IHPA will undertake a costing study in EDs in 2016 to capture this data and the outcomes of this study will inform the development of the new emergency care classification.

IHPA's decision

IHPA has determined that Urgency Related Groups Version 1.4 and Urgency Disposition Groups Version 1.3 will be used for pricing emergency activity in NEP16.

Next steps and future work

IHPA will work with jurisdictions to undertake a detailed and targeted costing study in 2016 which will form the basis for the development of the new emergency care classification system in 2017. The costing study will be based on data collected by selected EDs and emergency services around Australia, capturing information on patient-level characteristics and their associated costs.

Stakeholders will have the opportunity to provide input on the development of the new emergency care classification through a public consultation paper which IHPA intends to release in late 2016.

4.7 Teaching, training and research

Teaching, training and research (TTR) activities represent an important role of the public hospital system alongside the provision of care to patients. However, there is currently no acceptable classification system for TTR, nor are there mature, nationally consistent data collections for activity or cost data which would allow IHPA to price TTR using ABF.

The National Health Reform Agreement requires that IHPA provide advice to the COAG Health Council on the feasibility of transitioning funding for TTR to an ABF system by 30 June 2018. IHPA provided advice to the COAG Health Council in late 2014 that the work IHPA has undertaken to date indicates that the development of systems which underpin ABF are feasible for teaching and training. This view is shared by jurisdictions and clinical, academic and peak body stakeholders. However, IHPA also advised that further work is required to obtain robust data prior to providing advice on the feasibility of ABF for research.

IHPA has proceeded to the next step of developing a TTR classification by undertaking a comprehensive TTR costing study at a representative sample of public hospitals. The study will run until early 2016, after which work will commence on the development of a teaching and training classification system.

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IHPA also continues to improve its ongoing data collection of TTR activities, with a Hospital Teaching, Training and Research Data Set Specification included in IHPA's *Three Year Data Plan 2015-16 to 2017-18*.

IHPA will continue to block fund TTR activity in ABF hospitals in NEC16 and until such time that the classification is developed. The TTR block funding amounts will be determined with advice from jurisdictions and consistent with IHPA's Block Funding Guidelines developed for NEC15.

Feedback received

Clinical stakeholders continued to support IHPA's development of an ABF classification system for TTR. This included the Royal College of Pathologists of Australasia, RACP and ANZSGM. Universities Australia and the Medical Technology Association of Australia supported the continued development of a TTR classification as it reflects an appreciation of the complexity of these functions which are vital to quality and capacity in public hospitals and the health system as a whole.

Queensland and Western Australia supported the development of a teaching and training classification.

Tasmania and the Northern Territory indicated that the development of a new TTR classification is a low priority and should be deferred as the provision of TTR activity data from 1 July 2015 will be difficult for jurisdictions.

IHPA's decision

In 2016-17 IHPA will determine block funding amounts for teaching, training and research activity based on jurisdictional advice.

Next steps and future work

IHPA will continue to develop a teaching and training classification in 2015-16, informed by a comprehensive costing study, as well as further assessing the feasibility of ABF for research.

4.8 Australian Mental Health Care Classification

IHPA continues to develop a new mental health care classification for classifying and pricing mental health services on an activity basis across both the admitted and non-admitted settings. This work is guided by a Mental Health Working Group which includes clinicians, consumers and carers, as well as jurisdictional representatives.

The classification is intended to improve the clinical meaningfulness of the way mental health care services are classified, better account for new models of mental health care and enhance the cost predictiveness of the pricing model.

The Australian Mental Health Care Classification (AMHCC) Version 1 is under development and will be released for public consultation in late 2015. Classification development builds on earlier work to define and cost mental health care and includes a number of variables that describe how a mental health consumer's diagnosis impacts their daily activities.

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IHPA will pilot Version 1 of the AMHCC at a small number of sites nationally in late 2015 to test the clinical acceptability and explanatory power of the classification and to identify the data collection and other infrastructure requirements and system changes that are required.

IHPA expects to commence development of the second version of the AMHCC in early 2016. IHPA anticipates that an ongoing refinement process for the AMHCC, similar to the AR-DRG classification, will be implemented following the release of Version 2 of the AMHCC.

4.8.1 Pricing mental health services

In the Pricing Frameworks 2014-15 and 2015-16, IHPA foreshadowed pricing mental health services using the AMHCC from 1 July 2016. However, the Consultation Paper set out IHPA's intention to defer implementation of the new classification for pricing purposes until 1 July 2017, with further detail to be provided in the second *Public Consultation Paper on the Development of the Australian Mental Health Care Classification* to be published in late 2015.

Deferring for one year provides time to evaluate and incorporate the outcomes of the pilot and provide system managers and clinicians the lead time required to make the system changes to capture the key data elements in the classification. It would also allow time for stakeholders to undertake training and education to support implementation at the local level.

Feedback received

Western Australia supported the continued development of the AMHCC, noting that the current DRGs for mental health patients do not sufficiently account for differences in acuity and there is significant volatility in DRG price weights for mental health activity. New South Wales recommended that IHPA commence development of Version 2 of the AMHCC as a priority because the classification requires ongoing and substantive refinements to improve its cost predictiveness and to ensure it is clinically meaningful.

Queensland, Western Australia, Tasmania and the Royal Australian and New Zealand College of Psychiatrists supported IHPA's intention to defer the pricing of mental health services using the AMHCC until NEP17 on the basis that it will allow time for education and training for clinicians and for information and technology systems to be updated to collect the new data element of phase of care.

Victoria recommended that IHPA revise the timeframe for the development and implementation of the AMHCC to ensure that a high quality national model that supports utility for management of the health system is produced in the final classification.

IHPA's decision

IHPA's approach to pricing mental health services in 2016-17 will remain unchanged from 2015-16. Admitted mental health services will continue to be priced using the Australian Refined Diagnosis Related Groups system, whilst non-admitted mental health services will be block funded.

The pricing of mental health services using the Australian Mental Health Care classification has been deferred until NEP17.

Next steps and future work

IHPA will continue to develop the AMHCC, with the intention of pricing mental health services using the new classification from 1 July 2017.

5. Costing and counting rules

5.1 National Hospital Cost Data Collection

The National Hospital Cost Data Collection (NHDC) is the primary data collection that IHPA relies on to develop the NEP and price weights for the funding of public hospital services on an activity basis, as well as to develop the NEC for block funded hospitals. Jurisdictional data submissions to the NHDC are informed by the Australian Hospital Patient Costing Standards (AHPCS).

IHPA published Version 3.1 of the AHPCS in late 2014 which addressed a number of the issues raised in the [Strategic Review of the National Hospital Cost Data Collection](#).

IHPA is undertaking a comprehensive review of the AHPCS and intends to release AHPCS Version 4 in 2016, along with supporting materials to assist system managers in undertaking costing activities in public hospitals in a nationally consistent way. The comprehensive review has been informed by consultation with jurisdictions and other stakeholders. IHPA undertook public consultation on priority development areas in 2015. The comprehensive review includes a study which is evaluating alternative cost allocation methods and will assist in determining the preferred cost allocation methods for the AHPCS.

Feedback received

Western Australia and Tasmania supported IHPA's comprehensive review of the AHPCS and development of AHPCS Version 4. Victoria provided in-principle support for the review. New South Wales regarded the release and use of AHPCS Version 4 for Round 19 of the NHDC as too ambitious.

IHPA will refer this feedback to the NHDC Advisory Committee for its consideration.

IHPA's decision

The Australian Hospital Patient Costing Standards Version 3.1 are to be used in Round 19 of the National Hospital Cost Data Collection.

Next steps and future work

IHPA intends to release Version 4 of the AHPCS in 2016 for use in future rounds of the NHDC. IHPA will make an assessment of the magnitude of system changes required for AHPCS Version 4 once they are finalised. This will inform the final implementation timeline.

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

6.1 Technical improvements

IHPA has developed a sophisticated and robust pricing model that underpins the determination of the NEP. The model is described in detail in the [Technical Specifications](#) on IHPA's website. Some jurisdictions have requested that IHPA consider technical improvements to the cost models underpinning the NEP.

6.1.1 Alternative geographical classification systems

Remoteness has been shown to be a significant cost driver for the provision of public hospital services. For this reason, it is considered in both the NEP model and the NEC model as one of a variety of factors. IHPA's current approach to determining remoteness is to use the Australian Bureau of Statistics' 2011 Australian Statistical Geography Standard Remoteness Area (ASGS-RA) classification.

In the Consultation Paper IHPA proposed to investigate the [Modified Monash Model](#) as an alternative to the ASGS-RA classification for determining patient and hospital remoteness. Similar to the ASGS-RA classification, the Modified Monash Model categorises metropolitan, regional, rural and remote areas according to geographical location, but also introduces new categories in regional and rural remoteness areas based on town size.

The Commonwealth Department of Health has adopted the Modified Monash Model for use in its District of Workforce Shortage map, which is used to identify medical workforce shortages across Australia. IHPA proposed to investigate the Modified Monash Model to ascertain if the classification could help to better explain the unavoidable costs of service delivery in some areas of regional and remote Australia where some stakeholders claim the existing ASGS-RA classification fails to do so.

Feedback received

In their responses to the Consultation Paper, the Commonwealth, New South Wales, Victoria, Western Australia, South Australia, Tasmania, the Queensland Nurses' Union (QNU) and the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) supported investigating the Modified Monash Model for determining remoteness.

The QNU argued that a population-based method is likely to be more effective in addressing the unavoidable costs of service delivery in remote locations and offers a more equitable distribution of funds.

The Northern Territory, Women's Healthcare Australasia (WHA) and Children's Healthcare Australasia (CHA) strongly supported the continued use of the existing ASGS-RA classification on the basis that the Modified Monash Model does not make allowance for the costs of service delivery in remote locations.

IHPA reviewed the performance of the Modified Monash Model for determining patient and hospital remoteness in the National Pricing Model. IHPA's analysis found that the Modified Monash Model does not result in any improvement in identifying costs associated with patient and hospital remoteness compared to the ASGS-RA classification and may have the unintended consequence of disadvantaging small hospitals in outer regional areas. This result is not entirely unexpected given that the Modified Monash Model has the primary purpose of identifying primary health care workforce shortages which is a different policy objective to identifying legitimate and unavoidable costs for rural hospitals. Tasmania supports this outcome.

For this reason, IHPA will continue to use the ASGS-RA classification in 2016-17.

IHPA's decision

IHPA will continue to use the Australian Statistical Geography Standard Remoteness Area classification for determining patient and hospital remoteness for NEP16 and NEC16.

Next steps and future work

IHPA will continue to explore opportunities to improve the performance of the cost models where appropriate.

6.2 Adjustments to the National Efficient Price

6.2.1 Overview

Section 131(1)(d) of the *National Health Reform Act 2011* requires IHPA to determine "adjustments to the NEP to reflect legitimate and unavoidable variations in the costs of delivering health care services". Clause B13 of the National Health Reform Agreement (NHRA) additionally states that IHPA "must have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery including hospital type and size; hospital location, including regional and remote status; and patient complexity, including Indigenous status."

IHPA tests 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. IHPA's decisions are based on national data sources, but will be informed by additional data provided by states and territories where appropriate.

IHPA will examine patient-based characteristics in the cost of providing public hospital services as a first priority before considering hospital or provider-based characteristics. This policy reinforces the principle that funding should follow the patient wherever possible.

IHPA developed the [Assessment of Legitimate and Unavoidable Cost Variations Framework](#) in 2013 to assist state and territory governments in making applications for consideration of whether a service has legitimate and unavoidable cost variations not adequately recognised

in the National Pricing Model. If agreed, IHPA then determines whether an adjustment to the NEP is necessary to account for the variation. Jurisdictions may continue to propose potential unavoidable cost variations under the Framework on an annual basis.

6.2.2 Adjustments to be evaluated for NEP16 and feedback received

IHPA has analysed the proposals for adjustments which were identified and canvassed in the Consultation Paper. IHPA's position on the proposals and stakeholder feedback is provided below.

Patients with an intellectual disability

During IHPA's consultation on the Pricing Framework 2015-16, New South Wales, the Royal Australasian College of Physicians (RACP) and the Australian Association of Developmental Disability Medicine requested that IHPA review the costs of treating patients with an intellectual disability to determine whether an adjustment is necessary.

Feedback received

In their submissions on the Consultation Paper, New South Wales, the RACP and the QNU supported further consideration of whether an adjustment is warranted for admitted patients with an intellectual disability. The RACP referenced research indicating that persons with an intellectual disability are more likely to experience longer periods of hospitalisation than the general community and for care to involve multiple health care professionals.

Tasmania noted that cost data for patients with an intellectual disability is not robust and improvements to cost allocations are required prior to considering an adjustment.

IHPA analysed the national cost data for patients with diagnoses relevant to intellectual disability recorded for their care and concluded that the patient cohort was adequately priced in NEP15, suggesting that the Australian Refined Diagnosis Related Groups classification system adequately accounts for the costs of treating these patients.

Culturally and linguistically diverse patients

Some stakeholders have also suggested that IHPA should consider an adjustment for culturally and linguistically diverse (CALD) patients.

As national data sets do not capture the variables which allow for CALD patients to be identified, IHPA has used additional data sets held by states and territories to investigate whether an adjustment is warranted. This analysis indicates that the costs of CALD patients are not materially different from other patients at the national level.

Feedback received

Western Australia, WHA, CHA and the QNU supported further consideration of whether an adjustment is warranted for CALD patients. WHA and CHA were particularly concerned that the use of interpreter services is under-resourced for women's and children's hospital services.

IHPA published the [Culturally and Linguistically Diverse Patient Costing Study Report](#) in March 2015. The report concluded that an adjustment is not warranted for CALD patients and that significant improvements in the allocation of costs associated with providing interpreter services to CALD patients was required. IHPA recognises that the cost allocations for services specific to CALD patients can be improved and has referred this issue as a priority area for development in AHPCS Version 4. Victoria, South Australia, Tasmania and the RANZCO supported this approach in their submissions on the Consultation Paper.

Remoteness area adjustment

IHPA's current approach to the Remoteness Area Adjustment is to provide an adjustment for admitted patients accessing a public hospital service where that person's residential address is within an area that is classified as being outer regional, remote, or very remote in the Australian Bureau of Statistics' Australian Statistical Geography Standard Remoteness Area classification system. This approach reflects the legitimate and unavoidable costs of providing public hospital services in regional areas.

In their response to the NEP15 Determination, Western Australia requested that IHPA consider the issue of fly-in, fly-out workers and tourists (predominately from metropolitan areas) who are treated in outer regional and remote hospitals. Western Australia stated that its hospitals are at a disadvantage as the patients do not receive a Remoteness Area Adjustment because the adjustment is based on their residential post code.

Feedback received

In their responses to the Consultation Paper, New South Wales, Western Australia, Tasmania, the RANZCO and the QNU also supported IHPA considering hospital location when applying the Remoteness Area Adjustment.

Victoria and South Australia did not support a change for NEP16 to the Remoteness Area Adjustment as further analysis is required to demonstrate that it will materially add value to the National Pricing Model.

IHPA considers that the materiality of accounting for the small proportion of patients who are treated in hospitals which are more remote than their postcode is outweighed by the added complexity it would introduce to the National Pricing Model.

IHPA therefore does not intend to amend the Remoteness Area Adjustment for NEP16.

Emergency care age adjustment

IHPA committed in the Consultation Paper to exploring whether an age-related adjustment should be introduced for emergency care for NEP16.

Feedback received

In their responses to the Consultation Paper, Victoria, Tasmania, Catholic Health Australia, the RANZCO and the QNU supported investigating an emergency care age adjustment. Tasmania also requested that IHPA consider targeting an age adjustment to emergency care patients over 65 years in age.

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In analysing the data, IHPA found that a patient's age had a substantial impact on the cost of providing emergency care services and that these costs are not adequately accounted for in the Urgency Related Groups classification system. IHPA will therefore introduce an age-related adjustment for Emergency Department and Emergency Service patients for NEP16 and will confirm the final approach in the NEP16 Determination.

Feedback received on other adjustments

New South Wales recommended that IHPA consider an adjustment for trauma patients. IHPA has examined this issue and found that trauma patients were adequately accounted for in the National Pricing Model in NEP15 and does not propose to reconsider this issue in NEP16.

Western Australia recommended that IHPA consider an adjustment for hospital peer groups. IHPA has considered this issue on numerous occasions in prior years, with no evidence to suggest a systemic cost differential between hospitals on the basis of their peer group.

New South Wales and Tasmania recommended that IHPA expand eligibility for the Dialysis Adjustment to all admitted patients. IHPA has examined this issue and found that the cost differential for admitted subacute dialysis patients was not material.

Victoria recommend that IHPA consider discontinuing the Paediatric Adjustment given that the introduction of Version 8 of the Australian Refined Diagnosis Related Groups classification should have improved the measurement of paediatric patient complexity and its impact on cost. IHPA notes that AR-DRG Version 8 has reduced the cost difference for these patients, however the cost differential remains material enough to justify the adjustment. Tasmania supported the continued application of the Paediatric Adjustment.

The Australian and New Zealand Society for Geriatric Medicine recommended an adjustment for admitted patients with an existing diagnosis of dementia. This diagnosis impacts on the timely and efficient delivery of care, as well as delaying recovery from a health intervention. IHPA's view is that the admitted acute classification system already sufficiently accounts for a secondary diagnosis of dementia when determining patient complexity and IHPA has taken steps to address the diagnoses in Version 4 of the Australian National Subacute and Non-Acute Patient classification. As outlined in Section 4.4, a project is also underway to collect additional data on patients accessing geriatric evaluation and management services to inform future classification development.

The RANZCO recommended that IHPA consider whether an age-related adjustment is warranted for patients in other hospital settings, not just EDs. IHPA has considered this issue for admitted acute and subacute patients and did not identify a price differential which is attributable to age.

Victoria supported IHPA's decisions with regard to the additional adjustments proposed by other jurisdictions and stakeholders.

6.2.3 Stability of adjustments

In their submissions on the Consultation Paper, the Royal Australian and New Zealand College of Psychiatrists, WHA and CHA expressed concern regarding the volatility of pricing between

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years for some child and adolescent mental health services and paediatric services due to changes in the size of the Specialist Psychiatric Adjustment and Paediatric Adjustment.

IHPA reviews the stability of the adjustments applied to the NEP over previous years. For NEP14 and NEP15, adjustments were determined on a rolling average of up to three years of historical data in order to maximise stability of these adjustments. IHPA will continue this approach for NEP16.

IHPA revised its methodology for the Specialist Psychiatric Care Adjustment for NEP15 to better recognise the costs of providing these services to all admitted acute patients. This methodological change meant that IHPA was unable to stabilise the adjustment between NEP14 and NEP15. IHPA notes that changes in the size of the Paediatric Adjustment between years have also been driven by substantial changes in the underlying hospital cost data supplied by jurisdictions. IHPA intends to stabilise these adjustments for NEP16.

IHPA's decision

For NEP16 the Pricing Authority has determined to apply these evidence-based adjustments:

- Paediatric Adjustments for a person who is aged up to and including 17 years and is admitted to a Specialised Children's Hospital for admitted acute patients or treated in any facility for admitted subacute patients;
- Specialist Psychiatric Age Adjustment for a person who has one or more psychiatric care days during their admission, with the rate of adjustment dependent on the person's age and whether or not they have a mental health-related primary diagnosis;
- Remoteness Area Adjustment for a person whose residential address is within an area that is classified as being outer regional, remote, or very remote in the Australian Bureau of Statistics' Australian Statistical Geography Standard, with the rate of adjustment dependent on the person's geographical classification;
- Indigenous Adjustment for a person who identifies as being of Aboriginal and/or Torres Strait Islander origin;
- Radiotherapy Adjustment for a person with a specified ICD-10-AM 9th edition radiotherapy procedure code recorded in their medical record; and
- Dialysis Adjustment for an admitted acute patient who receives dialysis whilst admitted to hospital for other causes (and are not assigned to the AR-DRG L61Z Haemodialysis or AR-DRG L68Z Peritoneal Dialysis);
- Intensive Care Unit Adjustment for an admitted acute patient who has spent time within a Specified Intensive Care Unit;
- Private Patient Service Adjustment and Private Patient Accommodation Adjustment for admitted private patients;
- Multidisciplinary Clinic Adjustment for patients which have a service event involving three or more health care providers (each of a different specialty) in the non-admitted setting; and
- Emergency Care Age Adjustment is for patients who present to an Emergency Department or Emergency Service, with the rate of adjustment dependent on the person's age.

Specific details for these and any additional adjustments will be confirmed in the NEP16 Determination.

Next steps and future work

IHPA will continue to undertake a program of work to establish the factors resulting in legitimate and unavoidable variations in the costs of providing public hospital services.

IHPA will continue to review its existing adjustments as classification systems improve, with the aim of discontinuing adjustments associated with input costs or which are facility-based when it is feasible to do so.

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

7.1 Overview

The National Health Reform Agreement (NHRA) requires IHPA to set the price for admitted private patients in public hospitals accounting for payments made by other parties including private health insurers (for prosthesis and the default bed day rate) and the Medicare Benefits Schedule (MBS).

Under the NHRA, IHPA is prevented from pricing private non-admitted patient services.

7.2 Costing private patients

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

Special Purpose Funds generally do not appear in hospital accounts used for costing in the NHCDC. This leads to an under-attribution of total medical costs across all patients as costs associated with medical practitioners are applied equally across public and private patients.

In NEP15 IHPA corrected for missing medical costs by inflating the cost of all patients by 1.9 percent. This correction factor was based on Hospital Casemix Protocol data which enabled more specific identification of the missing private patients' costs.

In the Pricing Framework 2015-16, stakeholders broadly supported IHPA phasing out the correction factor in future years when it is feasible to do so. IHPA released Version 3.1 of the Australian Hospital Patient Costing Standards (AHPCS) in late 2014 for states and territories to use in Round 18 of the NHCDC. This version of the standards allows for a significant improvement in the way private patient costs are captured and will allow for the phasing out of the correction factor in the future.

IHPA's application of the correction factor assumes that all private patient costs are missing and that these costs are spread across both private and public patients. However, IHPA has identified some hospitals which appear to be reporting specialist medical costs in the NHCDC cost data.

IHPA will work with states and territories to better identify how private patient costs were included in the NHCDC for Round 18 and ascertain if any revision need be made to the existing methodology used to correct for missing private patient cost data.

Feedback received

Victoria, Queensland, Western Australia and Tasmania supported IHPA further investigating the varying costing approaches used by jurisdictions and their public hospitals to account for private patient costs.

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Western Australia, Tasmania and the Australian Capital Territory did not support the phasing out of the private patient correction factor as there is no consistent approach nationally to the identification of the medical costs of private patients.

IHPA's decision

IHPA will work with jurisdictions to verify the method used by each jurisdiction to account for private patient medical costs. This analysis will inform consideration of whether refinements to the private patient correction factor are required.

IHPA will confirm its final approach for the private patient adjustments in the NEP16 Determination.

Next steps and future work

IHPA has identified the costing of private patients as a priority area in the development of Version 4 of the AHPCS and will work with jurisdictions to further refine the approach for capturing these costs in the future.

8. Treatment of other Commonwealth programs

8.1 Overview

Under Clause A6 of the National Health Reform Agreement (NHRA), IHPA is required to discount funding that the Commonwealth provides to public hospitals through programs other than the NHRA to prevent the hospital being funded twice for the service. The two major programs are blood products, funded through the National Blood Agreement (NBA), and Commonwealth pharmaceutical programs including:

- Highly Specialised Drugs (Section 100 funding)
- Pharmaceutical Benefits Scheme (PBS) - Herceptin: Early Stage Breast Cancer (Section 100 funding)
- Pharmaceutical Reform Agreements - PBS Access Program
- Pharmaceutical Reform Agreements - Efficient Funding of Chemotherapy (Section 100 funding)

IHPA is not proposing to change the treatment of these programs for NEP16.

IHPA is working with jurisdictions to investigate how blood costs can be more accurately captured in the National Hospital Cost Data Collection (NHCDC) in future years.

Feedback received

The Australian Red Cross Blood Service (ARCBS) has continued to recommend a multi-stage approach to capture the full cost of blood products in the NHCDC. IHPA is working with jurisdictions to improve the way in which blood costs are captured in the NHCDC and expects these improvements to be incorporated into Version 4 of the Australian Hospital Patient Costing Standards. Victoria provided in-principle support for this exploratory work regarding blood costs.

The ARCBS has also continued to recommend the incorporation of blood costs into the NEP for public hospital services and the introduction of differentiated pricing to provide an incentive structure for managing the use of blood products. IHPA notes that any changes to the pricing of blood products will require amendment to both the NBA and the NHRA. Tasmania did not support the incorporation of blood costs into the NEP.

IHPA's decision

IHPA will maintain the existing approach of removing blood costs and Commonwealth pharmaceutical program payments from the National Hospital Cost Data Collection prior to determining NEP16.

Next steps and future work

IHPA will continue to work with jurisdictions and other stakeholders to develop an improved approach to the treatment of blood and blood products costs in future years.

9. Bundled pricing

9.1 Overview

Like many Activity Based Funding (ABF) systems internationally, IHPA has generally adopted an approach to pricing hospital services based on discrete episodes of care. For example, a patient who attends an Emergency Department and is subsequently admitted to hospital with a fractured neck of femur may then receive admitted rehabilitation services in a subacute setting. Under the existing approach to pricing, this would be considered as three discrete episodes of care.

IHPA recognises that there is potential to better align pricing incentives across settings for care paths such as those described above by introducing bundled pricing approaches, where a single price across three settings of care is determined. This potentially gives hospital managers greater room to develop innovative models of care for these patient groups, without being deterred by pricing models based around traditional care settings.

IHPA also recognises that bundled pricing for chronic conditions can significantly reduce the bureaucratic overhead associated with reporting activity on a regular basis. Therefore IHPA introduced bundled pricing for a number of home-delivered chronic disease services in NEP15 and these price weights will be retained for NEP16.

9.2 Bundled pricing in future years

IHPA has identified a number of services which could potentially benefit from bundled pricing. In the Consultation Paper, IHPA sought stakeholder feedback on whether the services below would benefit from a broader bundling approach, as well as nomination of additional services that IHPA should consider for future years.

Uncomplicated maternity care

IHPA is exploring the feasibility of a bundled price for uncomplicated maternity care services, including antenatal and postnatal services and the admission for birth. Uncomplicated maternity care services are potentially amenable to bundled pricing as they follow a relatively predictable care pathway with clear starting and concluding points to episodes. They are also high volume services, meaning that small improvements in service delivery can result in significant savings to the health system.

IHPA has completed a baseline review of the literature which has identified potential variation in the service delivery of different jurisdictions. [The Commonwealth Clinical Practice Guidelines – Antenatal Care](#) are nationally agreed guidelines for maternity care. They recommend seven (for subsequent pregnancies) to ten (for a first pregnancy) antenatal visits for a maternity care episode. A review of public data sources has indicated that over 86 per cent of pregnant women in South Australia had seven visits or more¹ and 97 per cent

¹ SA Health (September 2014) [Pregnancy Outcome in South Australia 2012](#), p.29

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had five or more in 2012.² However, approximately 15 per cent of women in the Australian Capital Territory had less than five antenatal visits in 2012.²

This data suggests that bundled pricing for uncomplicated maternity care could potentially support the implementation of the nationally agreed guidelines.

Stroke

IHPA is exploring the feasibility of bundled pricing for stroke patients across the entire episode of care, including admitted acute, subacute and non-admitted settings. Strokes may be amenable to bundled pricing as they are common, the care episode generally lasts for a definable period of time, and high costs offer potentially significant savings to the health system.

Due to differences in the severity of strokes, IHPA is considering bundled price weights which are weighted for complexity and notes that there are a range of issues involved in differentiating between stroke bundles.

Joint replacement

IHPA is exploring whether joint replacement (particularly for elective hip and knee replacement surgeries) is amenable to bundled pricing for care across settings.

IHPA has identified joint replacement surgeries as being potentially amenable to bundled pricing as they are high volume, span multiple settings (non-admitted pre-operative assessment, admitted acute, subacute and follow up) and have a relatively predictable care pathway for most patients.

Feedback received

IHPA's proposed approach to bundled pricing

South Australia, the Northern Territory, the Royal Australasian College of Physicians and Medtronic supported IHPA's proposed approach to bundled pricing in future years, noting it can encourage providers to coordinate patient care across multiple episodes and settings and increase health providers' accountability for delivering high-quality patient care.

New South Wales, Victoria, the Australian Stroke Coalition (ASC) and the Queensland Nurses' Union (QNU) gave in-principle support to further investigation of bundled pricing. This was conditional on bundled pricing being aligned with evidence-based models of care and cognisant of the broader context of the White Paper on the Reform of the Federation which is considering how health services should be funded and purchased. The ASC, National Stroke Foundation (NSF) and Medtronic added that that a bundled price should include clearly defined service inclusions and exclusions which are informed by clinical best practice and new health technologies. Victoria argued that implementation of a bundled pricing approach should follow an evaluation of its feasibility and the degree to which it aligns with IHPA's Pricing Guidelines.

The Commonwealth, Queensland, Western Australia, Tasmania, the Australian Capital Territory, the Royal Australian and New Zealand College of Ophthalmologists and Catholic

² AIHW (December 2014) [Australia's mothers and babies 2012](#), p.23

Health Australia did not support the proposed expansion of bundled pricing. The concerns were that it would unduly increase financial risk for jurisdictions as any cost variance would not be reimbursed, that it is not IHPA's role to use its pricing mechanisms to drive service improvement, that it would introduce more complexity into the National Pricing Model and that it would only cover public hospital services which does not confer significant benefit.

Bundled pricing options

Queensland, South Australia and Medtronic regarded services or patient episodes of care as amenable to bundled pricing if they are high volume, clinically homogenous and with highly predictable care pathways.

New South Wales, Medtronic, Maternity Choices Australia, the QNU, Women's Healthcare Australasia and Children's Healthcare Australasia supported IHPA further investigating the feasibility of bundled pricing for uncomplicated maternity care on the basis that it has an easily definable starting point and end point across all patients. The QNU added that bundled pricing for uncomplicated and complicated maternity care may incentivise midwife-centred continuity of care models which are associated with significant reductions in interventions such as epidurals, episiotomies and instrumental births.

New South Wales, the QNU and The Royal Australasian College of Physicians (RACP) supported IHPA further investigating the feasibility of bundled pricing for stroke care. These stakeholders as well as Queensland, Western Australia, Tasmania, the ASC, the NSF and Medtronic stated that this work must consider appropriate stratification for patient severity and complexity (for example ischaemic or haemorrhage).

New South Wales, the Australian and New Zealand Society for Geriatric Medicine, Medtronic, and the QNU supported investigating the feasibility of bundled pricing for elective joint replacement as it is high volume and the care provided has predictable outcomes for patients.

The Northern Territory and the RACP advocated exploring the benefits of applying a bundled pricing approach for patients at risk, or in the early stages, of chronic disease as it could lead to potentially significant cost savings to the health system if bundled pricing incentivises alternative models of care which lead to better patient outcomes.

Silver Chain recommended that IHPA consider bundled pricing for end of life care, specifically the last 90 days of life. Silver Chain noted research by the Grattan Institute that between 60 and 70 per cent of Australians would prefer to die at home, but the majority die in hospitals (54 per cent) or residential care (32 per cent).³ A bundled price could provide system managers with the financial flexibility to pursue alternative models of care, such as community based palliative care which reduces cost whilst improving the quality of patient care.

Implementation considerations

In their responses to the Consultation Paper, over twenty stakeholders provided a broad range of issues for IHPA to consider when investigating bundled pricing for future years.

³ Grattan Institute (September 2014) [Dying Well](#)

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Jurisdictions noted that there are currently data capability limitations which may prevent IHPA from identifying a patient's episode of care across settings. Jurisdictions also advised that IHPA should consider the administrative burden on system managers if it were to request a change in the way services are recorded to allow for bundled pricing.

South Australia, the QNU, the ASC, NSF and CHA also recommended that IHPA engage consumer groups, clinicians, professional bodies and health services in the formulation and implementation of any bundled price.

IHPA notes the many other issues raised by stakeholders. IHPA intends to work with jurisdictions and other stakeholders on the technical detail in developing any bundled price, including implementation concerns and broader stakeholder engagement.

IHPA's decision

IHPA will retain the non-admitted bundled price weights introduced in NEP15 for home-delivered chronic disease services.

IHPA will not introduce additional bundled price weights for NEP16.

Next steps and future work

IHPA will convene an advisory group comprising jurisdictions, clinicians and other key stakeholders to develop a bundled pricing approach for use in future years.

10. Pricing for safety and quality

10.1 Overview

Under Clause B12(a) of the National Health Reform Agreement (NHRA) IHPA must “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” in setting the NEP. The NHRA does not specify or constrain how IHPA might seek to give effect to this broad set of responsibilities. Clause B12(a) also indicates that IHPA have regard to other important policy objectives such as quality and access as it undertakes its price-setting role.

10.2 IHPA and the Commission collaboration

IHPA and the Australian Commission on Safety and Quality in Health Care (the Commission) are working in partnership to explore options for incorporating quality considerations in the NEP in the future. A Joint Working Party (JWP) of senior clinicians nominated by both organisations oversees this work.

The agencies are seeking to better understand how providing patient-level information to clinicians can improve quality. To this end, the agencies developed a draft national set of high-priority complications in 2014 and recently concluded a trial in four hospitals of this draft national set to assess whether it is clinically meaningful and useful, feasible to monitor and whether the complications are appropriately captured within administrative data sets. The findings of this study will be available later in 2015.

The JWP established a sub-committee in late 2014 to investigate potential approaches to best-practice pricing, with an initial focus on the management of hip fracture patients.

Under a best-practice pricing approach, prices are determined based on the health care provider delivering a best-practice standard of care to patients. This approach has the potential to incentivise best-practice care and, if implemented, augments the current ABF approach where prices are based on the average cost of care.

The sub-committee identified that a best-practice pricing scheme should be complemented by the provision of timely, relevant and comparable clinical information to clinicians.

The sub-committee has concluded its work and has recommended that IHPA develop a national best-practice price for hip fracture care for implementation in future years, subject to resolving a number of implementation issues. The best-practice price should align with the Commission’s [Hip Fracture Clinical Care Standard](#) as it forms the evidence-base for a national care pathway for hip fracture care which has support from clinicians and consumers.

A report detailing the proposed approach to best-practice pricing will be published by IHPA and the Commission in late 2015.

IHPA intends to work with jurisdictions and other stakeholders to further examine the viability and implications of implementing a best-practice pricing approach for hip fracture care in future years.

Feedback received

IHPA received broad support from jurisdictions and other stakeholders for introducing a best-practice pricing approach for hip fracture care in future years.

New South Wales, the Commission, Medtronic, the Medical Technology Association of Australia and the Australian and New Zealand Society for Geriatric Medicine supported IHPA's intention to introduce a best-practice pricing approach for hip fracture care in future years.

The Commonwealth, Western Australia and South Australia supported in-principle the introduction of a best-practice price, provided there is sufficient evidence to demonstrate that it will deliver improvements in patient outcomes.

Victoria supported the further development of a best-practice pricing approach for hip fracture care, whilst noting that this work may be pre-emptive in light of the uncertainty as to the Commonwealth's mechanism for funding public hospital services after 1 July 2017.

Although Queensland has implemented state-based pricing for quality for fractured neck of femur, Queensland opposes a national approach for pricing quality arguing that clinical and performance management is the responsibility of jurisdictions as the system managers. Tasmania stated its opposition on similar grounds.

Stakeholders provided a number of implementation considerations which IHPA will consider when determining a best-practice price for hip fracture care in future years. In particular, jurisdictions noted that work is required to augment their administrative data collection systems to ensure that they capture the best-practice indicators used for pricing. Other stakeholders were primarily concerned with ensuring strong and sustained clinical engagement, and that IHPA should ensure that there are no unintended consequences from introducing best-practice pricing that leave hospitals financially worse off.

IHPA's decision

IHPA will work with jurisdictions and other stakeholders to further examine the viability and implications of implementing a best-practice pricing approach for hip fracture care in future years.

IHPA will not make any adjustments to the NEP for safety and quality for NEP16.

Next steps and future work

In conjunction with a wide range of stakeholders, IHPA will work with the Commission to identify the suite of implementation issues that need to be resolved prior to confirming a best-practice pricing scheme for hip fracture care for future years. These issues include determining the cost of best-practice hip fracture care and ensuring that it aligns with the Commission's Hip Fracture Clinical Care Standard, developing data set specifications for the indicators selected to determine best-practice, as well as undertaking further rounds of stakeholder consultation.

IHPA and the Commission will also investigate the feasibility of using best-practice pricing for other conditions, informed by the Commission's work on clinical care standards.

11. The Evaluation of the Impact of the Implementation of National Activity Based Funding for Public Hospital Services

11.1 Overview

IHPA is undertaking an *Evaluation of the Impact of the Implementation of National Activity Based Funding for Public Hospital Services*. The evaluation's main objective is to understand the impacts of the national Activity Based Funding (ABF) system as to allow for its continuous improvement. The evaluation has two phases:

- Phase one is the development of an evaluation framework methodology and establishment of a baseline; and
- Phase two is the undertaking of the evaluation using the criteria and baseline.

Focusing on the first four years of national ABF implementation (2012-13 to 2015-16), the evaluation will assess changes arising from the implementation of ABF such as:

- Efficiency of health services (service delivery costs, activity levels);
- Efficient allocation of resources (resource usage, use of ABF as a management tool);
- Transparency of funding arrangements (publication of information);
- Sustainability of financing (information to support decision making);
- Quality, safety and appropriateness of care (quality of care indicators, length of stay, appropriateness, patient safety);
- Access to public hospital services (access to health care services including in terms of time and equity of access); and
- Identification of possible expected and unexpected incentives (changes in practices, changes in provision of care).

The evaluation will also examine the national ABF system's impact on data collections and the use of data.

In mid-2014 IHPA engaged an independent consortium to undertake phase one of the evaluation. Phase one is expected to be completed in the first half of 2016 and a report published on IHPA's website.

The Pricing Authority is yet to determine when phase two will be undertaken.

Feedback received

New South Wales and Western Australia provided in-principle support for the evaluation.

The Commonwealth, Queensland, South Australia, the Northern Territory and Catholic Health Australia supported undertaking phase two of the evaluation in 2016-17 as it will improve the design and implementation of ABF systems in the future, as well as highlighting the effects of a national ABF system. Queensland argued that the evaluation needs to be completed prior to development of the 2017-18 NEP Determination and Federal Budget.

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Victoria provided in-principle support for the evaluation of national ABF and recommended that it focus on the impact of the introduction of ABF across jurisdictions and local system management processes.

The Australian Capital Territory argued that phase two of the evaluation appears less relevant and would be of questionable value given the Commonwealth Government's proposed changes to public hospital funding arrangements from 1 July 2017.

Next steps and future work

Phase one is expected to be completed in the first half of 2016 and the Pricing Authority will subsequently consider the timing for phase two.

12. Setting the National Efficient Cost

12.1 National Efficient Cost 2016-17

The National Health Reform Agreement (NHRA) recognises that some services are better funded through block grants, including relevant services in regional and rural communities or services where the technical requirement for applying ABF are not able to be satisfied (Clause A1(c)-(e)).

The NHRA requires IHPA to establish block funding eligibility criteria, which are:

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.

Through the Pricing Framework 2015-16 IHPA introduced revised 'low volume' thresholds to determine whether a public hospital is eligible to receive block funding. IHPA considered the underlying data to be sufficiently robust to include all activity in the low volume thresholds and not just the admitted acute activity. 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 (ASGS)) and they provide $\leq 1,800$ acute inpatient NWAU per annum; or
- in a rural area (defined as all remaining areas, including 'inner regional', 'outer regional', 'remote' and 'very remote' in the ASGS) and they provide $\leq 3,500$ total NWAU per annum.

In accordance with the NHRA, IHPA provided these new criteria to the Council of Australian Governments (COAG) for approval. Without pre-empting a decision by COAG, IHPA proceeded to implement these revised activity thresholds in NEC15.

In NEC15 IHPA also introduced a new statistical methodology for calculating a small rural block funded hospital's efficient cost based on hospital size, location and type.

These refinements to the NEC model were broadly supported by stakeholders and have improved the model's stability and predictability within and between hospital groupings, as well as across years, and will lead to greater accuracy in determining hospital eligibility for block funding from year to year.

IHPA has evaluated the impact of the Modified Monash Model remoteness classification on the NEC model and determined that it would not deliver a clear improvement to identifying costs associated with hospital remoteness in the block funding model and may have the unintended consequence of disadvantaging small rural hospitals in outer regional areas.

IHPA is not proposing any major changes for NEC16, given the significant methodological improvements made to the block funding model in NEC15. In 2016, IHPA will continue to work with states and territories to improve the reporting of expenditure and activity data for small hospitals, and undertake further research to better understand the cost drivers of small hospital services.

12.2 Block funded services in Activity Based Funded hospitals

IHPA determines block funding amounts based on jurisdictional advice for a range of services in public hospitals which do not meet the technical requirements for applying Activity Based Funding (ABF). In NEC15, these services were teaching, training and research (TTR), non-admitted mental health services and services on the 'A17 List' which are not subject to ABF.

IHPA will continue this approach in NEC16 and until such time that these services are able to be incorporated into the ABF classification systems. Detail on the specific services which will receive block funding will be confirmed in the NEC16 Determination.

IHPA's decision

IHPA will continue the methodology used in NEC15 for determining NEC16.

For NEC16 IHPA will continue to block fund teaching, training and research expenditure in Activity Based Funded (ABF) hospitals, non-admitted mental health services and non-ABF services on the 'A17 List'.

Next steps and future work

IHPA will continue to explore refinements to the NEC model in future years, with the intention of further improving the model's stability and predictability within and between hospital groupings.