Northern Territory Department of Health Response to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19

4. Classifications used by IHPA to describe public hospital services

4.3 Australian Refined Diagnosis Related Groups classification

Consultation question

- What additional areas should IHPA consider in developing Version 10 of the Australian Refined Diagnosis Related Groups classification system?
- Do you support the phasing out of older versions of the Australian Refined Diagnosis Related Groups classification system?
- What time frame would be sufficient for the health care sector to transition to the more recent versions of the classification?

The NT considers that contemporary revisions to Versions 8 and 9 will not be fully understood for several years as there are long lead times for the classification to be effectively applied.

Notwithstanding the new complexity that each version introduces, the NT considers that practical constraints such as system enhancements, lengthy educational programs and performance evaluation of coded results contribute to delays in its effective implementation. These limitations are compounded by a shortage in skilled workforce and especially the ability to attract and retain such staff in remote locations.

Given the above, NT questions the value of general refinement of the AR-DRG systems biannually and suggests that the IHPA instead undertake comprehensive analysis to identify any specific limitations with the contemporary classification systems. Work could then be targeted to address agreed objectives and proposed refinements will have defined or anticipated outcomes for funding and pricing models.

A key objective that the NT supports IHPA investigating is the ability of Version 9 to capture chronic illness that is prevalent in remote Australia. It is well documented that the "total burden of disease is higher among people living in the Northern Territory, Very remote areas, areas of the lowest socioeconomic group, and among Aboriginal and Torres Strait Islander people"[1].

Indirectly and through use of patient loadings, it is agreed that remote patients cost more. Such patient level loadings in large part recognise the limitation of the classification system to reflect these significant cost variations. On this basis the NT supports that IHPA undertake targeted investigations of the limitations to Version 9 and develop refinements to address these in Version 10 including anticipated outcomes for pricing and funding models.

[1] AIHW 2017. The burden of chronic respiratory conditions in Australia. Australian Burden of Disease Study series no. 14. Cat. no. BOD 15. Canberra: AIHW.

4.5.1 Multidisciplinary case conferences where the patient is not present

Consultation question

- Do you support the proposal to shadow price non-admitted multidisciplinary case conferences where the patient is not present for NEP18?

NT notes that the report on non-admitted MDCC recommends that in addition to revised definition of a MDCC and amendment to the non-admitted counting rules to support reporting of these activities that..

.. *"A study collecting event level cost driver data would need to be considered to obtain a more reliable estimate of MDCC's costs. Such a study would also enable an assessment of whether or not multiple MDCC classes are warranted."*

The report also identifies that it will be difficult to ensure consistent application of a definition without the introduction of more robust administrative processes. This will likely introduce a higher burden of documentation on health services and may unduly constrain how an MDCC can operate.

To enable the counting and classification of MDCCs, existing data collection processes will need to be modified. In the short to medium term it will be difficult for health services to modify their systems to accommodate the collection of this data. A work-around solution would need to be adopted by health services, which itself could create problems with consistency and accuracy.

Given these findings, the NT does not support shadow price for non-admitted multidisciplinary case conferences until:

- An appropriate costing study is undertaken to identify cost drivers and facilitate comparable results of cost analysis nationally;
- a mechanism of assurance can be developed to ensure consistent application nationally as this data will inform price weights nationally; and
- data collection issues are addressed such that they do not unduly constrain MDCC operations.

4.5.2 Home ventilation

Consultation question

- Do you support investigation of the creation of multiple classes in the classification for home ventilation?

The NT supports creation of multiple classes of home ventilation. Should cost data not support the creation of multiple classes, NT supports IHPA block funding these services given national volatility.

5. Data collection

5.1 National Hospital Cost Data Collection (NHCDC)

The importance of the NHCDC continues to increase, especially as counting and classification elements improve and pricing models become more complex. The last strategic review of the NHCDC was undertaken in 2013 and since then the majority of priority areas have been addressed. The NT supports that the IHPA undertake a further strategic review of the NHCDC to assess what significant priority areas exist for development in the medium to long term.

A priority area for the NT is to improve the NHCDC's ability to inform remoteness loadings in emergency department and non-admitted data. Historically, IHPA's analysis has indicated that due to poor cost data for both non-admitted and emergency department care, Indigenous and locality adjustments are not possible to calculate in the same way as they are in the admitted patient care setting where data is of high quality and has a long time series. This limitation serves to disadvantage the NT considerably (this is further discussed in section 6.2– Adjustments to the National Efficient Price).

5.1.1 Australian Hospital Patient Costing Standards (AHPCS)

Nationally, there is a shortage of a skilled labour force in the area of patient product costing, where local knowledge and business process have a strong influence in what is provided to the NHCDC. The NT supports that IHPA investigate contemporary costing methodologies, such as time-driven activity-based costing in value-chain process, which may be suitable for implementation in a health care environment. Other concepts the IHPA may consider is segment reporting within the NHCDC to enhance the transparency of interdepartmental services that occurs within hospitals and address issues of costing clinical liaison services or other similar "intermediate products".

These innovative costing methods are to provide strategic focus for future development of the AHPCS and ensure that cost results maintain the precision required for increasingly complex pricing and funding models. The NT considers that such focus will also help to strengthen hospital costing in Australia through judicious adoption of more mainstream management accounting methods, increasing transparency, skill transferability and national comparability of cost results.

The NT also supports that the IHPA develop educational material and information sharing opportunities to assist the continued development of the national labour force and promote consistency in application of the AHPCS. Specifically, the NT would support tools such as an online forum for contributors to share how they apply the AHPCS at a hospital level and allow knowledge to more easily transfer across the nation and be retained over time. Given the recent development of version 4 of the AHPCS, such a tool will be instrumental in accelerating its implementation nationally but also help identify limitations of the standards that may have been missed during their development. The NT supports that the IHPA provide leadership and coordination for such strategies and investigate innovative ways to consolidate costing knowledge from around the nation.

6. Setting the National Efficient Price for activity based funded public hospitals

6.1 Technical improvements

Consultation question

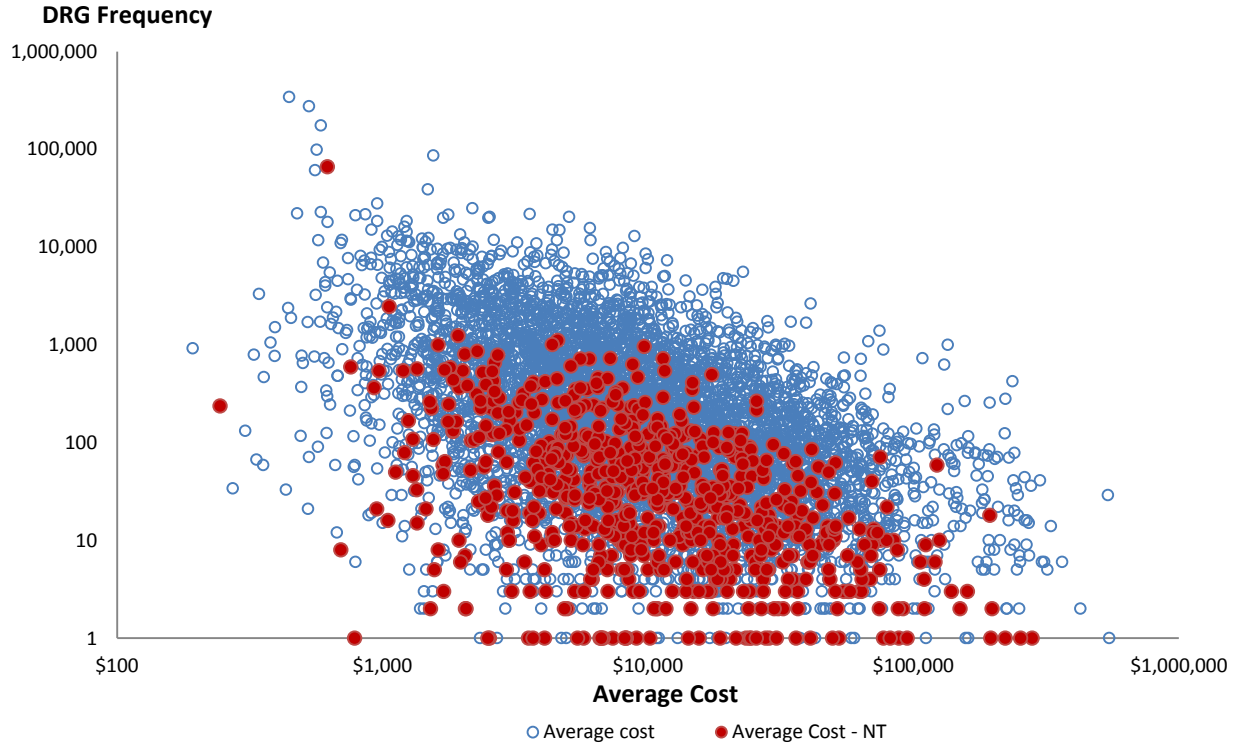
- Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2018-19?

Scale and scope

The NT believes that structural constraints can affect a hospital facility's ability to operate at the national efficient price and this limitation is directly related to the scale and scope of services that it provides. The concepts of efficiencies that are achieved through scale versus scope is not new, however the NT believes that the pricing framework unfairly disadvantages smaller facilities that cannot achieve the volume of activity for all the services that it must deliver.

A high level analysis of national NHCDC 2014-15 data, illustrated in Chart 1 below, shows that at the state level, the average DRG's cost has a negative association to the frequency of that DRG. Plainly, as a system, the more separations in a DRG that are provided by a jurisdiction the better is that jurisdiction's ability to provide each separation at a lower average cost.

Chart 1: Scale economies in hospital cost, state level DRGs, 2014-15 NHCDC



Importantly and when compared with nationally, NT DRG data are clustered around the lower right hand of the graph, indicating NT faces both lower volume and higher cost because of the lower volume operation for its scope of services. On average, the NT has 80% fewer separations per DRG, which cost about 15% more than nationally.

Table 1: Geometric mean of DRG separations and average cost

	Geometric State Mean	
	Separations per DRG	Average cost per DRG
Nationally	128	$9,293
NT	26	$10,614
Per cent difference	-80%	14.2%

It is acknowledged that the above analysis does not account for patient loadings incorporated in IHPA's pricing framework and that it reflects a state level analysis, however this analysis demonstrates in simple terms that scope and volume of services provided will impact a system to lower its average cost. The Pricing Framework focuses on patient criteria almost exclusively, which means that such structural issues will not be addressed. The examples where structural constraints are factored in to the Pricing Framework are loading for high cost services such as ICU and paediatrics, however these would exclusively address large hospital facilities in urban centres.

The NT strongly recommends that the IHPA investigates the extent to which structural limitations can limit small facilities ability to operate at the efficient price, and ensure that such facilities are not unfairly penalised in the National Pricing Framework.

6.2 Adjustments to the National Efficient Price

Consultation question

- What are the priority areas for IHPA to consider when evaluating adjustments to NEP18?
- What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.

Current Pricing Framework Loadings

The experience of hospital clinicians in the Northern Territory is that Indigenous and remote patients suffer more serious illnesses and injuries, and take more time in both outpatients and the emergency department than other Australians, and therefore the locality adjustments should also apply to emergency department and non-admitted patients.

The absence of a remoteness loading for emergency and non-admitted services serves to disadvantage the NT considerably and in effect provides incentive for hospital services to be provided in an admitted setting as cost pressures for the NT are less well recognised in other settings. Where services cannot be provided in an admitted setting, the NT effectively forgoes locality and Indigenous loadings for which it is known that cost pressures exists.

The effect of this is demonstrated in the below scenario model (Table 2), which takes the total NWAU for Tennant Creek Hospital, which provides a significant volume of renal dialysis as an admitted service. This scenario assumes that current renal dialysis, which is provided as admitted services, is provided as a non-admitted service. The results show that in this case Tennant Creek Hospital would be severely disadvantaged and would forgo the remoteness adjustment that is applied to the admitted settings, in effect reducing its funding levels by over 11%.

Table 2: Renal dialysis NWAU (NEP 17) impact scenario.

Adjustment element	Setting	NWAU		Total
		Other	Renal	
Base price weight				
	NA	698	-	698
	ADM	1,484	746	2,231
	ED	1,052	-	1,052
Sub Total		**3,234**	**746**	**3,981**
Adj: activity inflator				
radio	ADM	-	-	-
dialysis	ADM	13	-	13
Sub Total		**13**	**-**	**13**
Adj: inflate client cost				
Indigenous	NA	26	-	26
	ADM	49	29	79
	ED	31	-	31
Age	ED	12	-	12
		-		-
Private pat	ADM	1		1
Remoteness	ADM	358	186	544
Sub Total		**476**	**215**	**691**
Adj: inflate provider cost				
ICU	ADM	-	-	-
spa	ADM	-	-	-
multiprov	NA	-	-	-
paed	ADM	-	-	-
Sub Total		**-**	**-**	**-**
Total		**3,723**	**961**	**4,685**
Renal scenario - should renal dialysis be provided as a Non Admitted services				
Base price weight	NA		419	
adj_indigenous	NA		17	
Sub Total			**436**	
Total		**3,723**	**436**	**4,159**

This scenario demonstrates that facilities that provide services to remote population are disadvantaged to the extent that they do not admit these patients and are able to appropriately

recognise a remoteness loading. Across the NT, a great number of services are provided in communities and remote centres, which are delivered as outpatients clinics via a specialist outreach program.

NT recommends that IHPA standardise funding between settings (admitted or non-admitted), including any known loadings, where services are standardised such as renal dialysis and chemotherapy. NT also recommends that IHPA apply the remoteness loading to non-admitted and emergency settings acknowledging that this is a real cost pressure which is accurately evaluated in the admitted setting.

Inter Hospital Transfers

The NT notes that under the National Health Reform Agreement, services are to be subject to activity based funding wherever practicable. The NT also notes the national commitment to the Medicare principles, which includes making arrangements to ensure that equitable access to health and emergency services for all eligible persons, regardless of their geographic location.

The NT maintains that IHPA's proposed approach of including high cost outlier episodes in calculation of the Patient Remoteness Area Adjustment fails to fully recognise the large unavoidable expenditure associated with interstate transfer. For the NT, the shortfall is estimated at just under $15 million and this represents a material deficit for a small jurisdiction.

The NT strongly recommends removing these elements from the NEP and associated adjustments and transitioning to a block funding arrangement.

9. Setting the National Efficient Cost

9.1.1 Transferring services from ABF hospitals to block funded hospitals

Consultation questions

- Should IHPA ensure that there is no financial penalty due to the transfer of public hospital services from ABF hospitals to block funded hospitals?
- If so, how should this be carried out?

NT supports that there should be no financial penalty in transferring services from an ABF hospital to block funded hospital. NT recommends that IHPA investigate an option to carry this out for consideration by jurisdictional stakeholders.

9.3.1 Residential mental health care services

Consultation question

- Do you support IHPA's proposal to continue to block fund residential mental health care in future years?

NT supports continuation of to block funding for residential mental health until appropriate volume of activity and data are available to identify cost drivers.

10. Bundled pricing for maternity care

Consultation questions

- Do you support the proposed bundled pricing model for maternity care?
- Do you agree with IHPA's assessment of the preconditions to bundled pricing?
- Do you support investigation of whether the Individual Healthcare Identifier or another unique patient identifier could be included in IHPA's national data sets?

The NT supports implementation of bundled pricing for maternity care and agrees that consistent patient identifiers across settings as a way to link services is a key prerequisite to effectively price and fund bundled services. The NT supports the IHPA investigating appropriate patient identifiers for inclusion in future data collections.

11. Innovative funding models

Consultation questions

- What issues should IHPA consider when examining innovative funding model proposals from jurisdictions?
- Should IHPA consider new models of value-based care, and what foundations are needed to facilitate this?

The health status of Indigenous patients in the Northern Territory is worse than any other sub-population in any other jurisdiction in Australia. Further effort and resourcing is required to make real improvements, with innovative services and funding approaches in order to "close the gap" between the health outcomes of Indigenous people and other Australians.

Future funding models should build on the existing models, and including exploring means of taking into account the following material cost drivers:

- the underlying health status of the population utilising the health services. As indicated above, funding should have a view to improving overall outcomes with an emphasis on the most disadvantaged. The funding model should recognise the unique funding needs to achieve these outcomes for a population segment;
- the interaction between scale, scope and cost in hospitals which will always have smaller volumes; and
- access to health care that better identifies isolation of patients and incorporates measures for population density.

12. Pricing and funding for safety and quality

Application of funding adjustment

Consultation question

- Do you support the proposed risk adjustment model for HACs? Are there other factors that IHPA should assess for inclusion in the model?
- Do you agree that HACs third and fourth degree perineal lacerations during delivery and neonatal birth trauma be excluded from any funding adjustment?

The NT supports the risk adjustment model. Over the shadow funding period, NT expects maturity of HAC data to continue to improve. NT recommends that IHPA and ACSQHC continue to review the list of nationally agreed HACs and their risk adjustments in light of any significant data improvements.

NT supports exclusion from any funding adjustment of third and fourth degree perineal lacerations during delivery and neonatal birth trauma.

12.6.3 Criteria for assessing pricing and funding options

Consultation question

- Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing and funding adjustments for avoidable hospital readmissions? Are there any other criteria that should be considered?

The NT supports use of these assessment criteria.