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

Our Ref: F-AA-72056-8
Contact: Giulia Clifford (08 9222 2458)

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Via email: James.Downie@ihpa.gov.au
submissions.ihpa@ihpa.gov.au

Dear Mr Downie James

CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR PUBLIC HOSPITAL SERVICES 2022-23 – WA SUBMISSION

Thank you for the opportunity to provide a submission to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022-23.*

Western Australia's consolidated feedback is provided in Attachment A.

The State's response to the COVID-19 pandemic has resulted in substantial changes to service delivery, models of care and activity levels across all areas of the Western Australia (WA) health system. These changes have significant implications on the costing and pricing of public hospital services and will need to be investigated and accounted for over the next several years.

WA will continue to monitor the outcome of the second year shadow pricing of admitted mental health services during 2021-22 to ensure any cost variations within each of the end classes of the Australian Mental Health Care Classification (AMHCC) and cost variations across jurisdictions are adequately addressed.

It is recommended that shadow pricing of community mental health services using the AMHCC continues in 2022-23. This will allow WA to develop and implement relevant costing systems and processes.

189 Royal Street East Perth Western Australia 6004
Telephone (08) 9222 4222 TTY 133 677
PO Box 8172 Perth Business Centre Western Australia 6849
ABN 28 684 750 332
www.health.wa.gov.au

WA is supportive of IHPA's plans regarding funding model enhancements and continued investigations of alternative funding models. WA would welcome an incentive-based approach to avoidable hospital readmissions and will continue working with IHPA on improving patient safety and quality outcomes.

Please note that further comments will be provided during the statutory 45-day Ministerial consultation period when the Draft Pricing Framework 2022-23 is released.

If you have any queries, please contact Pratthana Hunt, A/Director Budget Strategy on (08) 9222 4340 or at pratthana.hunt@health.wa.gov.au.

Yours sincerely

Angela Kelly
A/DIRECTOR GENERAL

8 July 2021

Att: A: WA Submission

ATTACHMENT A

WESTERN AUSTRALIA'S SUBMISSION TO THE

CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2022-23

Introduction

Western Australia (WA) welcomes the opportunity to provide feedback to the Independent Hospital Pricing Authority (IHPA) on the *Consultation Paper for the Pricing Framework for Australian Public Hospital Services 2022-23*.

Impact of COVID-19

1. ***Consultation Question - What feedback do you have on IHPA's proposed approach for using the 2019–20 cost and activity data to assess the short-term activity and potential pricing impacts of COVID-19 on NEP22?***

WA supports in principle IHPA's approach to investigate the available COVID-19 impacted costed activity data for the 2019-20 period (3 months). It should be noted that the short-term impacts observed using 2019-20 data have become longer term and potentially permanent hospital costs.

WA supports early analysis of relevant data to understand and inform potential pricing impacts of COVID-19 on NEP22. However thorough analysis should be undertaken, particularly with respect to pricing relating to changes in hospital service delivery and models of care. Those have changed multiple times over the pandemic journey and in some instances will not revert to pre-COVID-19 service delivery/models of care e.g. the use of PPE in hospital setting and increase in virtual care. It is possible that what changed in 2019-20 will have changed again in 2020-21 and will also be different across jurisdictions due to the varying impact of COVID-19 in each State/Territory. Similarly, within jurisdiction there may be changes, perhaps not evident in the cost data, related to changes in patient care. For example, WA rural hospitals had very few specific COVID-19 clinics, meaning patients presented to Emergency Department (ED) regardless of COVID-19 like symptoms whereas in the metropolitan area, patients presented or were directed immediately to COVID-19 fever clinics for COVID-19 like symptoms. Hence there was a significant drop in Urgency Related Group respiratory related ED presentations in metropolitan versus rural WA. An additional impact worth understanding is changes to elective surgery patterns i.e., the on and off nature of non-urgent elective surgery and possible flow on effects to acuity and cost.

Any COVID-19 activity and cost analysis using 2019-20 data needs to be balanced with analysis of all cost and activity data as patterns/changes may be presented regardless of any perceived impacts from COVID-19, such as change in Diagnosis Related Groups (DRG) version, diagnosis complexity and coding practices.

WA is looking forward to working closely with IHPA during the workshops planned for July and August 2021 to refine the approach for NEP22 and ensure changes in service delivery, volume and cost of activity are appropriately captured.

2. *Consultation Question - Are there any recommendations for how IHPA should account for COVID-19 in the coming years?*

While COVID-19 has resulted in reduced presentations in 2019-20, changes in practise and protocol to respond to the pandemic will likely push up per patient unit costs in future years due to the following factors:

- increased personal protective equipment (PPE) use;
- increased use of isolation facilities in hospitals for patients with or suspected of having COVID-19;
- repurposing of existing hospital space for creation of makeshift isolation accommodation in general wards;
- increased utilisation of COVID-19 pathology tests;
- increased use of other diagnostics to exclude COVID-19 complications or make positive alternative diagnoses;
- staff contingency models such as surge capacity to ensure business continuity e.g. for frontline health professionals. At the same time this is happening, there will be health professionals with possible COVID-19 exposure who will have to take time off (possibly at the same time in some areas), therefore reducing the available workforce;
- potentially higher staff costs due to the need to perform surgeries after hours and on weekends to manage backlogs;
- increased training required to ensure frontline health professionals are practice ready earlier than normal given the above and potential for reduced staff;
- workforce shortages and pressures including related to management of accrued leave once travel restrictions are lifted;
- addressing the health needs of vulnerable and complex patients who had cancelled appointments at the start of the outbreak who may now suffer an exacerbation of their conditions and that require more intensive attention and treatment;
- increased transport costs due to potential relocation of patients as isolation requirements for suspected/probable/confirmed COVID-19 patients can significantly reduce sites' capacity; and
- increased community accommodation costs for patients fit for community isolation but without alternative means of safe isolation e.g. Indigenous patients from remote communities who cannot safely isolate or quarantine in their communities while awaiting test results or completion of quarantine period.

Regarding changes in models of care, WA notes that some specialist services which are for the most part outpatient based have moved to primarily telehealth-based care. This brings with it its own set of issues as services as a matter of new policy have had to offer telehealth as a substitute to any face to face appointments which are classified as non-urgent, even when patients are reluctant to use this medium. This resulted in

several cancelled appointments and additional administrative burden related to appointment booking management.

It is recommended that changes discussed in detail in Question 2, should be investigated and accounted for over the next several years.

Classifications used to describe and price public hospital services

Development cycles for classifications

3. ***Consultation Question – Do you support the proposal to establish standard development cycles for all classification systems***
4. ***Consultation Question – Is there a preferred timeframe for the length of the development cycle, noting the admitted acute care classifications have a three-year development cycle?***

WA is supportive of establishing standard development cycles for all classification systems over time or at the very least a review process that, depending on outcomes, would lead to a development cycle. This should be balanced with the change/implementation requirements and challenges that jurisdictions may have including associated costs.

Although it may not always be practicable, reviewing classification systems on the same cycle would result in better synergies and understanding of changes and the flow on impact.

On occasions, reviews or developments should be considered outside the standard development cycle if warranted by significant changes in service delivery or other relevant circumstances. The complexity and scale of changes should be taken into account.

Some stakeholders indicated that while a shorter cycle would better support clinical currency and represent the ever-changing landscape in regard to the new service and technologies, a large complex change would require significant work to be completed locally.

The length of the development cycle may be dependent on the maturity of the classification. For example, it may be better to review the Australian Emergency Care Classification (AECC) sooner as it is a newer classification than the Australian National Sub-acute and Non-acute Patient (AN-SNAP) classification which is more mature and less subject to material changes.

As a starting point, similar to acute admitted classifications, WA supports a three-year development cycle for all the classifications to best capture a broad scope of classification updates and to allow sufficient time for uptake and implementation.

As provided in the Addendum to the National Health Reform Agreement 2020-25 (the Addendum), jurisdictions need to be provided with adequate time to implement any major changes before pricing based on the revised classification commences.

5. ***Consultation Question – Do you have any feedback on what measures should be standard as part of the review and development of an updated version of an established classification?***

WA supports the establishment of a minimum set of measures to aid standard development cycle. These measures could include:

- assessment of classification performance using the latest cost and activity data;
- review and refinement of complexity splits;
- review of variables contributing to complexity,
- review of existing variables and consideration of new ones used for grouping;
- consultation with health consumers;
- user acceptance testing across clinical and corporate users; and
- review of ICT infrastructure capability e.g. for coding written records vs electronic medical records.

It should be noted that socioeconomic status including homelessness has been recommended by a number of stakeholders for review in all settings.

Subacute and Non-Acute Care

6. ***Consultation Question – Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute service for NEP22?***

WA does not foresee any barriers to using AN-SNAP V 5.0 to price admitted subacute and non-acute services for NEP22.

WA supports modest changes to the classification including:

- the proposal to recognise frailty as a cost driver for subacute care by incorporating a Frailty Risk Score into the classification of geriatric evaluation and management and non-acute episodes of care;
- inclusion of a new impairment type group for joint replacement activity;
- changes to the complexity threshold used for splitting episodes; and
- changes to the order that variables are applied.

In relation to the suggested use of the Rockwood Clinical Frailty Scale, WA is currently not collecting the item and work needs to be progressed to assess feasibility of doing so.

Non-Admitted Care

7. ***Consultation Question - How can IHPA support state and territory readiness for recommencing the non-admitted care costing study?***

A number of WA sites committed to participating in the study. Six of them commenced and one completed data collection before it was put on hold due to COVID-19. Participating sites would be keen to review the results and feedback regarding the robustness of data collection. The following steps would be beneficial in re-engaging the sites:

- provide analysis and outcomes of additional data captured in the pilot and costing study;
- disseminate lessons learnt from the pilot to study sites;
- re-survey of participants to establish availability of resources given that there will have been operational changes at many sites; and
- develop a revised workplan.

It should be noted that COVID-19 preparedness and response remain a priority for health services and increasing pressures related to the demand for hospital services may pose as significant barriers.

Whilst the evolving pandemic continues to bring challenges to public hospitals, it also provides opportunities to redesign services and delivery models e.g. expansion of telehealth. Some work practices have changed to adopt to the 'new normal' and the costing study should recognise these changes including current service delivery models.

Noting not all sites have an electronic medical record yet, there may also be significant variation across jurisdictions resulting from differing levels of digital maturity.

WA would welcome the opportunity to be involved in discussions around planning to re-commence the study as soon as it is practical to do so.

8. *Consultation Question - Are there any impediments to pricing admitted and community mental health care using AMHCC Version 1.0 for NEP22?*

Admitted Services

The 2019-20 dataset is the first one in which WA has included costs for admitted mental health services at phase of care level. WA has experienced some technical challenges and constraints that make it difficult to allocate costs correctly at the phase level.
A potential impediment to pricing mental health services is data quality and significant cost variation within each AMHCC end class. It would be important to understand the cost variations across each jurisdiction which could have unintended incentives for services not being appropriately priced. WA will continue to monitor the analysis outcome of the second year shadow pricing.

Community Services

WA does not currently cost community mental health services however work is in progress to address costing requirements. Additional time is required for implementing costing systems and processes to address the gaps. WA is aiming to commence costing at phase level using the 2021-22 data.

Second year of shadow pricing of community services should continue in 2022-23 as provided for in the Addendum to determine if data is robust enough for pricing purposes.

Although not directly related to Question 8, stakeholders suggest that 'attendances not admitted under psychiatry, but with psychiatry input' requires more robust data

capture of patient characteristics and admitting diagnosis to reflect complexity – a consideration for future AMHCC revisions.

SETTING THE NATIONAL EFFICIENT PRICE

9. *Consultation Question - What costs associated with patient transport in rural areas are not adequately captured by existing adjustments within the national pricing model?*

WA suggests that the adjustment for patient transport should incorporate the cost of escorts to accompany patients from their rural homes to specialist care. Rural patients facing hospitalisation alone are disadvantaged in every aspect of hospitalisation. The provision of patient escorts would improve comfort, communication, and adherence to care including reducing discharge against medical advice, hence addressing the psychosocial aspects of medical care which can be as important as the biomedical aspects.

While there are State and Territory based Patient Assisted Travel Schemes, a review of these schemes revealed their non-uniform principles of eligibility, and non-uniform and inadequate travel and accommodation benefits. It is essential that such costs are captured to ensure appropriate funding of patient transport services so that patients may access clinically appropriate specialist care in a timely manner, whether ambulatory or inpatient.

Royal Flying Doctors Service inter hospital transfers and associated data linkage to costed encounters are problematic or non-existent, which makes assessment of adequacy difficult.

10. *Consultation Question - What factors should IHPA consider in reviewing the Specified Intensive Care Unit eligibility criteria and adjustment?*

WA would suggest that the current key metrics related to the time a patient spent in ICU and hours on mechanical ventilation appear practical and are easily validated. However, WA recommends that CMV hours cut-off value be re-visited for appropriateness moving forwards. Patient acuity metrics and level/type of ICU should also be considered to understand whether these will affect the level of adjustment.

11. *Consultation Question - What factors should IHPA consider in reviewing the Indigenous adjustment?*

In reviewing the Indigenous adjustment, IHPA should focus on changes that translate into tangible and equitable hospital care outcomes and measures between Aboriginal and non-Aboriginal patients in the foreseeable timeline.

A few factors have been recommended by WA stakeholders as worth reviewing:

- cultural competency and governance within a service e.g. assistance of Aboriginal Health Worker, Aboriginal Health Practitioner and/or Aboriginal Liaison Officer. These activities can have a direct impact on event outcomes and measures such as Discharge Against Medical Advice and Take Own Leave, Hospital Readmissions and Access to Hospital Procedures;

- proximity of the indigenous community to a hospital, not postcode remoteness, using distance in kilometres or other measures (such as the Australian Bureau of Statistics Local Government Area or Statistical Local Area measures);
- a tiered approach factoring patient acuity/complexity, or a relative scoring based on general population compared to indigenous population, higher prevalence of certain disease/chronic conditions in the indigenous population and associated complications could potentially translate into a DRG based indigenous loading; and
- residential status (homelessness, community-based or rental accommodation).

12. Consultation Question - What evidence is there to support increased costs for genetic services or socioeconomic status?

Genetic Services

The costs of genetic testing need further investigation due to the complex and lengthy nature of the consultation. As geneticists often provide advice and care through multidisciplinary and cross-organisation teams due to the rare nature of genetic disorders, their activities may not be adequately captured in existing ABF models. It would be worth investigating the amount of occasions of services counted as clinical Geneticists may only have direct contact with a few family members while providing tailored advice for many members of the family, leading to a low number of Non-Admitted Patients Occasion of Service (NAPOOS) recorded per family. This can lead to a skewed assessment of the cost of service in general cost centres for genetic services.

The response to this question incorporates five components, namely (i) benefits of incorporating genetics and genomics into Australian health services, (ii) progress towards creating evidence and addressing issues to optimally harness genetic and genomic-enabled health care, (iii) who delivers health services enabled by genetics and genomics, (iv) increased demand for genetic and genomic tests, and (v) suggestions for how ABF could be modified to more appropriately fund genetic and genomic services. Details are provided in Attachment A.1. WA would support the examination of these issues via a costing study to assess any cost differential.

Socioeconomic status

WA acknowledges that there are already weightings for DRG complexity which may capture some of the special challenges of low Socioeconomic status (SES) patients, patients with high need with regard to SES may still not be sufficiently well captured by DRG complexity. A study to investigate this concern would need to include data capture and the development of clear definitions.

It should be noted that SES issues impact on the ability to deliver services in rural and remote locations in both volume and cost and the two should be examined for their overlap and relationship to implied Safety and Quality measures.

The following publications, proposed for IHPA's consideration, report on findings suggesting that hospitalised patients of lower socioeconomic status have longer stays and require more resources:

1)The costs of inequality: whole population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation.[1]

2) Do the poor cost more? A multihospital study of patient's socioeconomic status and use of hospital resources. [2]

13. Consultation Question - What evidence can be provided to support any additional adjustments that IHPA should consider for NEP22?

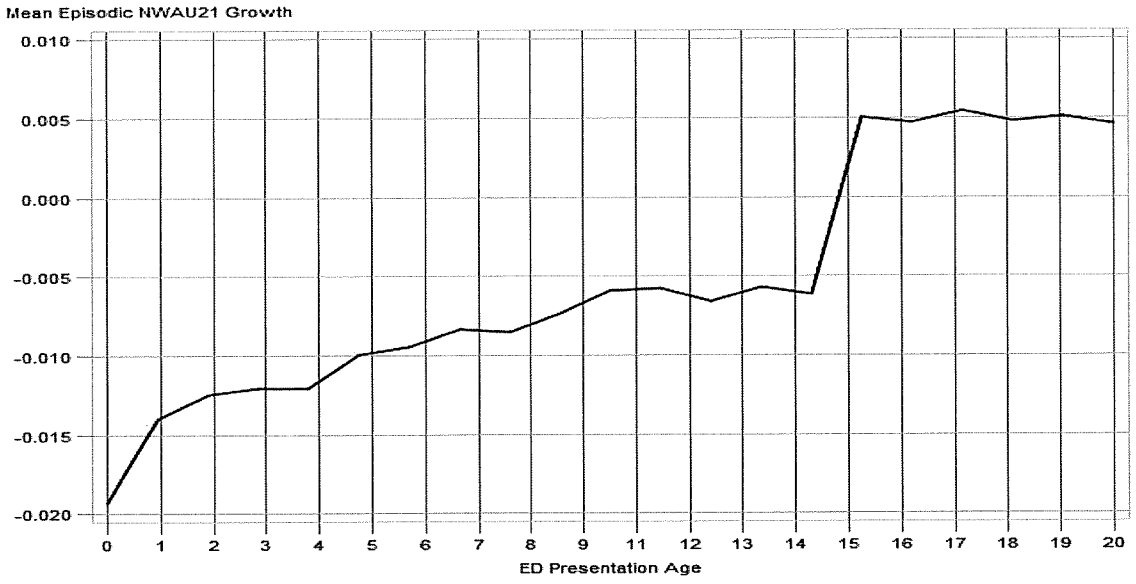
WA supports valid, evidence-based adjustments to the pricing model and as advised in last year's submission, encourages IHPA to further explore the possibility of implementing financial incentives as opposed to disincentives (i.e. financial penalties) to promote better, efficient healthcare and to avoid unintended consequences.

WA recommends the following adjustments for IHPA's consideration:

Age adjustment for younger and paediatric ED presentations

WA's analysis has indicated a strong unfavourable backcast ratio for younger patients in 2019-20 WA data, which had a flow on effect to the Local Health Network (LHN) which is a specialist children's hospital and has a backcast ratio of 0.91. The analysis includes all in-scope WA ED presentations for 2019-20 and excludes emergency services and presentations with an AECC error end class for a more robust comparison. Figure 1 below shows the mean episodic NWAU growth between NEP21 and NEP20 by ED presentation age. Presentations for aged 14 and below were negative whilst at 15 and above was positive. An age adjustment under the AECC for younger/paediatric patients would ensure services provided in ED of a specialist children's hospital are more accurately priced and funded.

Figure1. NWAU growth by ED presentation age (from NEP20 to NEP21)



[1] *The Cost of Inequality*, M Asaira, T. Doran, R. Cookson, JECH Online First, published on May 17, 2016 as 10.1136/jech-2016-207447.

[2] *Do the poor cost more*? AM Epstein, Rs Stern J S Weissman, N Engl J Med, 1 990 Apr 19;322(16):1122-8. doi: 10.1056/NEJM199004193221606.

Disability adjustment

It was also suggested that IHPA investigates further the extent to which the NEP should incorporate a separate adjustment for disability so that it can be sufficiently weighted to overcome the systemic barriers to the provision of healthcare that may be faced by people with disabilities (regardless of location or specific diagnosis).

While people with disabilities may have other characteristics, which are already covered by some of the existing adjustments (e.g. need for dialysis, remoteness, paediatric, ICU), an investigation of whether systemic cost factors associated with disability may indicate a requirement for a separate NEP adjustment for this group of patients so that they have equitable access to public healthcare.

This could include a study to look into costs associated with:

- special transportation to the hospital (and potentially within the hospital);
- accommodations that may need to be made to hospital infrastructure;
- provision of carers and assistants to ensure that their needs, wants and different experiences are respected; and
- additional time taken on behalf of physicians and other medical professionals to work in partnership with these patients to ensure that care is tailored and equitable.

Mother-Baby Units

As raised in last year's submission, WA supports further investigation of increased costs of Mother and Baby Units to ensure this model of care is appropriately funded and the availability of the service across Australia is not compromised. A specific costing study would be the most efficient way of assessing the true cost of delivering the service and WA would be willing to participate.

13. Consultation Question - Are there other clinical areas where introducing price harmonisation should be considered?

WA stakeholders suggested two areas for consideration:

- violence, abuse and neglect services including Family and Domestic Violence, Sexual Assault and Abuse; and
- treatment of anaemia with blood transfusions and infusions of blood products such as gamma globulin, platelets and other serum transfusions.

WA is also supportive of IHPA undertaking clinical consultation through its Advisory Committees to further investigate price harmonisation for dialysis and chemotherapy for NEP22. This will need to consider a higher comorbidity risk profile of inpatients (and associated cost variation), as well as paediatric specific factors.

14. Consultation Question - What factors should IHPA consider in investigating whether methodology changes are required for funding unqualified newborns?

Whilst unqualified newborns are funded under their mother's admission, the amount is not always sufficient to cover the cost of care. This may include costs associated with assessment of the newborn and corresponding administration processes. These

services remain necessary to support this specialised cohort and thus further investigation of funding requirements is recommended.

Commonwealth regulations (qualified versus unqualified) have not been updated since 1997 and no longer fit contemporary care including:

- Keeping babies with their mother's where possible rather than the current requirement of admitting all 'qualified' to Special Care Nursery (SCN) to receive acute/subacute care i.e. low birth weight requiring tube feeds. It should be noted that for rural hospitals this means displacing and or separating mother, baby and father in order to transfer to an appropriate facility for 'qualified' care which could be interstate or up to 6 hours away by plane.
- Rise in maternal risk factor screening and management impacting care needs of baby that do not warrant separation from mother.
- Advances in technology so that babies no longer require as intensive observation as previously and the new technology is no longer a barrier to the baby staying with their parent (especially in a shared room) i.e. jaundice now managed via bilisuits rather than under lights in an incubator;
- Newborn antibiotics for maternal Group B streptococcus status unknown or inadequate intrapartum prophylaxis for GBS positive;
- Change in criteria for diagnosing Gestational Diabetes (GDM) has doubled the rate of GDM which has implications for blood sugar monitoring and closer observations for newborns; and
- Evidence based care now includes 24 hours of close observation for newborn subgaleal haemorrhage post instrumental birth.

An audit of unqualified babies revealed that 66% were receiving additional medical intervention and care. Current arrangements tend to create confusion over funding allocation (if any) where an unexpectedly unwell neonate is born at a maternity site without a SCN and requires one to one midwifery/medical care awaiting retrieval/transfer to tertiary care. In country areas, this can be a for up to 12-14 hours.

Additionally, WA supports investigation of birthweight, level of intervention (i.e., ICD), hospital transfer as factors potentially associated with increased costs for unqualified newborns.

15. Consultation Question - Are there any objections to IHPA phasing out the private patient correction factor for NEP22?

WA would be supportive of removing the private patient correction factor provided it can be demonstrated that all material missing costs are included in the National Hospital Cost Data Collection.

SETTING THE NATIONAL EFFICIENT COST

16. Consultation Question - What are the potential consequences of transitioning block funded standalone hospitals that provide specialist mental health services to ABF?

WA has one facility (Next Step) under this category. There would be concerns with potential funding fluctuations at the state level with transitioning services from block

funding to an "untested" AMHCC, noting the model would need to be validated and be able to account for very long stay patients that exist in this facility.

FUTURE FUNDING MODELS

17. Consultation Question - What other considerations should IHPA have in investigating innovative models of care and exploring trials of new and innovative funding approaches?

WA encourages IHPA to continue to explore innovative funding models and welcomes discussion on these, particularly those that improve health outcomes, promote/increase hospital service avoidance and provides incentives to providers.

IHPA's future work on innovative funding models should support the testing and trialling of new models of care with the goal of improving patient experience and health outcomes. Options that provide flexibility and cover the breadth of the patient journey/episode outside of just the hospital setting should be considered, recognising that this is challenging under the Addendum where the scope is currently limited to public hospital services.

Whilst WA agree with funding models moving towards community-focused, value based care and a focus on outcomes, it is important to balance this with supporting current hospital infrastructure. Moreover, the obvious flaw within an ABF system is the incentive to increase volume (do more, get paid more). There needs to be a counter-balance for this, noting that IHPA is exploring options such as bundled or capitation payments.

In response to IHPA's *Discussion Paper on Future Funding Models*, WA suggested the inclusion of criteria to inform the development of funding methodologies for innovative models of care and recommended that IHPA considers the expansion of innovative models of care beyond the hospital setting into different activity streams.

WA stakeholders also suggested the following initiatives to be explored:

- IHPA could consider a funding model for initiatives that demonstrate investment in evidence-based services and primary health care partnerships to ensure the sustainability and relevance of future funding models.
- A review of cultural differences in midwifery vs obstetrics led care may inform innovative funding approaches.

WA will continue to participate in the national discussions, noting work is currently underway in WA to implement the various recommendations of the *Sustainable Health Review* related to quality and value for the patient, supporting new models of care and joint commissioning.

18. Consultation Question - What innovative models of care or services are states and territories intending to trial for NEP22?

Based on the WA Sustainable Health Review recommendations 17 and 18[3], there is focus on the need for the development of new funding and commissioning models to create a more sustainable health system. In 2021-22 and beyond, WA Health will be exploring options and piloting projects to help drive these initiatives.

One of the current key considerations is the establishment of a flexible funding approach based on population health needs and outcomes to enable and support innovation projects to improve timely and appropriate access to high quality care.

PRICING AND FUNDING FOR SAFETY AND QUALITY

19. Consultation Question - What should IHPA consider when developing evaluation measures for evaluating safety and quality reforms?

WA welcomes an incentive-based approach to evaluating and improving patient safety and quality outcomes. IHPA needs to ensure that evaluation measures do not have any perverse impact on the clinical outcomes being reformed.

The following issues are proposed when developing evaluation measures:

- patient outcomes across continuum of care as opposed to episode of care approach;
- reduction in length of stay, number of complications;
- increased initiatives/programs related to specific safety and quality reform;
- system funding and capacity (public hospital system should not be penalised for disease prevention when it falls outside of its scope);
- change management; and
- positive incentives e.g. funding reallocation for effective safety and quality projects with a standard measurable effect on patient outcomes.

20. Consultation Question - What pricing and funding approaches should be explored by IHPA for reducing avoidable and preventable hospitalisations?

The current model largely involves applying penalties for identified safety and quality measures. Can the IHPA explore a model which rewards LHNs for improved patient safety? A model which is incentive based would be viewed favourably from an implementation perspective by the LHNs.

LHNs now have teams that investigate Hospital Acquired Complications (HACs) and Avoidable Hospital Readmissions (AHRs). After clinical review a number of HAC/AHR

---

[3] ***Recommendation 17:*** *Implement a new funding and commissioning model for the WA health system from July 2021 focused on quality and value for the patient and community, supporting new models of care and joint commissioning.*

Recommendation 18*: Establish an agreement between the Departments of Treasury and Health for a sustainable funding footprint to support the necessary change and reinvestment required in the health system in particular over the next three to five years.*

adjustments require reversal. It is recommended IHPA considers a retrospective adjustment ideally applied in time for the National Health Funding Body full year reconciliation process.

IHPA should also promote programs that reflects the patient journey across acute, sub-acute, rehabilitation and community settings to deliver sustainable impact for patients.

21. Consultation Question - What assessment criteria should IHPA consider in evaluating the merit of different pricing and funding approaches for reducing avoidable and preventable hospitalisations?

WA suggests that IHPA consider criteria such that:

- the penalties/incentives are aligned with achieving the desired outcome;
- there should be no detrimental impact on the patient;
- the model does not become overly complex for jurisdictions to understand/explain and implement; and
- does not create adverse consequence or opportunity for gaming by LHNs/jurisdictions.

ADDITIONAL COMMENTS

Teaching training and research (TTR)

Whilst there is no question specific to TTR, WA would like to understand the comments under section 5.7 of the Consultation Paper regarding implementation plan, shadow pricing and related timeframes for the Australian Teaching and Training Classification.

Hospital Acquired Complications (HAC)

Sequencing of events and HAC identification:

Through the internal HAC review, it was identified that the sequence of events in a patient episode is not necessarily considered when allocating a HAC including processes/procedures that may be misconstrued as a HAC. Key examples include:

- Timelines of treatment is not evident in the coded data and just simply using very specific criteria can lead to false positives. This is most evident in surgical complications such as haemorrhage/haematomas (code T81.0) with a transfusion. If a patient presents with anaemia, the transfusion may be given BEFORE the surgery so unrelated to the procedure. The coded data should indicate this using an 'anaemia' diagnosis code and where this occurs with code T81.0, it is a flag the transfusion could be unrelated. Not sure how these cases could be excluded, but they should be considered non-HACs when verified.

- Coding of Pump blood. This is blood 'returned' to the patient following Cardio-pulmonary Bypass (CPB) surgery. In coding classifications, it is coded as an 'autologous' blood transfusion (92060-00 Administration of autologous blood). Clinically this is not a transfusion as such. CPB machine replaces the heart's pumping activity during surgery, including filtering the blood and moving it around the body. The remaining blood once the machine is turned off is known as 'pump blood' and simply returned to the patient until the heart is full.

- Clinical questions on administration of 'albumex' as part of the 'transfusion of blood products' codes. It is used to replace fluid in the blood vessels due to acute loss of blood or plasma. The clinicians do not believe this is a true 'blood product', however the non-clinical view is, it is derived from human albumin and so it fits the criteria as well as any other blood product used for blood loss. May be infused for other clinical reasons.

- T81.0 is not only to represent a haemorrhage/haematoma. It is also used for haemoserous wound ooze that meets the coding criteria. This, with the transfusion code, and return to theatre, looks like they are related but they are not in this case, hence a false positive event. Coding cannot identify these cases on its own, but should be considered non-HAC when verified.

Attachment A.1

Factors/issues for consideration in response to Consultation Question 12

What evidence is there to support increased costs for genetic services?

i) Benefits of incorporating genetics and genomics into Australian health services

Genetics and genomics can be applied across the human lifespan and for a very large breadth and number of health conditions and create economic savings through earlier and more accurate risk prediction, diagnoses and prognoses, provision of tailored (precision/personalised) medicine and avoidance of unnecessary treatments. This creates immense prospect to fundamentally shift health care from a system aimed at improving outcomes for the "average" patient per condition, towards a more precise and personalised approach to the effective prevention, treatment and management of health conditions.

ii) Progress towards creating evidence and addressing issues to optimally harness genetic and genomic-enabled health care

In order for healthcare provision in Australia to optimally benefit from the opportunities that genetics and genomics bring, the issues these disruptive technologies raise need to be appropriately addressed and managed. These issues include creating the evidence of a rapidly advancing technology having increasing utility across essentially all health areas; emerging innovative models for clinical care and service delivery; suitable funding mechanisms; increasing service demand; workforce shortages; limited genetic and genomic literacy and education of other healthcare professionals and the public; inequity of access; considerations for the appropriate collection, use, storage and management of genomic data; and addressing the ethical, social and legal issues related to genomics in health.

In Australia there has been significant investment into translational genetic and genomics research projects in the healthcare setting to address aspects of these issues, such as the Australian Genomics Health Alliance, the Melbourne Genomics Health Alliance and Queensland Genomics. Proof-of-concept projects have produced robust medical, scientific and economic evidence of the diagnostic, clinical, personal, familial and population benefits of genomic testing across a range of specialities[1].

However, despite these pilot projects being successful, a large impediment to their positive findings being translated into routine health care beyond the duration of their time-limited funding is the lack of sustainable and designated funding for the genetic and genomic testing itself and the necessary associated processes to appropriately deliver these tests, such as multidisciplinary patient referral, genomic test review and decisions for optimal care and management. This means that significant collaboration, investment, momentum and expertise is not being harnessed in a manner to ensure the continuation and expansion of optimal health outcomes for Australian patients and economic benefits to Australian health systems.

iii) Who delivers genetic and genomic services in Australia?

Traditionally, the main health professionals delivering genetic services have been clinical geneticists and genetic counsellors at dedicated clinics. Given the rapid

expansion of knowledge about the role of genomics in disease, the demand to refer patients to these services has significantly grown over recent years. Additionally, the demand for participation of clinical geneticists and genetic counsellors in the services delivered by other health professionals has also considerably increased across virtually all medical specialties (e.g. cardiac genetics, renal genetics, neurogenetics, oncology). This has led to the establishment of multidisciplinary clinics (sometimes called "joint clinics"), combining clinical geneticist and/or genetic counsellor expertise with other/mainstream medical specialists to improve the diagnosis and management of people with genetic conditions.

These relationships have enabled collaboration and have driven a culture that supports multi-disciplinary and holistic health care, with a focus on information sharing between these parties and communicating the implications of genomic testing to patients and their families. This ensures the safety and quality of genomic testing and the upskilling of other medical specialists. In addition, case review meetings are very important by facilitating discussion about the suitability for a genomic test and the decision as to which test should be ordered for which patient, and then interpreting test results. These meetings usually include clinical genetics expertise, other medical specialists and importantly laboratory/medical scientists and/or molecular pathologists.

Moreover, some medical specialties are "mainstreaming" the delivery of aspects of genetics and genomics into their routine delivery of health care, without the (regular) involvement of a clinical geneticist or a genetic counsellor.

iv) Increased demand for genetic and genomic tests as utility and cost-effectiveness grows

Currently, genomic tests are most often ordered in the non-admitted (outpatient) services setting, yet the value and frequency of their use for admitted acute services (e.g. neonatal intensive care units) is strongly emerging. Recent consultation with a range of genetic service providers across Australia indicated that one of the biggest contributors to the increasing cost of their services is a significant increase in the frequency of the demand for genetic and genomic testing, including complex "high" cost tests.

Genetic testing is not new to health care, yet it has undergone rapid and significant transformation, especially since the introduction of massively parallel sequencing (also known as "next generation sequencing"). This method can sequence genes at high speed and at an increasingly affordable cost, enabling the study of multiple genes or even entire genomes simultaneously ("genomics"). Genomic sequencing can significantly increase the chances of and reduce the time taken to achieve a diagnosis for patients with suspected genetic diseases when compared to traditional genetic testing methods, which often involved running multiple individual tests for specific genes sequentially.

Alongside these technological advancements, genetic and genomic research has led to a precipitous development period in the understanding of the role of DNA variation in human health and disease. This has resulted in the growing body of robust evidence about how genetic and genomic testing can improve health service delivery and health outcomes for individuals and populations. The clinical utility of such testing has increased significantly across a range of medical specialities and indications, most notably in the areas of rare disease and cancers.

As understanding has grown across health professionals and the general population as to how genetic and genomic tests can improve healthcare delivery and health outcomes, the demand on accessing these tests has also considerably increased. However, stakeholders within the public hospital setting are consistently reporting a lack of accessible funding for genetic and genomic tests and as a result, many health professionals convey constraints in ordering the number of tests they feel are appropriate to deliver the necessary standard of health care to their patients.

v) Suggestions for how ABF could be modified to more appropriately fund genetic and genomic services.

Below are suggestions as to some of the approaches that IHPA could consider in determining mechanisms for ABF to better reflect the true cost of delivering genetic and genomic services. To contribute towards the production of data to enable IHPA to better understand the delivery of these services, Genetic Services of WA (GSWA) was part of a recent non-admitted care costing study (NACCS) in collaboration with IHPA. As this study was suspended due to COVID-19, GSWA looks forward to the study recommencing and encourages other clinical genetic services from across Australia to also be involved.

a. Incorporating the costs of genetic and genomic tests

To realise the broad patient and health system benefits of genomics, evidence-based and cost-effective genomic testing needs to be available to all in the population for whom it could be appropriate. However, the lack of a fit-for-purpose funding model for public patients is leading to an inequity of access to genomic tests, which increases the risks that the gap in health outcomes for vulnerable populations will become wider.

IHPA's Pricing Guidelines state that the pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new health technologies that improve patient outcomes. Thus, in theory the pricing of ABF for clinical genetics services should adequately cover required pathology services and interventions, including genomic tests. However, it appears evident that ABF pricing for non-admitted clinical genetic services has not yet been able to respond in a timely and effective manner to the rapid advances in the utility of genomic tests.

To demonstrate this situation, the fee assigned to the small (but growing) number of genetic and genomic tests included on the Medicare Benefits Schedule can be used. Less complicated genetic and chromosomal tests are recognised to typically have a lower cost (e.g. Medicare items 73291, $230.95; 73348, $250; 73339, $400). However more recent and emerging genomic tests analysing multiple genes are more expensive (e.g. Medicare items 73296, $1200; 73358, $2100) depending on the clinical indications and technology required. In comparison, in 2021 the ABF price for outpatient service events provided by a clinical geneticist and genetic counsellor are $961 (code 20.08) and $232 (code 40.53) respectively. This could potentially be caused by the three year lag in NEP development as well as the fact that these services have not been accurately costed in the past and had only recently picked up patient level costing.

It appears therefore that the ABF pricing for clinical geneticists and genetic counsellors is inadequate to cover the true cost of providing a service event to a patient for whom a genetic or genomic test is ordered. Although it is recognised that not all patients will be deemed suitable to receive a genetic or genomic test, it is feared that with the current pricing there will be a financial disincentive, or indeed an inability to order such

tests, even when they are deemed appropriate and necessary to provide a suitable standard of health care.

It is recommended that costing studies occur in multiple jurisdictions to better understand the usage and cost of genetic and genomic tests in the delivery of clinical genetic services. It is not evident that data previously supplied to IHPA as part of regular reporting, has incorporated these values in the costings of these services. However, it is recognised that a one-size-fits all approach to these services may not be suitable. Therefore, further consideration should be undertaken to review the differences and similarities for those patients typically cared for by these services (e.g. those who do not have genetic/genomic tests indicated vs those who are provided with a less complex/costly test vs those who are provided with a more complex and costly test). This may form part of the new Non-Admitted Care Classification work that IHPA is undertaking to better reflect the characteristics of outpatients and the complexity of their care.

An aspect to remain cognisant of is that initial genetic and genomic testing volume data are not likely to be truly representative of the ideal scenario of how many patients should be receiving these tests. This is because genetic services currently report being particularly conservative in how many genetic and genomic tests are ordered due to financial constraints (e.g. no dedicated budget). As such, it is assumed that existing testing rates under-represent the rates that would be appropriate if clinical utility and cost-effectiveness evidence were applied across patient cohorts. It is anticipated that upfront investment will likely be required to generate the appropriate clinical scenarios involving the use of genetic and genomic tests to be costed for IHPA, and then in turn the corresponding pricing modifications made to ABF for delivery of these services.

It is believed that a similar situation exists for other specialist services that order genetic and genomic tests as part of healthcare delivery for a proportion of patients. IHPA, along with key stakeholders, is encouraged to consider these circumstances and to deliberate what might be the ideal mechanism for incorporating appropriate testing costs into a range of other relevant healthcare services.

Another example of the prospect of genetics and genomics being incorporated into health care is via screening and population-based screening programs. Australian Newborn Bloodspot Screening (NBS) Programs are public health initiatives that currently offer screening for around 25 rare genetic conditions to all babies born in the country. The current testing methods are biochemical, but there is growing pressure to add first tier genetic testing to these screening programs and this is anticipated to increase in coming years. For example, the Federal Health Minister recently recommended that all states and territories consider implementing genetic screening for spinal muscular atrophy into the NBS testing panel.

These historically low-cost programs have generally been funded through block-funding arrangements between State and Territory Government Health Departments/Ministries and the pathology provider conducting the screening test, but there is presently no mechanism for increasing the funding amount to account for new genetic screening tests. As the activity of taking the bloodspot samples is delivered by hospitals under a standard maternity package, tying the pathology testing to a maternity service event could provide a standardised approach to funding genetic screening tests that are implemented into these programs. A costing study could be undertaken to inform the inclusion of screening tests for newborns into maternity service events.

b. Correctly accounting for contributed time

As already described, the participation of multiple healthcare professionals (e.g. clinical geneticists, genetic counsellors, laboratory scientists, molecular pathologists, a variety of other medical specialists) in multidisciplinary team clinics and case conference reviews relating to many scenarios of genetic/genomic healthcare delivery is considered best practice nationally and internationally. Due to the nature of these consultations the teams might not always meet the requirements of the current counting rules and potential ineligibility for funding acts as disincentive. It is therefore recommended that consideration of this situation occurs collectively between IHPA and relevant stakeholders to determine whether existing costing mechanisms should be covering these duties, and if so, whether jurisdictions are suitably capturing these data and attributing the contributions to relevant service events in the costed data provided to IHPA.

One highly beneficial and specific example of these multidisciplinary meetings is the relatively recent commencement of molecular tumour boards (MTBs). These allow thorough discussion and interpretation of the results from comprehensive and complex genomic tests for cancer patients, and this occurs in conjunction with the relevant clinical presentation of the patients, to result in a molecular diagnostic report. This report includes information about treatment options (including possible participation in clinical trials), prognosis, and considerations future risk and implications for family members. In last year's submission, WA recommended the introduction of a Tier 2 clinic code for MTBs, which IHPA has agreed to consider as part of the annual refinement of the Tier 2 clinic classification.