Government of South Australia

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Professor Michael Pervan
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Dear Professor Pervan

RE: CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRLAIAN PUBLIC HOSPITAL SERVICES 2024-25

Thank you for your email on 14 June 2023 inviting public feedback on the consultation paper on the Pricing Framework for 2024-25.

Attached is SA Health's response to the questions raised in the consultation paper along with additional comments on areas of interest for SA.

If you have any questions, please contact Catherine Shadbolt on 8226 6491 or email Catherine.shadbolt@sa.gov.au

Yours sincerely

JULIENNE TEPOHE
Deputy Chief Executive, Commissioning and Performance

24/ 7 /2023

Attach: SA Health Response to the Consultation on Paper on the Pricing Framework for Australian Public Hospital Services

SA Health Response

Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25

On 14 June 2023 the Independent Health and Aged Care Pricing Authority (IHACPA) released its Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25 for public comment. SA Health welcomes the opportunity to provide feedback and is supportive of the continual collaborative improvements to the framework.

The response has been developed following consultation within the Department of Health and Wellbeing and across Local Health Networks (LHNs). Responses to the questions included in the consultation paper are below with additional topics that were not covered by questions provided added at the end of this submission. Each section refers to the consultation paper.

Please contact Krystyna Parrott, Associate Director, Activity Based Management and Funding (Health.ABF@sa.gov.au) for further clarification on the response.

Section 3: Classification used to describe and price public hospital services

3.2 Subacute and non-acute care

Are there any significant barriers to pricing admitted subacute and non-acute care using AN-SNAP Version 5.0 for NEP24?

The implementation of AN-SNAP V5.0 rests on the robustness of the clinical documentation and subsequent coding of the diagnosis codes used to determine Frailty. The ability to be more specific regarding the comorbidities that relate to frailty is welcomed this could lead to unintended consequences in the first year of implementation.

When DRG V8.0 was implemented, there was a change in understanding what codes were required to increase complexity in patients. SA believe we may see the coding of diagnosis codes linked to frailty increase in clinical documentation. While more appropriate documentation and coding is welcomed there are significant concerns that this could lead to a retrospective adjustment to 2024-25 NWAU results like what occurred with DRG V.8.0.

If IHACPA decide to implement AN-SNAP V5.0 SA wants assurances that there will be no retrospective penalties applied due to improvements in documentation and coding, these improvements are expected as clinicians become more familiar with the frailty score and how it works.

Concerns have been raised internally regarding the actual codes used to determine codes and the logic behind why some codes are included and other codes not. For example, J18 codes (pneumonia) used as a measure of frailty but why are other pneumonia codes not used such as J12 to J15 range that are more specific? In SA we encourage clinical coders to code the best code that reflects the patient's diagnoses and there could be a shift to using less specific or appropriate codes There is further concern that some additional diagnosis codes being applied for frailty would contradict the way ICD-10-AM codes and ACS002 are applied.

Before implementation is considered it is recommended that an IHACPA led workshop be convened with clinicians and clinical coders to work through their concerns and removing this barrier from using AN-SNAP V5.0

3.3 Emergency care

Are there any other areas in the AECC that IHACPA should consider as part of the classification refinement work program?

There are several areas where SA feel that the AECC could be improved, either by additional loadings or flags for determining complexity of the patient.

- There is a difference between care provided to paediatric patients compared to adults especially in principle referral sites. As the classification and costing data improves each year this review should be done annually to ensure a loading is not required. Paediatric patients should also be reviewed in the complexity algorithms to ensure more recent data is not showing new trends requiring adjustments.
- It is acknowledged that in subsequent versions of the AECC IHACPA will start reviewing the impacts of procedures undertaken as part of emergency care provided. Some of areas SA would want as part of this review are:
    - Intubation of patients
    - Use of resuscitation bays and time spent
    - Other complex procedures performed as part of emergency care
    - Need for patients to have one-on-one security (similar to nurse specialling)
    - Transport costs when moving between metro and regional areas due to lack of principal referral services available in the area.
- The impact of secondary diagnosis codes have on complexity requires review. There should also be a requirement for these costs to be submitted to IHACPA

What clinical areas and/or structural features should IHACPA consider in the development of the EPD Short List 13th Edition?

No response.

3.4 Non-admitted care

Are there any other proposed refinement areas for the Tier 2 Non-Admitted Services Classification for 2024-25?

SA has identified the following considerations for the 2024-25 Tier 2 classification

- SA supports a new Tier 2 clinic for home subcutaneous immunoglobulin (SCIg) infusions as replacement therapy for persons with an immunodeficiency where they qualify for immunoglobulin replacement under the select criteria and do not require intravenous immunoglobulin (IVIg) treatment.
- With improvements in costing data this should allow for more consideration of different cost drivers moving forward that may have an impact on price weights. Note some of

these suggestions may be better placed in the development of the new non-admitted classification but provided for consideration.

- Provide additional clinics to account for more complex services, for example complex anaesthesia or complex non-admitted medical procedures.
- An improved multidisciplinary loading that considers the different number of clinicians that may be present. Clinics that routinely have two clinicians present are currently out of scope and those that have over five involved are treated the same as those with three present.
- Consideration needs to be given to clinics that may see the patient attending/being attended to more than once a day. For example, palliative care services that are not admitted but have multiple visits per day by nurses to maintain their comfort at home. Also, overnight nursing services can be provided too, and the current price weight does not consider the time spent providing care.
- Whilst it is acknowledged that it is difficult to capture appropriate data, there is an increasing need for the use of translator services. In the past Australian Bureau of Statistics data have not been satisfactory to create a loading around culturally and linguistic diverse people, however it may be worth investigation to make the capture of some mandatory flags within datasets. In this case a flag to identify that a translator was used, this would then provide a way to distinguish between the costs of those that require this service. This could also be implemented for security as well. If there is no discernible difference, then the flag codes could be removed.

3.5 Mental health care

Following three years of shadow pricing and the development of risk mitigation strategies to support the transition to ABF, are there any significant barriers to pricing community mental health care using AMHCC Version 1.0 for NEP24?

South Australia is still supportive of moving community mental health to activity based funding as this will provide transparency in service provision, and the resources and expenditure associated with this activity. Two key areas that require more confidence for implementation is the data that is being collected is robust enough to allocate to resource categories and that the costing data is felt to be reflective of the care provided. In jurisdictional meetings there is very little support for the data that is being used to cost and price these services, even from those submitting it. As this is the case it is hard for jurisdictions to have confidence in the accuracy of the price weights IHACPA produce for funding these services.

Another clear delineation required is the outpatient services provided in hospital to mental health patients. Should all service events provided to a patient receiving community mental health care be bundled together or can they be claimed separately? A decision needs to be made whether these services fit into the outpatient category or the community mental health category so that potential misreporting does not occur.

Are there any other measures that will assist in transitioning community mental health care from block funding to ABF for NEP24?

A key concern in transitioning from block funding to activity-based funding is the impact that it may have on the base Commonwealth funding and the way growth will be calculated. This data is still in its infancy and has a few more years' worth of improvement. Basing the amount of funding that is provided for these vital community services on this data runs a significant risk to service provision unless there are mechanisms put in place to at least have a no worse off policy for the first couple of years. Acknowledging that funding is not part of IHACPA's remit but for jurisdictions to have more comfort in the price weights currently being produced.

Another area is for jurisdictions to have control over which services move from block funding to activity-based funding. With concerns raised around the phase of care for a community mental health consumer the price weights may not necessarily reflect the services provided to the consumer nor the resources required to provide those services.

Section 4: Setting the national efficient price

4.1 Impact of COVID-19

How did the COVID-19 pandemic response impact activity and cost data in 2021–22, such as through significant events like lockdowns, and how should these impacts be accounted for in the NEP and National Efficient Cost Determinations for 2024–25?

In our response for 2023-24 SA acknowledged that there were impacts to hospital services in terms of types of patients coming through the doors and the change in costs. The residual impact of COVID still continues to impact the costs of cleaning, the cost and amounts required of personal protective equipment, even the need to Rapid Antigen Test to undertake quick testing as required.

A review of the way services have been provided both during lockdowns and after would also be beneficial. In some areas, for example respiratory, models of care moved to hospital in the home where appropriate to keep the vulnerable patients out of hospital. The models of care being provided have adapted due to restrictions imposed by COVID and those that work successfully are being continued, especially where beneficial for the patient.

There is also a different cohort of patients coming through the hospitals, in part due to delayed care during COVID. Elective surgery has a backlog that is still being cleared and some patients who did not seek care during COVID are now coming in with more complicated conditions. Those patients seeking treatment for chronic conditions any delays during COVID may have led to exacerbations of their condition which may change the type and cost of care. This is difficult to quantify this year, but overseas research suggests that the cost of patients with delayed care for chronic conditions can be higher by between 7% and 11%. SA recommends that there needs to be some modelling undertaken to fully determine the cost of deferred care of the system.

Staffing costs have increased since COVID caused in part to the continued lack of staff, particularly in regional areas. During COVID and ongoing where a patient does have COVID hospitals have implemented dedicated nurses who only attend these patients, this can lead to increased nursing costs to cover the remaining areas on the ward. While some of the issues are not COVID related it will be difficult to determine where the shift occurred as staff costs started increasing during the pandemic and are not abating.

In relation to an impact on activity due to COVID the impact has been beyond COVID-19 related hospital acute care. There have been increases in our activity for diagnosis of depression and anxiety, which needs supports both in the hospital setting and increased needs in community. This has changed the models of care and cost profiles.

Together with this we have seen a surge in people experiencing acute behavioural problems which has impacted our cost profile. These patients have a longer length of stay than the average length of stay.

For NEP24, what evidence is available regarding the clinical management of patients with a COVID-19 diagnosis to support different treatment of activity?

The 2021-22 costing data will have a significant amount of COVID-19 included given the stage Australia was at in the pandemic. However, there should be close monitoring of the application of the COVID loading across the jurisdictions and what this might mean in future

years as COVID becomes more business as usual. There may be a need to hold a workshop with the costing practitioners to understand the costs coming out for 2022-23 and if there are any changes to the cost of these patients. While the data will not be ready for use in 2024-25 it may be able to inform the need for adjustments and the level required.

Consideration is required for the impact of long COVID not only on outpatient services but patients being admitted to hospital. It may be that the cost of providing care for COVID patients does not require an adjustment, however the adjustment may be required for those receiving care for long COVID.

To support these long COVID patients and those with chronic disease SA is continuing with virtual health offerings, and increasing the health at home options both inpatient and non-admitted.

4.2 Adjustments to the national efficient price

For NEP24, what evidence is available to inform the review of the ICU adjustment?

South Australia supports a review of the ICU adjustment and the criteria for sites to qualify for it. One of the issues related to ICUs that are collocated with HDUs, and how the funding is allocated. Sites may have these units collocated to enable the site to flex-up and flex-down the beds as required but this means the electronic medical records are not able to distinguish between the beds and hence activity that would not qualify in another site is being funded in these collocated sites. This would have an impact on costs as the HDU costs should be part of the DRG price weight but if unable to be isolated is disadvantaging those that are able to split the costs. This will also support our contracting arrangements with the private sector.

Other cost drivers include:

- Access to specialised clinicians
- Ability to move to a stepdown unit like a separate HDU
- The nurse patient ratios, in most cases this is one-to-one
- Whether the ICUs are used for elective surgeries
- Number of single rooms available for isolation
- The provision of Medical Emergency Teams (METs) and/or retrieval teams

The impact of limited ICUs in regional areas and the additional responsibilities that this can place on regional HDUs. Not being appropriately funded for certain types of care are becoming a barrier for regional sites to keep patients rather than transfer them to metro sites. Another barrier of transferring patients is that clinicians and nurses are not being fully exposed to the types of care to maintain the standards required. While this is an important factor in metro sites it is even more important for regional sites given the difficulties attracting and retaining staff.

For NEP24, what evidence is available to inform the review of the paediatric adjustment?

South Australia also supports the review of the paediatric adjustment and which sites qualify for it. Consideration must be given to those sites in the past that have not qualified for adjustments but are major referral centres for paediatric patients in their jurisdiction.

Areas for consideration include:

- The availability of a dedicated paediatric unit staffed by qualified paediatricians; this includes a designated area for emergency care.
- Ability to admit paediatric patients to an ICU at the site

- The site is the destination for transfers of more complex paediatric patients.
- The interplay at sites where a NICU and a PICU exist and attribution of ICU hours to both. For example, those in NICUs that are transferred to a PICU mid-stay would still fall under a neonate DRG however this is an impost on the PICU that is unrecognised.

4.3 NEP indexation methodology

To inform the NEP indexation methodology review, what alternative indices or metrics are publicly available and applicable at a national level, that demonstrate an evidence-based correlation between price inflation and cost increases in the delivery of Australian public hospital services? Additionally, what are the underlying drivers of cost growth contributing to these cost increases?

The costing data that will be used to determine the 2024-25 NEP is based on 2021-22 costs that are known to not show the impact that inflation has had on the cost of living. The Australian Bureau of Statistics (ABS) has several price indices (that are updated regularly) that should be considered for the review in the indexation methodology. These include:

- The Consumer Price Index, with specific attention to the change in medical and hospital services (currently reported as 3.8% increase since last quarter), food and non-alcoholic beverages (1.6% increase) and Insurance and financial services (1.9% increase). These are examples of areas that impact the effective running of a hospital.
- The Wage Price Index, which addresses the changes to wages over years, for example in the last year (March 2023 Quarter) the health care and social assistance has changed by 3.2%. However, administration and support services have increased by 3.8%, which is an area vital to running a hospital.
- The Producer Price Index is another ABS index that should be considered in the review. This index relates to the price change in the production of goods and services of which medical services and allied health services are identified separately.
- The ABS Selected Living Cost Index contains information on the cost on households for health services, while the NEP relates to the public sector the increase could indicate a movement of patients from private health insurance to the public sector.
- While not aware of an appropriate index inclusion of the impact on importing medical devices, medications and personal protective equipment and associated price rises will affect the cost of providing services.

Some of the key areas of underlying drivers of cost growth are:

- Increasing usage of agency staffing, both medical and nursing, with an increase in Locums in the regional areas due to inability to recruit.
- Nursing staff costs are being driven by overtime and double shifts again due to staff shortages and inability to recruit to SA
- Increasing costs in cleaning due to the increased requirements following COVID, we are operating now at the standards that we should have always been at
- PPE costs are not at the COVD levels but they have not dropped to the pre-COVID levels
- Transport costs are increasing, particularly aerial and interhospital transfers, driven by usage and increasing contract costs
- There are costs associated with the failure of other parts of the health continuum such as inability to be placed in aged care facilities, NDIS places and support for mental health patients in the community. The problems with primary care are driving more patients through the ED and the high volume low triage presentations creates bottlenecks which increases costs

- Energy costs are increasing higher than CPI
- Having to ensure pay parity with outsourced providers does not allow for contracting out efficiencies
- ICT and digital costs are increasing
- Increased costs within regional areas across all cost types, but largely salary and wages and the cost of transporting staff in and associated costs of accommodation.

4.4 Harmonising price weights across care settings

What potential risks should IHACPA consider in progressing price harmonisation of chemotherapy and dialysis for future NEP Determinations?

South Australia has been very consistent on the need for price harmonisation, particularly in chemotherapy. SA Health has been wearing a significant funding risk due to the lack of movement in this area where our costs are not reflective of the weights in the NEP.

To ensure fair and efficient pricing, and subsequent funding, (which are overarching pricing guidelines) it is necessary for IHACPA to provide analysis on the costs used to determine the admitted vs non-admitted price weights. In particular, the level of PBS costs used and more importantly excluded from the process. The National Benchmarking Portal pharmacy is one of the key differences between jurisdictions and this must be addressed to ensure fairness in pricing going forward. What's more the analysis should look at the funding gain/loss that jurisdictions have incurred over the last five years to show that this isn't a COVD artefact.

Discussions with clinicians and experts in this area have indicated that intravenous chemotherapy is administered the same whether the patient is admitted or not. As consistently referenced in SA responses the Department requires detailed analytical data to use in our meetings with oncologists and haematologists to explain why they are receiving a price weight that is significantly lower than the cost of providing the service.

Are there any other public hospital services that are potential candidates for price weight harmonisation across settings?

All classes in the 10 series (procedures/interventions) of the Tier 2 classification should be investigated for price harmonisation. Most of these classes could be provided in an admitted setting or non-admitted which is determined by local admissions policies rather that what care is provided.

Some of the harmonisation would be more suited to the new non-admitted classification. For example, a flag to determine if a general anaesthetic was used or not would provide a better guide on which endoscopies could be harmonised across settings. Another area is where a Tier 2 class has a cost profile that indicates two differing types of care being provided. The service events with the higher costs may be better aligned with admitted services.

Section 5: Setting the national efficient cost

5.4 NEC indexation methodology

To inform the NEC indexation methodology review, what alternative indices or metrics are publicly available and applicable at a national level, that demonstrate an evidence-based correlation between price inflation and cost increases in the expenditure of small rural hospitals, specialist metropolitan hospitals or block-funded services? Additionally, what are the underlying drivers of cost growth unique to these services?

The types of indices that should be considered for the NEC are the same as for the NEP, however there should be a regional lens placed over them. For example, one of the greatest

costs for regional sites is the cost of staff to keep the site running. Regional sites not only are required to pay wages in accordance with industrial relations, but it is also becoming more prevalent to provide an attraction/retention allowance on top of that. Part of the salary packaging can include accommodation and travel as fly-in fly-out models are now becoming standard, and lack of commercial flights means charter is the only option.

Another cost pressure is capital and information technology, while either out-of-scope for the NHRA or considered part of the price is a significant impairment to providing the regional populations with appropriate care. The cost of bringing in contractors to update equipment comes with loadings that again become cost prohibitive to providing appropriate care. These issues need to be considered as part of the NEC indexation if the aim is to enable regional sites to be able to provide care without moving patients to metro sites.

Section 6: Data collection

6.1 Assurance of cost data

What assurance approaches should IHACPA consider, to ensure NHCDC data is prepared in line with the AHPCS, and that would reduce duplication of data reporting for states and territories?

Differences in the costing process across the jurisdictions can have an impact on appropriate setting of price weights and benchmarking. South Australia recommends that there is a greater focus on the costing working group to develop this consistency and that all jurisdictions produce a technical report on how the following processes are managed:

- How the general ledger is built and what costs are removed, and any additions included.
- What is included in each costs bucket and be more prescriptive
- How direct and indirect costs are allocated
- How each service is built and the methodology behind this.
- What reclass rules are used to allocate costs
- How often and what methodology is used to determine PFRACs.
- How do jurisdictions ensure consistency between their sites if costing is not centralised.

6.2 Virtual models of care

Given virtual care is a broad and evolving space, what specific areas and care streams where virtual care is being delivered should IHACPA prioritise for further investigation to inform future data collection, classification, and pricing refinement?

Do jurisdictions have the capacity to submit cost data for activity reported under the emergency care virtual care data specifications?

SA Health has already implemented two virtual emergency care services that have been well received by the community and an area where expansion may be considered in future years. The models of care differ from existing community based services and hospital in the home and could become pivotal in providing care to patients locate in regional areas going forward.

As this area is evolving it is not known whether a “virtual care” classification is required, or virtual care should be included as a flag for existing classifications. While it is still too early in the development process a national costing study of virtual services provided will be required to inform how to best account for this new type of activity.

In the interim SA is committed to providing activity and costing data to IHACPA to inform the process going forward.

Further Comments

Do you have any further comments to inform the development of the NEP and NEC Determinations for 2024–25?

4.5 Unqualified newborns

South Australia continues to be supportive of the review of unqualified newborns and how their costs are accounted for. All newborn costs should be identified separately to provide a greater transparency of the cost of caring for this patient cohort. This is where NICU hours could be used in a similar fashion to the ICU loading for non-NICU patients.

As for the definition of a qualified newborn, we believe that IHACPA is in a good position to advocate on behalf of jurisdictions for a review of the legislation that determines a newborns status. The definition as it stands is very prohibitive to does not foster clinical innovations which is one of the system design pricing guidelines. For example, the location of acute care should not be limited to a NICU if it can be provided outside of the unit and is more beneficial to the mother and child.

8.2 Trialling of innovative models of care

The trialling of new innovative models of care is strongly supported by SA however, it is recommended that these services be discussed at the IHACPA Technical Advisory Group to understand how they may align to current pricing frameworks and other jurisdictional services.

For more information

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