Independent Health and Aged Care Pricing Authority

Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26

NSW response

NSW Health's (NSW) response below is made with reference to the relevant sections of the Independent Health and Aged Care Pricing Authority's (IHACPA's) *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26*.

1. Introduction

1.3 IHACPA's broader work program

NSW notes the following advice from IHACPA 'due to the volume and complexity of this work, and the lead time to implement changes to classifications and data collections that underpin refinements to the national pricing model, this work often requires multiple years to complete, thus impacting the development of future determinations.' (pg. 4).

The impact from delays in IHACPA's work program is felt at all levels within a jurisdiction and can result in a significant negative contribution margin.

2. Pricing Guidelines

2.1 The Pricing Guidelines

NSW requests under the fifth point of the 'System Design Guidelines', IHACPA include the criteria for using activity based funding (ABF) where practicable and appropriate to reflect the clinical care provided. This amendment would be in line with the seventh point where adjustments are based on 'patient-related rather than provider-related characteristics'.

3. Classifications used to describe and price public hospital services

3.1 Admitted acute care

3.1.1 ICD-10-AM/ACHI/ACS Thirteenth Edition

The price weights for Drug and Alcohol Diagnosis Related Groups (DRGs) (V60A to V62A) are significantly undervalued. The average length of stay (ALOS) listed for these DRGs is significantly shorter than expected length of stay (LOS) for successful treatment.

3.1.2 Cluster coding

NSW notes the results from the cluster coding pilot held in early 2024 are still pending and these results will inform the final process. NSW requests results from the pilot are circulated to jurisdictions prior to any planned implementation of cluster coding to ensure cluster coding will be a benefit to jurisdictions.

Concerns are held for the implications cluster coding will have on coder workforce as it may increase the frequency of documentation queries to determine the relation between conditions.

Clarification in sought on whether cluster coding will affect the impact of codes on Diagnosis Complexity Level (DCL) and/or bump the DRG to a higher complexity.

In preparation for ICD-11 and given the significant changes, NSW recommends IHACPA provide comprehensive support to jurisdictions to ensure the anticipated changes for jurisdictions are well understood, particularly coding requirements and workforce impact.

3.2 Subacute and non-acute care

The implementation of the Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 5.0 is supported by NSW, however analysis on its effectiveness has not been shared with jurisdictions. NSW requests this analysis is circulated to jurisdictions prior to endorsing and supporting AN-SNAP Version 5.0 for the National Efficient Price Determination 2025–26.

NSW recommends IHACPA investigate the changes to the AN-SNAP classification structure, such as an alternative complexity model that utilises an overall complexity score, such as the complexity model implemented for acute and Emergency Departments (ED).

There should also be consideration of current and future models of care utilised in the subacute and non acute space and how AN-SNAP will need to evolve to capture these models, for example Rehab in The Home and InReach. This work could explore different clinical care pathways into areas such as aged care and disability and their interaction with particular care types, such as maintenance care, geriatric evaluation and management and palliative, or variables such as age, frailty, or dementia.

Other potential refinements/adjusters IHACPA could consider for AN-SNAP include:

- substance misuse
- homelessness
- mental health
- physical and intellectual disability
- aged care
- carer status (pre and post discharge)
- residential aged care facility status before and after
- rurality/remoteness.

3.3 Emergency care

3.3.1 Australian Emergency Care Classification Version 1.1

Consultation Question:
Question 1: What, if any, barriers are there to pricing emergency department services using the Australian Emergency Care Classification (AECC) Version 1.1 without a shadow pricing period for NEP25?

Feedback from NSW local health districts (LHDs) on barriers to pricing ED services without shadow pricing AECC Version 1.1 include minimal staff education and training support to implement classification changes.

3.3.2 Refinements to the Australian Emergency Care Classification

Consultation Question:
Question 2: Are there any other proposed refinement areas to be considered in the development of an updated version of the Australian Emergency Care Classification?

Identifying patients with alcohol and other drug use has been challenging as this may not always be recorded as a principal diagnosis. Under the response to the Special Commission of Inquiry into the drug ‘Ice’, NSW is supporting the implementation and evaluation of three

Safe Assessment Units in three NSW LHDs. These short-stay units are co-located with EDs and aim to provide integrated care, treatment and support for patients who are acutely intoxicated or presenting with, or at risk of, acute, severe behavioural disturbance associated with substance use, psychiatric conditions, psychosocial crisis or a combination of these. This is an innovative model of care that requires data collection to measure impacts on ED use and transition to specialist and/or community care. Patients may also have co-occurring principal diagnoses (mental health and alcohol and other drugs). NSW recommends Safe Assessment Units are considered as a proposed refinement for the AECC as they may help identify patient complexity and more accurate diagnosis for people presenting to the ED with psychiatric or addiction related issues.

Diagnosis does not always reflect complexity and should be considered for the AECC. The presenting problem may be used to give some indication of complexity, however there are issues with using urgency as a proxy for complexity as some low urgency patients may require more investigation when compared to higher urgency patients.

There are a number of vulnerable patients treated in EDs, including those experiencing homelessness, who are often more likely to represent and require additional services and supports. They may have a range of comorbidities that require treatment for both their mental and physical well-being. NSW also recommends considering the impact of these social complexities as part of the AECC.

Feedback from NSW LHDs on other proposed refinements to the AECC include:

- additional weightings applied for mental health patients who require extra human resources, treatment or consultation in an ED
- additional weightings applied for resuscitation patients, this would be similar to the ICU weight applied for Acute patients who are resuscitated.

Consultation Question:

Question 3: Are there any barriers or known issues associated with reporting patient level data, specifically in relation to reporting principal diagnosis and patient's age in emergency services?

Aboriginality is often under-reported for a variety to reasons, including Aboriginal people not having trust and confidence in the health system due to past historical practices of discrimination. This issue needs to be taken into greater account when considering ED care and patient-level data. IHACPA could consider other methods for identifying aboriginal such as population datasets.

While Aboriginal people are over-represented in many diagnoses, the actual numbers may be smaller and therefore privacy, particularly in relation to mental health presentations and diagnoses may be a concern.

Difficulties exist in recording consultation by specialty departments into ED, such as Mental Health and Geriatric Medicine. This results in incomplete resource allocation within the costing process and hence undervalues the price weights.

Feedback from NSW LHDs on barriers/issues with reporting patient level data include:

- whilst NSW can generally record principal diagnosis, some patient administration systems are not aligned to the current classification breakdown required to be captured, especially if secondary diagnoses are being considered.
- accurately capturing data can be a challenge for locum workforces particularly in rural and regional settings

- consultations within ED by specialty areas are not well captured.

3.4 Non-admitted care

A better definition of services provided in the outpatient setting is required and should include community care and primary care separate to the ambulatory models of care which are delivered at a hospital. NSW recommends incentives may be an option to provide the right care, at the right time in the right place with more focus on care in the community, at home or via virtual methods.

NSW notes over the last two year, the home dialysis Tier 2 codes have seen their price weights more than halved which has significant implications for renal services. NSW has concerns that the price weight for Peritoneal Dialysis is inappropriately low given the costs incurred by the state. Renal dialysis - Home Delivered has decreased by two thirds in NWUA24. NSW requests changes of this magnitude are implemented over a two-year timeframe in the future to mitigate the impacts or that the stability policy is introduced for Non admitted services to ensure certainty of funding for services.

NSW recommends to avoid confusion around Subcutaneous Immunoglobulin (SCIg) being delivered to the home, the language is changed from ‘home delivered SCIg’ to ‘home administered SCIg’.

3.4.1 Tier 2 Non-Admitted Services Classification

Consultation Question:
Question 4: Are there any other proposed refinement areas to be considered for the Tier 2 Non-Admitted Services Classification for NEP25?

Proposed refinements from NSW LHDs for consideration as part of the Tier 2 classification include:

- further linkage between the Primary Health Care Sector and the Tertiary health care sector to ensure continuity of care and visibility of patient flow between the systems, for example GP referrals
- Tier 2 clinic 40.30 *Alcohol and other drugs* contains a number of interventions which have significantly varying resource demands, often in the non-client contact areas supporting the direct treatment, this may include:
    - case management for opioid substitution therapy
    - assertive management
    - court diversion
    - general drug and alcohol counselling.

3.5 Mental health care

NSW supports to current work-program to further review current classification systems.

NSW also supports a transparent review of Australian Mental Health Care Classification (AMHCC). NSW requests jurisdictions are extensively involved and consulted during this process. Changes to the classification have major implications for clinical processes, eMRs, clinical information systems, data extracts, data warehouses, analysis, reporting and state activity purchasing and monitoring which need to be considered by IHACPA.

3.5.2 Admitted mental health care

Considerations proposed by NSW LHDs for inclusion under AMHCC Version 1.1 include:

- age complexity score refinement
- extension of legal status across all age groups
- inclusion of a diagnosis within the complexity score
- consideration of an eating disorder same day end class.
- consideration of short stay classes where NOCC does not require outcome measures to be undertaken

3.5.3 Community mental health care

Considerations proposed by NSW LHDs for inclusion under AMHCC Version 1.1 include:

- providing clear guidelines for concurrent care across multiple ambulatory services to ensure correct end class allocation
- assurance the removal of fixed price weights will not negatively impact short LOS programs with minimal direct client contacts
- clarification on how services that have predominantly unidentified consumers will be funded
- inclusion of consultation liaison for ambulatory mental health care regardless of if client is known to the Community Team.
- inclusion of activity duration to reflect complexity of care delivered.

Consultation Question:

Question 5: What, if any, barriers are there to pricing admitted and community mental health care services using the Australian Mental Health Care Classification Version 1.1 for NEP25

NSW continues to make substantial investment in supporting AMHCC in Inpatient and Community settings and notes the following continued barriers:

- complexity and ambiguity of community episode and phase construction rules, and lack of alignment with clinical concepts
- lack of transparency and consultation in making material changes to AMHCC technical specifications
- perverse financial incentives in both settings which penalise improvements in data quality and risk incentivising clinicians to record unknown phases.

Additionally, the Consultation Paper states ‘IHACPA commenced the work program for the development of AMHCC Version 2.0 in early 2024’. Jurisdictional consultation or involvement in discussions on requirements, assumptions or constraints for the development of AMHCC Version 2.0 is yet to occur, NSW welcomes the opportunity to be involved in these discussions.

A fourth year of shadow pricing community mental health care services using the AMHCC and the continuation of block funding for community mental health under the NEC Determination 2024–25 is supported. NSW is committed to working with IHACPA through 2024 to address the AMHCC classification issues raised in previous communication and reiterates:

- AMHCC has not kept pace with models of care that require/encourage anonymity, for example NSW Safehaven services, Recovery College, Police Ambulance and Early Clinical Response (PACER), Safe Start, and GotiT services. Classifications should recognise models of service delivery rather than service delivery be amended to the classification.

- The funding model needs to accommodate services where anonymity is key to reaching vulnerable patients, noting that these types of services will continue to operate as anonymous services.
- Ongoing variability in data provision and collection between jurisdictions which, if unresolved, could risk implementing atypical price weights that do not appropriate reflect the cost of service.
- Poor alignment with the National Outcomes and Casemix Collection (NOCC) protocol and conflicting rules for data collection between IHACPA's Technical Specifications and NOCC protocols.
- The bundling of sub-specialties departs from general ambulatory services where patients, especially those with multiple chronic conditions, may have care provided by multiple teams which should be reflected separately. NSW is concerned that rolling up these service contacts from different mental health specialty teams and/or services into one specialty team (primary care team) diminishes the complexity of care provided in the community and may result in a risk of under reporting AMHCC in the community setting.
- Community mental health care is not being accurately reflected in the funding model rules proposed by IHACPA. Mental health care patients predominantly have multiple diagnoses and are treated by specialist mental health clinicians specific to that diagnosis. As such, mental health care patients are concurrently treated by an array of specialist mental health clinicians and/or services. However, AMHCC is expected to roll all activity, such as mental health phase of care or contacts, into one phase determined by a primary care team.
- Perverse pricing incentives for improving data quality, which threaten the integrity and credibility of the classification.

Furthermore, services with de-identified clients and several ambulatory or community mental health care services, such as Telephone Assistance Line, are unable to capture sufficient contact details on the consumers that they interact with, hence are unable to complete an identified contact form. There are a number of community mental health care services that provide services to populations where the service is unable to collect sufficient information to be able to register a consumer and/or complete an age appropriate HoNOS rating as the service they provide are triage services, for example the Telephone Assistance Line, due to the population targeted. These services are aimed at providing education or health promotion activities that assist in identifying vulnerable individuals requiring targeted assessment and treatment or because the service provides a support service to the main service providing mental health care. A substantial number of community services are considered triage, mental health promotion services or consultation-liaison services which would not necessarily complete an age appropriate HoNOS assessment and/or a Mental Health Phase of Care for an individual consumer. Hence, in these situations the only valid Mental Health Phase of Care would be 'Assessment Only / Initial Assessment'. Potentially the MH1 to MH12 classes could be used to cover some of these areas under a block arrangement but IHACPA have not provided sufficient education or tools for these classes to be well understood.

Consumers in the community who have an Involuntary Mental Health or Community Treatment Order (CTO) do not have a mental health legal status recognised by AHMCC. Consumers on CTOs or consumers under the *NSW Mental Health Cognitive Impairment Forensic Provisions Act* or *NSW Child Protection (Offenders Registration) Act 2000* also tend to be more resource intensive, due to the increased supervisory nature of their care and extensive reporting of progress to various statutory authorities. NSW recommends

recognition of mental health legal status, by way of an additional weighting to renumerate services for managing these consumers in an ambulatory setting.

AMHCC does not address how several ambulatory services, such as consultation or liaison services, Towards Zero Suicide, PACER, vulnerable persons and homelessness services and clozapine clinics record their activity. In addition, several other ambulatory mental health services, such as, Pathways to Community Living Initiative (PCLI), eating disorders, intellectual disability, specialist rehabilitation services, peer support and family and carer programs provide support services to other mental health services and do not necessarily complete a HoNOS rating or Mental Health Phase of Care, hence would fall outside of AMHCC. These secondary and ancillary services provide both crucial proactive specialist support to consumers under the care of a responsible service units and, tertiary consultation and liaison services to other services internal and external to mental health, however will be discounted by AMHCC.

These ancillary specialist support services provide an essential service that provides therapeutic interventions that impact on the health and wellbeing of the consumers, however, these services would not be expected to complete a Mental Health Phase of Care and outcome collection. These services would not be recognised as providing care at the same level to the same consumer as the responsible service unit, as these services would be assigned Unknown Phase / Unknown HoNOS. In a tightening financial environment, the inability to ensure these additional costs can be counted, may function as a disincentive for inclusion of these services within the treatment regime. Clear guidance on how these services will be considered, treated and funded would assist NSW in the transition.

3.6 Teaching and training

Consultation Question:
Question 6: Are there any persisting barriers to collecting activity data following the COVID-19 pandemic response? If so, what potential strategies could IHACPA use to support states and territories in overcoming these barriers?

Nil comment.

Consultation Question:
Question 7: What data-driven processes can be used to determine the efficient cost of teaching and training services to improve the transparency of block-funded amounts provided for these services, ahead of a potential longer-term transition to ABF

Currently, TT that is patient related is captured through the patient level costing methodology. The remaining TT is aligned to workforce development and service delivery rather than patient based and consequently is currently block-funded.

A cost benefit analysis to assess the appropriateness and determine if there is value in allocating TT at a patient level is requested by NSW and recommends a workshop with National Hospital Cost Data Collection Advisory Committee (NAC) to determine if and how the cost benefit analysis can be undertaken.

4. Setting the national efficient price

4.1 Impact of COVID-19

Surgical admissions were also significantly impacted during COVID-19 and should be considered for adjustment during 2021-2022.

4.1.1 Preparedness for the future

Consultation Question:

Question 8: What evidence can stakeholders provide that demonstrates the costs and changes to models of care associated with the COVID-19 pandemic response have persisted into 2022–23, or changed over time?

IHACPA committed to reviewing the costs of 2022–23 against the price set, given the assumptions that were made in the development of that price. NSW requests IHACPA undertake this analysis to assess impact and inform any adjustments that may be proposed.

There have been changes to the numbers and demographics of presentations to ED and acute care services. In mental health, the numbers of urgent care referrals to Acute Care Teams and non-clinical services has risen but the ED has remained stable from a presentations perspective. The profile of mental health ED presentations is changing.

For example, one Local District Network Return demonstrates ongoing costs associated with COVID-19 persisting into 2022–23 and 2023–24. In 2022–23, the total costs to an LHD were approximately $10.44M as demonstrated at Table 1. While Commonwealth funding ceased in December 2022, the LHD continued to incur costs associated with COVID-19 in the second half of the year. While this was reconciled, it did not occur until after funding ceased. In 2022–23 there were 2,811 inpatient bed days associated with COVID-19.

For 2023–24 July to December COVID-19 costs were $666,000.

Table 1. Costs associated with COVID-19

2022-23	Total	Post funding
Inpatient Impact	$4.59M	$1.02M
Emergency Impact	$2.47M	$1M
NAP Impact	$3.38M	$1.23M
Total	**$10.44M**	**$3.25M**

Consultation Question:

Question 9: What principles and processes could guide an appropriate pricing response to significant disruptions to the health system, including natural disasters and epidemics?

Implementing fixed and variable cost reporting is recommended to assist in developing a pricing response to natural disasters and pandemics.

NSW also requests the development of appropriate classification codes to enable local level hospital staff to capture and collect patient level data relating to the significant disruption. This mechanism would most likely need to include an adjustment similar to the COVID-19 Treatment Adjustment when activated.

4.2 Adjustments to the national efficient price

Regional and remote locations, including Aboriginal communities, are particularly impacted by significant disruptions to the health system. Therefore, the remoteness area and Indigenous adjustments should ensure that there are appropriate loadings to support these areas.

Clause 47 of the 2020–25 Addendum to National Health Reform Agreement (NHRA) (pg. 17) is supported by NSW.

Consultation Question:
Question 10: Should the ICU adjustment be restricted to a list of eligible hospitals? If so, what factors should be considered in determining the level of ICU complexity required to be eligible for the ICU adjustment, noting that individual units cannot be identified in the current national data collections?

NSW considers the current use of Mechanical Ventilation (MV) as a criterion for the eligibility list is no longer clinically appropriate. NSW strongly recommends IHACPA review all options included in the CU Literature Review Paper submitted by NSW through the Technical Advisory Committee (TAC) in July 2023 as well as other options provided by Jurisdictions through the formal TAC and Jurisdictional Advisory Committee discussions.

In the Work Program and Corporate Plan 2023–24, IHACPA agreed to deliver 'a review of the eligibility criteria for specified intensive care units and specialised children's hospitals' (pg. 12). In the draft Work Program and Corporate Plan 2024–25, IHACPA has also noted that 'the work plan will prioritise review of the intensive care unit adjustment… and [its] respective eligibility criteria for 2024–25g (pg. 13). NSW advises jurisdictions are yet to see the results of these reviews and any associated analyses or recommendations flowing from the review.

NSW reiterates any assessment of options should align with Figure 1: Pricing Guidelines, System Design Guidelines - 'Adjustments to the standard price should be based on patient-related rather than provider-related characteristics wherever practicable.' (pg. 8).

Feedback from NSW LHDs on what factors should be considered in determining the level of ICU complexity include:

- The ICU adjustment should not be limited to a list as services can evolve over time and change role delineation, therefore take on higher acuity. An example, Ryde Hospital now has an ICU not due to a redevelopment but due to a change in service needs for the local community and to meet the demand of the LHD.
- Eligible ICUs should not be defined on the basis of meeting a specified number of ICU hours, this penalises smaller hospitals that may not meet the threshold but nevertheless deliver high intensity care. The criteria should include any hospital that delivers ICU care to patients who require complex management and constant monitoring, receives the adjustment.
- ICU adjustment should consider other elements such as hospital size, rural location and case mix.
- Surgical NICU's should also be included as the current methodology of counting these activity is based on gestational age which results in major price/cost mismatches when compared to the same treatment in adult ICUs.

Additionally, further consultation with ICU clinicians is recommended to understand the clinical drivers that impact resources.

Consultation Question:

Question 11: Are there any barriers to a tiered adjustment that would allow for different ICU adjustment prices to apply, based on the characteristics of eligible hospitals or episodes of care within those hospitals?

NSW reiterates feedback provided in response to question 10 and notes a tiered adjustment may be beneficial but the characteristics of the hospital or episodes used in this adjustment should be driven by a consultative process with ICU clinicians and other key stakeholders whilst incorporating elements of the environmental scan undertaken by NSW which has ACI and ANZICS support. Additional data collections will need to be updated to capture the required information.

A possible barrier to a tiered adjustment could be the unintentional creation of a bias for ICU's that have had their adjustment removed or reduced and aim to transfer patients to other larger ICU's if it becomes less economically viable to care for these patients with a reduced adjuster. This could present the possibility that patients don't receive their care as close to home as could otherwise be possible.

If Diagnosis Related Groups (DRGs) are used as a criteria in episodes of care, it is crucial to note that the classification system and attached national weight activity unit is not always in line with the resources used. For example, two patients could be categorised in the same DRG with the same complexity level, and yet the patient journeys and resource utilisation could be completely disparate.

Consultation Question:

Question 12: Are there any barriers to including a fixed national weighted activity unit adjustment for eligible hospitals, regardless of activity levels?

NSW reiterates feedback provided in response to question 10.

Furthermore, the fixed national method does not sufficiently account for variation and complexity and from a mental health perspective, there is an unequitable access to resources which should be adjusted for.

4.2.2 Other adjustments and their eligibility criteria

Consultation Question:

Question 13: To support IHACPA's investigation, what factors may help explain the reduction, in the Indigenous adjustment observed in recent years? Additionally, what factors should be considered in refining the calculation and application of the Indigenous adjustment, so that it reflects the costs of public hospital services for Aboriginal and Torres Strait Islander peoples across Australia?

In NSW, Aboriginal and Torres Strait Islander costs have been trending upward over the last three years. This indicates that there has been significant decline in one or more other jurisdictions.

NSW recommends IHACPA undertake analysis around the factors causing the movements, including:

- whether there has been a change in reporting in numbers for the Aboriginal data flag
- a review of interactions between the indigenous adjustment and remote area adjustment, including price weight changes.

Additionally, NSW also recommends a costing study in undertaken to identify the requirements for Indigenous Australians in alignment with the National Closing the Gap

initiatives to progress and incentivise milestones through the national ABF funding model whether it be adjustments or other funding alternatives, for instance bundle payments or block funding.

Feedback from NSW LHDs on factors that may explain the reduction in the Indigenous adjustment include:

- The collection of Indigenous Status in the Electronic Medical Record (eMR) is not collected properly.
- Australian Bureau of Statistics has found that a person's identification can change at various points throughout their life, and can be a response to shifting social or personal circumstances, with identifying becoming increasingly complex over time due to the impact of different policies, legislation, and cultural safety.
- Considering social determinants along with additional factors may refine the application to better reflect the cost of care for those Indigenous patients experiencing profound degrees of complexity.
- Data is reliant on administrative staff asking the question at point of registration or contact with the service which may not necessarily occur.
- There may be data quality issues in collecting Indigenous status adequately at local hospital level information systems.

Factors taken into consideration including Aboriginality, age, gender, patient history, Stolen Generation Survivors and families, history of Discharges Against Medical Advice and incomplete ED attendances, urban, regional or remote setting, literacy, education, past/current trauma, homelessness, dependencies, comorbidities, chronic and complex care needs, access to family, kinship, employment status, and financial position may support more equitable access for Aboriginal people and assist with refining the calculation and application of the Indigenous adjustment.

Furthermore, examining the Indigenous adjustment alongside other adjustors impacting Indigenous patients such as Patient Residential Remoteness Area, Charlson Complexity Index and Dialysis may also assist with refining the Indigenous adjustment.

The benefits of holistic health and well-being approaches and the overall efficiency and positive health outcomes should be a key consideration in the costs of public hospital services.

4.3 Accounting for private patients in public hospitals

NSW requests consideration is given to areas, particularly rural and regional areas, where there is limited or no private or non-government organisations to compliment the public service. This impacts ability to attract staff to the areas, for example medical staff are not able to set up a private practice.

4.4 Harmonising price weights across care settings

NSW supports price weight harmonisation and requests IHACPA provide any analysis undertaken from the 2021–22 data to jurisdictions. NSW notes that this piece of work has been intended for completion for some years now and recommends timeframes are adhered to.

5. Setting the national efficient cost

5.1 Overview

NSW is currently examining the state funding approach for small public hospitals (block funded facilities) to identify opportunities to ensure small hospitals are adequately funded in line with the costs of delivering care.

There are higher costs associated with delivering care in rural and remote settings, however there is evidence these are not always adequately accounted for. Recommendation 36 (part d) from the NHRA Mid Term Review includes a review of regionality weighting to ensure rural and remote hospitals are funded fairly is supported.

5.2 The 'fixed-plus-variable' model

Under the National Efficient Cost Determination (NEC) Small Hospitals methodology, there is no provision to revise or update calculated cost to reflect current levels.

NSW notes the funding model has provided estimated costs less than the actual cost of facilities in NEC 2022–23 and requests the current Small Hospital funding model reflecting the fixed-plus-variable methodology is reviewed by IHACPA in the post-COVID climate.

Additionally, support is required for rural and regional areas to provide services with low volumes to ensure appropriate funding, for community obligation areas such as maternity services.

5.3 Standalone hospitals providing specialist mental health services and residential mental health care services

NSW recommends funding for standalone hospitals providing specialist mental health services and residential mental health care services considers low activity volume, where safe staffing levels are required.

NSW recommends the stand alone hospitals remain as is until the AMHCC is completely embedded and costs and funding have become stable.

6. Data collection

6.1 Cost and activity data collection

There is limited local costing capability in rural and remote areas which can affect the quality of costing data in small hospitals. NSW recommends this gap in data is considered as part of the funding methodology.

Consultation Question:
Question 14: How should IHACPA account for the changes in data reporting when developing a costed dataset?

Costing every occasion of service at a patient level is inefficient and does not add value. By ensuring that there is an appropriate distribution of data within the representative submission, the number of records would be immaterial.

Reporting on all activities and patient interactions in the current data sets is an unsustainable process and does not add value to the costed data set compared to a representative, statistically supported submission. NSW requests IHACPA reconsider the methodology around reference costs and data preparation adjustments.

NSW recommends a review of classes and hospitals on a case-by-case basis, particularly when there are significant changes in source system collection or value-add process systems, as this may occur at various times during the year. If a change occurs that impact the development of price weights, hospitals are consulted to discuss the impacts.

Feedback from NSW LHDs to account for data reporting changes include:

- business rules have the ability to back cast for prior years using the costing data asset
- understanding different models of care will impact activity and costed results.

Consultation Question:
Question 15: How can IHACPA ensure that the data collected is an appropriate, representative sample and that data collection methods account for changes to health system reporting capacity?

NSW recommends IHACPA adopt a methodology to ensure that cost submissions are statistically relevant and on trend compared to previous submissions.

Further recommendations include enabling automation and utilising updated systems such as PowerPerformance Manager 3.

Additionally, appropriate stratified analysis of collected costing data may be conducted with the consideration that a sub sample may be more representative at a sub group level than the representativeness of the whole sample in relation to the overall patient population.

6.2 Assurance of cost data

Consultation Question:
Question 16: What quality assurance approaches are being implemented at the hospital or state and territory level that should be considered by IHACPA to apply to national data collections?

NSW supports the investigation of cost variations through the facilitation of focus groups. The focus group should ensure there is representation from NAC and TAC with the findings presented for discussion in both forums.

Feedback from NSW LHDs on quality assurance processes utilised include:

- District Network Return audit programs have been developed and tailored to examine internal controls for the output of the costing process for specific areas as per the requirements of both the state and national needs.
- Heightened process of validation with the transition between HIE and EDWARD.
- Implementation of Data Quality for Improved Performance Programs and smart logics to prevent obvious data entry errors.
- Inclusion of data quality adjustors which penalise hospital and LHDs and acts as an incentive to invest in data quality.

6.3 National Benchmarking Portal

Consultation Question:
Question 17: What changes would enhance the user experience and functionality of the National Benchmarking Portal to inform improvements in public hospitals, and policy making?

NSW requests more timely data is available and the ability to drill down and analyse as per the cost buckets contributing the cost per episode on the National Benchmarking Portal.

8. Future funding models

8.2 Trialling of innovative models of care

‘Trials of innovative models of care may only occur through a bilateral agreement between the Australian Government and a state or territory, for a fixed period of time under clause A97 of the addendum.’ (pg. 30)

NSW advises there were significant delays encountered when implementing a bilateral agreement due to conflicting interpretations of the mechanics of this requirement with IHACPA and the Commonwealth. The overall process also lacks official annual review and feedback process to ensure funding is in line with services delivered. This can lead to operational issues as innovative models involves expansion of services requiring additional resources.

To support innovation, IHACPA should ensure that:

- the process and requirements for including innovative models of care in the NEC is streamlined and clear
- the process and requirements for transitioning from innovative models of care to business as usual under the next iteration of the National Health Reform Agreement need to be agreed and established between jurisdictions and IHACPA
- there are mechanisms in place to provide for limited activity and cost data reporting due to the innovative nature of these programs.

Innovative models of care should also focus on the value-add that health interventions provide. This area needs to be holistic and data-driven and also take into account socioeconomic disparities. The value that health interventions create may differ between groups, and to break the health social economic status nexus, it is critical to put equity at the heart of healthcare provision.

8.3 Virtual models of care

NSW supports IHACPA working on the Virtual Care Classification program and recommends adequate consideration is made for both ends of virtual care services, for example entities providing virtual care and entities receiving virtual care support. Additionally, the hidden benefits of virtual care should be recognised through new pricing and funding model incorporating the benefits from enabling capacity of existing health facilities and non-monetary benefits for patients.

There have been challengers to effectively report the delivery of virtual care for opioid treatment programs across NSW LHDs. This is a new model of care for the alcohol and other drugs sector that aims to enhance access to addiction medicine specialists in rural and remote NSW. Addiction medicine specialists are located in one LHD providing services to patients in a second LHD. As a part of this model of care TT is also provided and not captured in the data, limiting capacity to count or cost this activity across local health districts.

Barriers for rural and regional areas includes the electrical capacity of sites which may require significant capital upgrade. The allocation of capital funding to support establishment of equipment and services, particularly in inpatient settings would assist rural and regional areas.

9. Pricing and funding for safety and quality

9.3 Hospital acquired complications

Clarification is sought on whether the introduction of a funding adjustor for hospital acquired complications (HACs) has led to the desired outcome.

NSW recommends a further expert review of HAC definitions and DRGs, to minimise penalties for expected complications. For example:

- Hypoglycaemia: Previously, documentation published suggesting only applicable to diabetic patients on medication, this has been removed, it is now applied to all patients. There is an expectant level of blood sugar decrease in patient fasting for surgery.
- Renal Failure: International peer reviewed evidence identifies that more than 50 per cent of patient undergoing cardiac and/or lung transplant will experience acute renal failure.
- Cardiac complications – Arrhythmias: There is a degree of arrhythmia related to cardiac surgery and cardiac arrhythmias.
- Cardiac complications – Cardiac Arrest: Successful resuscitation is penalised.

9.5 Evaluation of safety and quality measures

The continued consideration of complexity when considering safety and quality indicators is recommended by NSW.

Consultation Question:
Question 18: What impact has the introduction of the pricing approaches for sentinel events, hospital acquired complications and avoidable hospital readmissions had on public hospital service delivery?

The introduction of these pricing approaches impact jurisdictions with more complex surgical patients that flow from other jurisdictions. These patients are at higher risk of sentinel events, HACs and avoidable hospital readmissions.

The models also create tension between quality of care delivery and workforce availability to meet demand.

Consultation Question:
Question 19: To inform the further development of safety and quality measures, are there other pricing-related approaches that could be used to reward high quality care? How can IHACPA identify such care in national data collections?

Recommendations for IHACPA to identify high quality care include:

- linkage between patient experience/outcomes (PREM/PROM) to activity and costing data
- alignment to Australian Commission on Safety And Quality In Health Care recommendations and work programs
- identification of LOS lower than national or state average for the DRG
- identifying data that reflects the model of care and use these as indicators, such as performing physical health care assessment in mental health, care reviews and evidence of patient care pathways.