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

Northern Territory Health Submission

NORTHERN TERRITORY GOVERNMENT

1. Foreword

This submission provides feedback on issues highlighted in the Independent Health and Aged Care Pricing Authority's (IHACPA) *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025-26*, particularly where there may be potential impacts to equity of access to hospital services or the financial stability of the Northern Territory public hospital system.

Some recommendations from the National Health Reform Agreement (NHRA) 2020-25 Addendum mid-term review can be progressed expediently by IHACPA, independently of negotiations on the next NHRA Addendum. It is critical for the NT that IHACPA addresses Recommendation 18 of the NHRA mid-term review prior to implementation of NEP25; that IHACPA introduce a pricing adjustment for smaller jurisdictions unable to operate at scale and without the cost base of larger jurisdictions. Furthermore, IHACPA should review and potentially update the calculation of the Indigenous, residential and treatment location adjustments to ensure they are operating as intended.

2. Pricing Guidelines

No comment.

3. Classifications used to describe and price public hospital services

3.1. Admitted acute care

IHACPA's proposal to implement cluster coding from 1 July 2025 as part of ICD-10-AM thirteenth edition will require enhancements to the NT's new patient administration system, which is being incrementally deployed to our hospitals, as well as the Enterprise Data Warehouse. NT Health may not be able to implement cluster coding within our systems prior to July 2025, despite best efforts.

3.2. Subacute and non-acute care

As noted in prior submissions, the NT hospital system continues to support maintenance care patients who are admitted in public hospitals due to failures in the health interfaces with aged care and disability care, services which are primarily a Commonwealth responsibility. NT Health consider that these maintenance care patients would not require extended hospital care if appropriate aged or disability care services were available in the community. As well as leading to sub-optimal patient care and experience, NT Health consider this a cost shift from the Commonwealth to jurisdictions. A more equitable pricing solution is proposed in section 4 of this submission. A new data element within the subacute classification could identify long stay patients who are clinically ready for discharge within the maintenance care-type. This will enable a fairer pricing approach for patients where there are barriers to discharge outside the direct control of hospitals.

NT Health requests IHACPA introduce a new data element within the maintenance care type to identify patients who are clinically ready for discharge to enable a fairer pricing approach for these episodes.

3.3. Emergency Care

Consultation question:

- What, if any, barriers are there to pricing emergency department services using the Australian Emergency Care Classification Version 1.1 without a shadow pricing period for NEP25?

NT Health notes that the proposed revision to the Australian Emergency Care Classification (AECC) is a modest change to the classification which moves records between complexities within each Emergency Care Diagnosis Group, which does not require shadow pricing.

NT Health requests IHACPA provide an assessment of funding impact of this minor revision in the classification as soon as possible prior to commencement of pricing in NEP25.

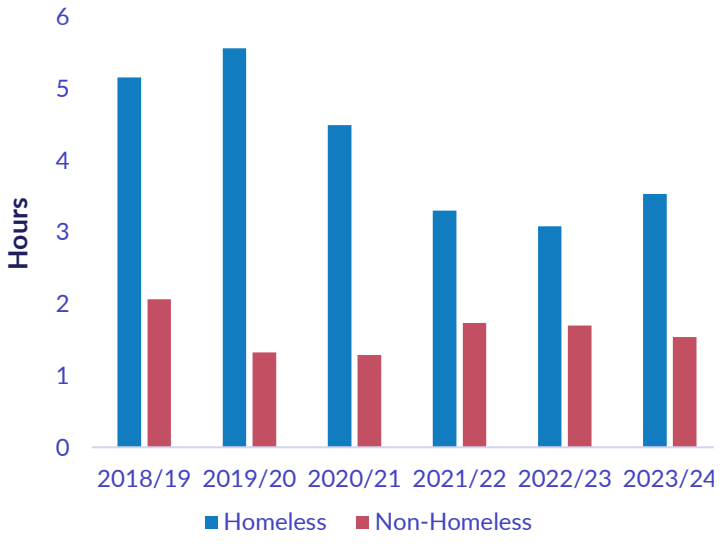
Consultation question:

- Are there any other proposed refinement areas to be considered in the development of an updated Australian Emergency Care Classification?

NT Health has observed that patients experiencing homelessness, including those in severely crowded dwellings, are likely to remain in the Emergency Department for longer and/or experience extended inpatient lengths of stay. This pattern is demonstrated in non-urgent presentations at Alice Springs Hospital where homeless status is consistently captured within the emergency setting. A lack of housing and familial support places these patients at additional risk of clinical deterioration post-discharge and outpatient appointment attendance is likely to be poor.

NT Health consider that data quality and reporting compliance would be better incentivised within the hospital system if the homeless status data variable is reflected in the calculation of the activity within the AECC classification.

Chart 1: Alice Springs Hospital Emergency Department, average length of stay for non-urgent presentations.



NT Health requests IHACPA revisit analysis of the effect of a diagnostic modifier of homelessness on the performance of the AECC.

NT Health requests that IHACPA further consider how the AECC could reflect this patient characteristic, and drive consistent collection of this data.

Consultation question:

- 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?

NT Health has recently encountered challenges reporting principal diagnosis for emergency presentations due to the implementation of a new patient administration system in our hospitals. NT Health is working to resolve these issues.

3.4. Non-admitted care

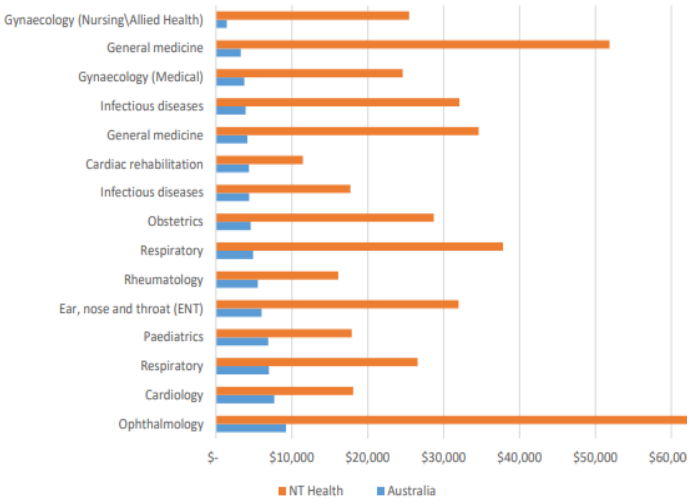
Consultation question

- Are there any other proposed refinement areas for the Tier 2 Non-Admitted Services Classification NEP25?

NT Health provides specialist outpatient care to over 70 very remote communities. Clinicians travel extremely long distances at significant cost to provide treatment. These off-campus specialist outreach service provide specialist care closer to home, allowing patients to stay closer to family and cultural support networks. Specialist outpatient services enable family and local health staff to attend consultations in familiar surroundings, improving communication and fostering improved understanding of remote community circumstances by hospital clinicians.

The NT has an average cost 79 percent higher than the national average for off-campus services, as observed through annual submissions to the National Hospital Cost Data Collection. The higher costs of this activity is particularly pronounced for certain specialist outpatient clinics shown in Chart 2.

Chart 2: Off-campus specialised outpatient non-admitted cost per NWAU21, NHCDC 2021-22



NT Health requests that IHACPA consider a variable other than hospital establishment to determine the patient treatment remoteness adjustment for non-admitted activity that occurs off-campus.

NT Health suggest a more accurate pricing adjustment that accounts for off-campus outreach services could be determined using a combination of data elements, including hospital establishment, patient's area of usual residence, service delivery setting and non-admitted patient service delivery mode.

3.5. Mental Health Care

Consultation question

- What, if any, barriers are there to pricing admitted and community mental health care using the Australian Mental Health Care Classification (AMHCC) Version1.1 for NEP25?

NT Health notes that the AMHCC does not reflect the costs of delivering community mental health services to patients in all circumstances.

NT's remote community mental health teams often travel significant distances at high cost to provide mental health services closer to a patient's place of residence. The hospital or establishment within which a community mental health team is administratively located is not always the most appropriate determinate of patient treatment location. Community mental health services are regularly delivered off-campus in locations which are often in a more remote area than the hospital establishment. As such, a treatment adjustment cannot be accurately calculated from the associated hospital establishment.

NT Health requests that IHACPA investigate the use of data items other than hospital establishment to identify treatment location of community mental health service contacts delivered off-campus.

3.6. Teaching and training

Consultation question:

- 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?
- 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?

NT Health notes that IHACPA and the Australian Government are working towards transitioning teaching and training from block to ABF. NT requests that IHACPA consider the practicability and administrative overhead required to enable the reporting of requisite data for such a transition, particularly for small jurisdictions.

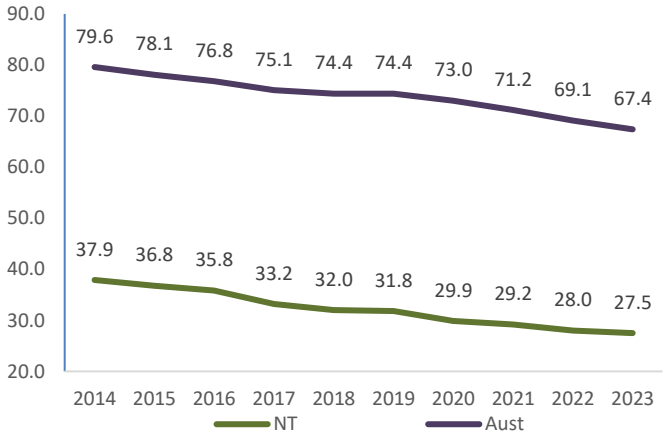
4. Setting the national efficient price

Long stay older patients

The 2020-25 NHRA mid-term review recommended the introduction of financial incentives to the national funding model to more equitably share financial risk between the Commonwealth and jurisdictions where hospital departure is delayed for older patients who are medically fit for discharge (Recommendation 9e).

Currently only 16 out of 559 aged care beds are available in the NT, a vacancy rate of 2.86 per cent. According to the Productivity Commission, in 2023 NT had 27.5 aged care beds per 1000 residents aged over 70 and Aboriginal people aged 50-59. This is the lowest rate in Australia, with the national average being 67.4 beds per 1000 residents. The rate of available aged care beds in the NT has declined significantly over the last decade as residential aged care places have not kept pace with an ageing population.

Chart 3: Operational aged care places per 1000 people age 70 or over & Aboriginal people age 50–69



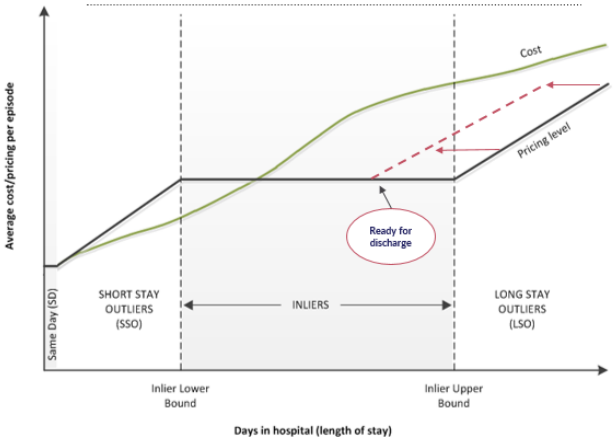
Source: *Source: Productivity Commission Report on Government Services 2024*

In March 2024, of 66 maintenance care patients ready to leave Royal Darwin and Palmerston Hospitals, 85% were prevented from doing so due to external factors outside the hospital's control including availability of aged care beds, aged care provider reluctance to accept patients with complex requirements,

and financial circumstances and complexity of families navigating the aged care system. These patients' readiness for discharge had been ascertained through assessment undertaken by an Aged Care Assessment Team.

The design of the national pricing model incentivises minimisation of the length of an admission by providing a fixed level of funding for 'inlier' patients. This policy is not appropriate for patients who cannot be placed in an aged care facilities for reasons outside the direct control of hospitals. A more appropriate pricing point for such patients is suggested in Figure 1.

Figure 1: Proposed funding model for long term maintenance care patients



NT Health requests that IHACPA modify the pricing model for long stay older patients who have received an assessment from an Aged Care Assessment Team and are deemed ready for discharge.

A per diem price should be paid from the point the patient is ready for discharge rather than from when they become a long stay outlier.

4.1. Impact of COVID-19

Consultation question

- 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?

No comment.

Consultation question:

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

In the event of major disruption to the health system, including natural disasters and epidemics, which results in lower than expected hospital activity without a commensurate reduction in costs, the Commonwealth and jurisdiction/s should share the financial burden. In these circumstances minimum funding entitlements should be determined based on the estimated activity to be delivered by the affected establishment/Local Hospital Network rather than actual NWAU delivered. This arrangements should be coupled by a pricing response that provides transitionary arrangements that supports the incremental recovery of the health system. Such a pricing response should recognise that some disruptions to the health system, such as the COVID-19 pandemic response, result in costs to the health system that persist in subsequent years.

4.2. Adjustments to the national efficient price

4.2.1. Intensive Care Unit adjustment

No comment.

4.2.2. Other adjustments and their eligibility criteria

Consultation question

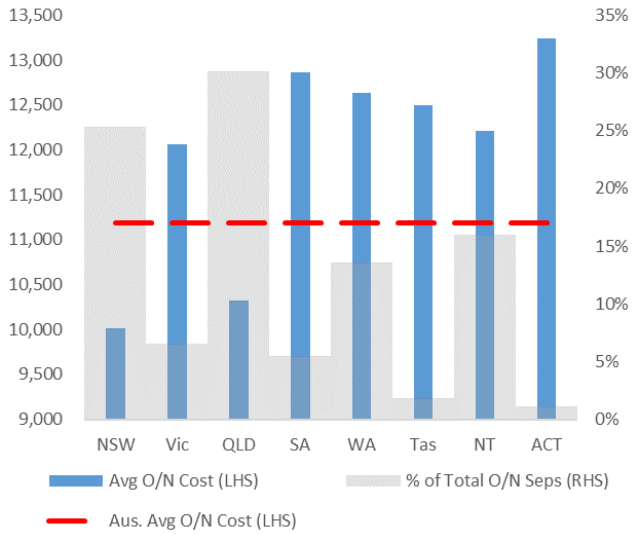
- To support IHACPA's investigation, what factors may help explain the reduction, in the Indigenous adjustment observed in recent years?
- Additionally, what factors should be considered in refining the calculation and application of the Indigenous adjustment, so that it reflects the costs of public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

Indigenous adjustment

NT Health welcomes IHACPA reviewing the Indigenous adjustment, as the NT's proportionally small total population (notwithstanding its high proportion of Indigenous population) and limited contribution to the national hospital cost data pool constrains our influence on its calculation. The effectiveness of the adjustment is a significant concern for the NT as 31 percent of the population is Aboriginal, and Aboriginal patients account for nearly 70 percent of acute separations.

New South Wales (NSW) and Queensland comprise over half of the nation's episodes of Aboriginal patients who are hospitalised overnight, but have a significantly lower average cost for these patients than all other jurisdictions as demonstrated in Chart 4.

Chart 4: Hospital overnight patients who are Aboriginal or Torres Strait Islander, 2020-21.



A material contributor to the declining effectiveness of the Indigenous adjustment relates to the significant increase in Aboriginal population as a result of increased self-identification by Australians who belong to a cohort with lower burden of disease. This phenomenon has been identified by the Australian Bureau of Statistics (ABS) in the national census and provides an explanation for the reduction in the total cost pool of Indigenous patients, when compared to the cohort which previously identified as Indigenous.

In the NT more than three-quarters of the change in Indigenous population between the 2016 and 2021 national census was accounted for by births, deaths and migration. In NSW, the jurisdiction with the highest number of people who identified as Indigenous, only one third of the change is accounted for by these factors, with most of the change due to an increase in people self-identifying as Indigenous.

While NT Health welcomes the recognition of all Indigenous Australians, it is imperative to ensure that the changing demographic makeup should not inadvertently undermine the purpose of the Indigenous adjustment, to account for the higher costs of providing services to a cohort experiencing severe disadvantage. The relative good health of a larger proportion of the Aboriginal population is to be celebrated but should not diminish efforts to lift the health of those Aboriginal people, such as those residing the remote NT, who continue to face a disproportionate burden of disease and major barriers to and complexities in provision of care.

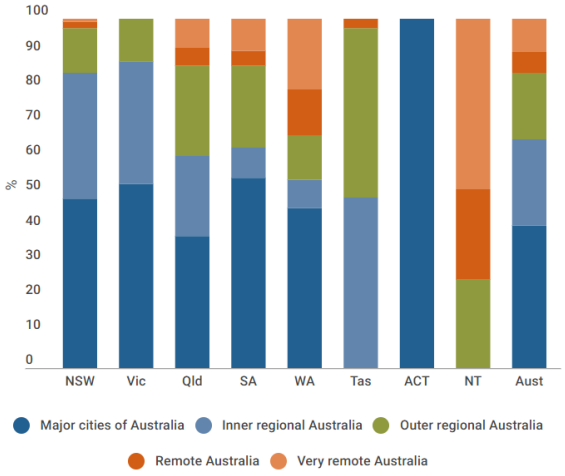
IHACPA should examine how the Indigenous adjustment could reflect the following factors relating to the costs of providing culturally appropriate and secure hospital care:

- homelessness, noting Aboriginal Territorians have the highest homelessness rates in Australia, mainly as a result of overcrowded housing. NT Health have requested that homelessness be

considered within the Emergency classification, and reprise this request in relation to the calculation of the Indigenous adjustment;

- burden of disease, barriers to care and cross-cultural complexities that affect hospital service delivery for Aboriginal Territorians;
- remoteness, noting the NT's Aboriginal population is substantially more concentrated in remote and very remote areas than other jurisdictions as illustrated in Chart 5; and
- language, as many Aboriginal Territorians speak a local Aboriginal language as their first language and speak English only as a second, third or fourth language at rates far higher than the rest of Australia. Respecting and catering for patients for whom English is not their home language further increases the challenges and costs in delivering culturally appropriate and secure care. Approximately 58 percent of the NT's Aboriginal people speak an Aboriginal language as their first language, compared with 9.5 percent nationally.

Chart 5: Remoteness distribution of Aboriginal population



NT Health requests that IHACPA review the criteria and basis for calculation of the Indigenous adjustment, in order to develop a more effective method based on a combination of patient characteristics including indigenous status, comorbidities, residential remoteness, language spoken at home and homelessness.

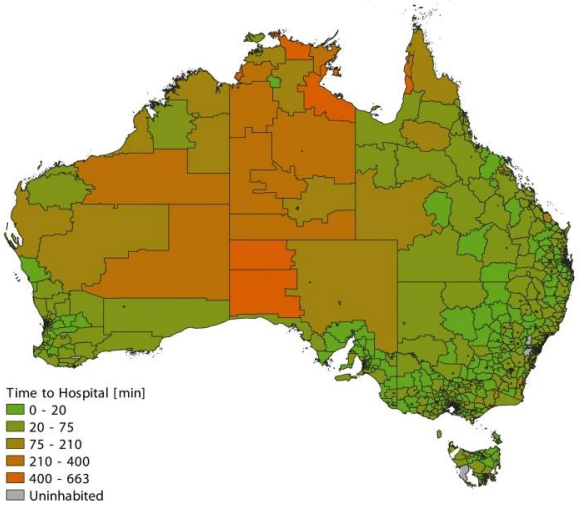
Patient Residential Remoteness Adjustment

Patient residential remoteness is closely related to Indigenous status in the NT as three-quarters of Aboriginal Territorians live in remote and very remote areas. NT Health is concerned that the current adjustment for patient remoteness does not fully account for the legitimate and unavoidable additional costs of providing hospital services to patients residing in remote areas.

Chart 6 shows the average travel time to hospital across the nation as a measure of health service accessibility. Sparsely populated areas in other jurisdictions are more proximate to hospitals by road than those in the NT. This support that a person's distance from a hospital has a more significant impact in the NT than other jurisdictions.

In 2022-23 remote and very remote overnight patients stayed in Royal Darwin and Palmerston hospitals for 40 percent longer than the nationally expected length of stay for these patients. Remote and very remote patients are routinely kept in hospital for significantly longer periods than other patients for the following reasons:

Chart 6: Time to nearest hospital by road



Source: Barbieri, S., Jorm, L. Travel times to hospitals in Australia. Sci Data 6, 248 (2019); https://doi.org/10.1038/s41597-019-0266-4

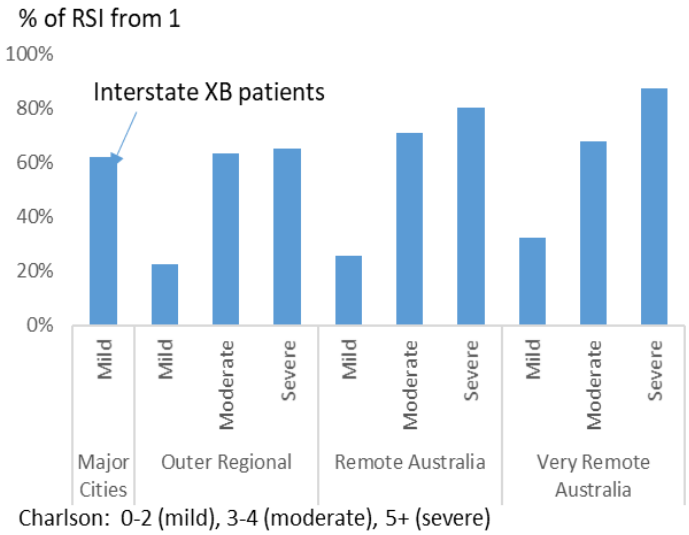
- patients travelling to hospital from a remote location are unlikely to return to hospital due to distance, and primary health services in remote communities have limited sub-acute and step-down care;
- high cost outreach services, which can also be impeded by seasonal weather conditions (some parts of the NT are inaccessible during the wet season) and cultural ceremonies;
- proactive testing due to the prevalence of comorbidity and chronic conditions to identify and treat undiagnosed complications; and
- risk of deterioration or re-infection for certain medical conditions if the patient returns home prematurely, due to overcrowded housing and limited wrap around services in their remote locality.

The clinically indicated practice of keeping remote and very remote patients in hospital for extended periods is particularly prevalent for neonatal, paediatric, obstetrics and gynaecology admissions. In particular, there are significant benefits to a child's development in providing additional wrap-around services to reduce risk of morbidity.

When the high burden of disease and comorbidities of the remote patient cohort are considered, measured by Charlson Score, remote and very remote overnight patients with moderate to severe comorbidities stayed in hospital up to 80 percent longer than would otherwise be expected (see Chart 7). Interstate residents with a mild Charlson score who were treated in NT hospitals also stayed longer than expected, which highlights the compounding effect on delayed discharge of treatment distance from a patients usual residence.

NT Health consider that the remoteness adjustment should be refined to account for the distance between the patient's admission to a tertiary hospital and their residence in addition to presenting comorbidities or burden of disease, as these factors combined results in extended hospital length of stay and delayed discharge.

Chart 7: Royal Darwin and Palmerston Hospital RSI, Overnight Patients by Residential Remoteness Status and Charlson Comorbidity Index



NT Health requests that IHACPA review the patient residential adjustment to consider a multiplication factor that includes the distance of the patient's admission treatment location (tertiary hospital) from their residential address and presence of comorbidities, which all contribute to delayed discharge.

Small Jurisdiction Price Adjustment

Recommendation 18 of the final report of the Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 called for IHACPA to review the calculation of the NEP to "*seek to reduce calculation complexity and address the particular funding challenges for smaller jurisdictions unable to operate at the scale and without the cost base of larger jurisdictions*."

IHACPA's letter dated 23 May 2024 to the heads of NT, ACT and Tasmania Health acknowledged "*the need to adjust funding mechanisms to ensure services are viable where the issues impacting on viability cannot be remediated within the jurisdiction*". The letter flagged introduction of a time limited small jurisdiction

adjustment, while more detailed analysis and consultation is undertaken to assess viability and develop ongoing adjustments to the national pricing model.

NT Health welcomes IHACPA's proposal and the opportunity to demonstrate the unique challenges confronted by the NT health system as a small jurisdiction. NT Health request that in parallel to this work that IHACPA review its materiality policy *'Assessment of Adjustments to the National Pricing Model"*. This policy should provide IHACPA the flexibility to allow the national efficient price to provide a relevant price signal for small jurisdictions as described in Clause A45.b of the NHRA. This clause states that the role of the national efficient price is to "provide a relevant price signal to States and Local Hospital Networks that will improve patient access to services, public hospital efficiency and funding effectiveness".

NT Health requests that IHACPA:

- applies an interim small jurisdiction adjustment in 2025-26 prior to assessing viability of ongoing adjustments to the pricing model; and
- in parallel, review its materiality threshold criteria to provide IHACPA the flexibility needed to adjust the national efficient price so it can support a relevant price signal for small jurisdictions in line with achieving the principles under Clause A45.b of the NHRA.

4.3. Accounting for private patients in public hospitals

No comment.

4.4 Harmonising price weights across care settings

NT Health reiterates the requirement for thorough investigation into clinical practices across jurisdictions to ensure it is appropriate to classify services across different settings into resource-homogenous groups. Price weight harmonisation should not mistakenly group patients where services differ. NT Health also recommends applying transitional arrangements and price stabilisation in circumstances where price harmonisation is deemed appropriate.

5. Setting the national efficient cost

No comment.

6. Data collection

6.1. Cost and activity data collection

Consultation questions

- How should IHACPA account for the changes in data reporting when developing a costed dataset?
- 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?

No comment.

6.2. Assurance of cost data

Consultation question

- 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?

No comment.

6.3. National Benchmarking Portal

Consultation question

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

The National Benchmarking Portal currently does not include any data for Gove Hospital in the NT, which we understand is due to the recent transition of the hospital from Block to Activity Based Funding from 2022-23. IHACPA has previously advised that Gove's data is likely to be added in early 2025 once NHCDC round 27 has been fully validated and finalised. The NT seeks consideration for expediting this timeframe in order to enhance the utility of the portal.

The functionality of the National Benchmarking Portal would also be improved by enabling comparison of demographic attributes that are used in IHACPA's pricing adjustment to the NEP such as Indigenous status and patient and treatment remoteness. This would enable stakeholders to benchmark activity and costs based on the attributes that also create adjustment to the NEP.

7. Treatment of other Commonwealth programs

No comment.

8. Future funding models

No comment.

9. Pricing and funding for safety and quality

Consultation questions

- 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?
- 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?

NT Health has previously provided feedback that the introduction of funding penalties for sentinel events, hospital acquired complications (HACs) and avoidable hospital readmissions (AHRs) has increased the complexity of the national funding model. NT Health recommends that an evaluation of safety and quality penalties assesses whether they have achieved:

- Improved patient outcomes.
- Incentivising providing the right care, in the right place, at the right time.
- Decreased avoidable demand for public hospital services.

- Creation of signals in the health system for reduction of preventable poor quality patient care, while supporting improvements in data quality and information available to inform clinicians' practice.

NT Health also recommends that IHACPA's evaluation consider the impact of the following:

- Existing processes or programs implemented by jurisdictions to improve quality and safety, such as the NT's escalation of care program, "Are You Worried?" for patients and their families to raise concerns about physiological and mental state deterioration while in care.
- Clinician awareness and response to penalties. This will enable an assessment of a direct causal link between funding penalties and clinical performance.
- Changes in data quality.

NT Health make Sentinel Events, HACs and AHRs visible to clinicians, however has no evidence that the financial penalties have any impact on clinical practice, particularly due to the reporting lag.