Pricing Framework for Australian Public Hospital Services 2025-26

Department of Health Submission to IHACPA

Queensland Health (QH) welcomes the opportunity to provide feedback on the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025–26* (the Framework), released on 14 May 2024 by The Independent Health and Aged Care Pricing Authority (IHACPA) for public feedback.

To provide representative feedback on the Framework, the Department of Health has consulted with all areas of QH including Departmental divisions and 16 Hospital and Health Services (HHSs). HHSs were advised that feedback can also be provided directly to IHACPA.

QH responses to the questions included in the consultation paper are below. QH has provided additional comments at the end of the submission in relation to areas not specifically referenced in the consultation paper on the Framework.

1. *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?*

Given AECC V1.1 represents a relatively minor technical change to the complexity model, QH supports pricing without a shadow year for NEP25.

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

QH has previously responded that IHACPA should explore patients that require additional resources in the Emergency Department (ED) that otherwise may be admitted for further supervision, investigation, or care. Examples include any procedural work such as cardioversion and dislocation reductions that require sedation / regional block / nerve blocks etc. This could be recognised by a documented procedure code similar to the Australian Classification of Health Interventions (ACHI) codes and the price weight be more representative of the care provided to the patient. IHACPA could consider defining a clinically acceptable admission criteria that recognises patients that require greater procedural care than a standard ED attendance.

Many Queensland hospitals adopt the Maternity assessment centre models, which is Emergency Care for maternity patients but operates separately to the ED. Currently services at these centres are recorded as admitted or non-admitted, but these classification systems do not adequately describe the clinical care provided. Future development of the AECC could consider incorporation of these services.

Queensland Emergency Departments and Emergency Services (ED/S) predominantly uses Cerner FirstNet which is commonly utilised across Australia. The implementation of FirstNet will continue to encompass all QH ED/S over the next few years. FirstNet classifies diagnoses using SNOMED-CT which is more clinically familiar and the reporting of data to IHACPA is required in ICD-10-AM. To manage this, Queensland uses a mapping tool which creates ongoing challenge and data quality

issues. ICD-10-AM is usually captured by qualified Clinical Coders where as in the Emergency context it is captured by doctors who are clinically unfamiliar with the classification. In addition, SNOMED-CT is purposefully designed to capture diagnoses at the point of care, whereas ICD-10-AM is an output tool designed to capture diagnostic themes at the end of the episode. Due consideration should be given by IHACPA as to whether ICD-10-AM is the most appropriate classification underpinning Emergency funding.

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?

Emergency services facilities are typically very small and have limited ability to capture the data required for pricing under the AECC. Even with the larger ED facilities there can be difficulty capturing the patient diagnosis with facilities instead reporting the presenting symptoms. Under the AECC, episodes where a presenting symptom is recorded as a principal diagnosis as opposed to the actual diagnosis would be grouped to a lower priced AECC end class, financially penalising small emergency services facilities. Considering the additional data requirements associated with the AECC, QH considers that emergency services should continue to be classified by the UDG classification.

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

QH considers that the Tier 2 end classes 40.07 *Pre-admission and pre-anaesthesia* and 40.59 *Post-acute care* require greater clarification as the capturing of this activity is causing concern in relation to medicare compliance. We feel that that these clinics should be exempt from clause G16 of the National Health Reform Agreement Addendum 2020-2025 (NHRA). The clause states, '*Where care is directly related to an episode of admitted patient care, it should be provided free of charge as a public hospital service where the patient chooses to be treated as a public patient'*. By definition these non-admitted services are directly related to an admitted service as they are designed to either reduce the complexity of the admission by identifying patient risk factors prior to surgery/procedure, or reduce the length of stay of the admitted episode. QH supports these clinics as examples of encouraging safe and efficient patient care, regardless of funding source but the Commonwealth Department of Health are viewing the use of these Tier 2 classes as a source of duplicate funding.

It's appreciated that the IHACPA is developing a new non-admitted care classification to better describe patient characteristics and care complexity and Queensland is excited to be assisting with this currently. It will be valuable if the new non-admitted care classification will better account for changes in care delivery and models of care, particularly as some services are transitioned into the non-admitted setting, such as Rapid Access Services or Clinics.

While the proposed extraction of data from State & Territory electronic medical record systems (through the proof-of-concept of the ANAPP) would make reporting much more efficient, it would be reliant upon the collection and visualisation of that data in a similar way to ensure appropriate comparisons. The transformation of unstructured data into a format that can be utilised for classification development would be beneficial if it can be achieved nationally. Queensland will continue their ongoing support to IHACPA to further enhance this dataset and remain willing to trial alternative approaches if the current ANAPP project does not yield the outcomes desired.

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*?*

QH does not support pricing with AMHCC V1.1 for NEP25 and instead supports a shadow pricing period. One of the overall concerns is that the changes to AMHCC 1.1 has been recalibrated using national mental health care data from 2018-19, 2019-20 and 2020-21, during the middle of the COVID pandemic, which may not be reflective of mental health care outside of a pandemic.

The changes to AMHCC 1.1 also reflect less records in end classes with unknown HoNOS, in general more records with High HoNOS complexity, and a reduction in records with Moderate HoNOS complexity except for Admitted, 0-17 years, where the opposite is true. It is recommended that the differences between the versions should be monitored in the shadow year.

Concerns described above aside, Queensland will be transitioning its CMH services to ABF in 2024-2025 via the QLD ABF model to continue our readiness and implementation activities as we are firmly in support of the vision to transparently report activity data to better inform future pricing. To date pre-implementation work appears to be going well and we look forward to addressing outstanding issues and concerns with our clinicians over the course of 2024-2025.

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 overcoming these barriers*?*

This question specifically relates to collecting data for the Australian Teaching and Training Classification (ATTC). Visibility of the number, discipline and location of students undertaking clinical placements remains an ongoing challenge for QH with respect to reporting. QH does not currently have the capacity to reliably report in ‘real time’ student clinical placement uptake and activity nor clinical placement capacity, which would require a substantial and ongoing investment to develop and implement.

Clinical placement data is generally only collected via a periodic manual survey of Hospital and Health Services to estimate total annual placement activity. This does not allow a shared understanding of placement data across partners, nor facilitate data-driven planning for current and future student placements.

Noting our concerns above, Queensland is very much in support of a better classification for Teaching and Training and remain willing to work with IHACPA to further work in this area.

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*?*

Identification of student placement information will need to incorporate tertiary sector information and the Unique Student Identifier is in place nationally to identify students undergoing higher education and nationally recognised training. There is potential opportunity to leverage this infrastructure to better identify student placement information.

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?

COVID-19 patients in ICU who have not been cleared require isolation in a room with negative pressure. This adds to cost in running negative pressure rooms (consuming HEPA filters and wearing out seals etc.) It also is likely to consume a nurse for that one patient. This would be the case even with a nonventilated ICU patient.

QH supports previous analysis undertaken by IHACPA on determining the COVID pricing adjustment for particular diagnosis related groups, noting that the scope of this adjustment has reduced over time. Regarding adjustments to the NEP for 2025-26, there would need to be a significant impact from COVID-19 on the 2022-23 cost model for this to be considered. QH notes that if a further price adjustment is considered for 2025-26, then this would necessitate a review of the 2022-23 NEP which was derived from a normalised 2019-20 cost model which assumed there would be no ongoing impact of COVID-19 by 2022-23.

QH suggests that it would be more appropriate for IHACPA to dedicate resources to consider the NEP determination process in light of the potential change to the national funding model from 2025-26 under the new addendum to the National Health Reform Agreement (addressed in more detail under 'other issues' at the end of this submission).

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

Because the NEP is set based on actual costs three years earlier, the NEP could not take into consideration the higher cost of providing services during the COVID-19 pandemic, and most of the analysis undertaken by IHACPA was focussed on ensuring future NEP determinations were not influenced by COVID-19-affected cost disruptions. Under the current funding model, it is not clear how a pricing response (such as an uplift in the 2019-20 NEP to reflect the higher actual costs per weighted activity unit) could have helped (even if it could have been calculated) given NHRA funding is capped. More important was the rapid funding response through the establishment of the COVID-19 NPA and implementation of the minimum funding guarantee. Having the ability to enact emergency legislation to allow funding to flow quickly would be beneficial.

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 to receive the ICU adjustment, noting that individual units cannot be identified in the current national data collections*?*

QH has previously suggested to IHACPA through the Technical Advisory Committee that a tiered list of eligible hospitals should be considered with a different loading applied by tier. This would allow for smaller regional facilities operating an ICU to be funded for the higher cost of providing these services. This is particularly relevant in Queensland the geographically dispersed population makes centralisation of ICU patients less feasible than in smaller states. In addition, the current approach favours large hospitals that are able to start up small ICU units and attract a loading as it is applied at

the facility level. Smaller hospitals not on the specified list would not receive a loading for a similar sized ICUs which could prevent this service being offered.

It is considered that eligibility criteria should apply to all potential tiers so that a funding adjustment does not encourage the establishment of small unsustainable units (less than 6 beds) which may have inadequate systems and poor patient care.

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*?*

Per the response to question 10, QH supports consideration of a tiered adjustment.

If based on eligible hospitals, the criteria could consider the nature of ICU units within the hospitals where burns, spinal and mechanical circulatory support are more expensive to provide and should attract a higher adjustment.

A tiered loading based on episode of care would be beneficial as this could be applied to all ICUs and not be limited to a specified list. The following episodes of care could be investigated as being high cost episode which in some cases require one-on-one nursing:

- Extracorporeal Membrane Oxygenation (ECMO)
- Inotrope and / or vasopressor requirement
- Coronary Artery Bypass Graft surgery that has post operative ventilation
- Invasive ventilation that is intubated or tracheostomised
- Patients receiving renal replacement therapy or dialysis
- Paediatric patients

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

Although there are no barriers as such, this would appear to be a shift away from funding activity to provision of a block amount to recognise the higher ongoing costs of running an ICU.

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*?*

It is not clear why the indigenous adjustment would be falling, though it would appear likely that the patient remoteness adjustment is accounting for some differential in costs. Other factors could include facilities not correctly allocating the cost of staff specifically employed to provide healthcare services to first nations patients (such as Aboriginal and Torres Strait Islander liaison officers), and instead spreading the costs across all healthcare episodes; first nations patients not wishing to be identified as first nations, voluntary early discharge which reduces patient length of stay. To assess the

indigenous adjustment further it would be useful to explore the cost profile of first nations versus non-first nations patients at a more granular level. For example, to see if there is a cost differential between first nations and non-first nations patients by location to see if the cost differential is significantly higher in remote locations versus metropolitan. The indigenous adjustment could also be calculated at the state/territory level to see if there are any significant differences which could be driving the national adjustment level.

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

All jurisdictions will have a challenge when legacy source systems are updated and new systems implemented may not have all the required data elements in the data request specifications. Even where all the data elements are available there is a significant amount of work in implementing new systems and the timeline for this implementation may impact meeting national submission timelines. This did occur with Queensland two years ago and while IHACPA was notified in writing and at numerous meetings that meeting the submission timeline for all local hospital networks would be difficult, Queensland was deemed as non-compliant based solely on the submission timeline with no consideration given for the prior notice.

All jurisdictions undertake a data quality approach to their dataset before submitting the final data to IHACPA. This is a process that should be endorsed. Where a significant data issue has been found by the jurisdiction and correction of such would prevent compliance with submission deadlines, Jurisdictions should be allowed to make an assessment on materiality and exclude establishments in whole or in part where it is considered that the submission of that facility's data may impact the national funding model negatively.

This should be noted by the Jurisdiction in the Data Quality Statement provided with each submission noting what the data quality issue was, what investigations were undertaken and an assessment of the materiality of the issue.

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*?*

Where a jurisdiction identifies a significant data issue in its NHCDC submission (such as unanticipated exclusion of facilities or concerning data items), as part of the provision of the Data Quality Statement, those Jurisdictions could provide a table that identifies all establishments that were costed – including those out of scope for the NHRA such as primary health care centres, oral health facilities, jurisdictional funded non-ABF services etc. This table should then include those establishments that were submitted with total costs and activity volumes. In addition, the inclusion of the AIHW peer group will help to identify the type of establishment.

Where an establishment has been found to have a material cost outcome impact due to missing data or data quality issues in the local costing process, it may not be a material impact at a jurisdiction level with total activity volume and costs, but at a lower level of end classification such as DRG level the inclusion of these records in the national dataset may skew average costs.

Where due to data quality issues, a jurisdiction has identified that one or more establishments should be excluded from the submission, this exclusion should be communicated from the departmental Chief Executive or Minister. If the total cost and activity volume falls below a certain threshold (for

example 85%) of each AIHW peer group as part of the submission, the jurisdiction should provide evidence to support that the data submission remains an appropriate, representative sample.

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*?*

In Queensland all the DRS error reports are run as part of the data transformation process. Queensland undertakes extensive end to end cost and activity reconciliation and identifies what has not been submitted and the reasons why a record was excluded from the submission.

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

While the benchmarking portal is a useful tool a key limitation is that users can only view data one year at a time, meaning the portal requires users to obtain multiple downloads to perform the very common task of trend analysis. Therefore, an ideal refinement would be the portal enabling viewing/accessing multiple years of data in a single table/download.

For examining table data, it would also be ideal that instead of only being able to select filters, users could also add slicers. This would enable more insightful views/tables to be constructed e.g. viewing hospitals by LHN simultaneously. Greater data detail (demographic and mobility information) to enable enhanced benchmarking would also be useful.

Finally, improving the timeliness of data available as there is a delay from when the new NWAU model is developed and published, with 2020-21 being the latest data currently available in the Benchmarking Portal.

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 pricing approaches for sentinel events, hospital acquired complications and avoidable hospital readmissions have focused the incidence of these events across hospitals through better integration into performance reporting. However, it is not clear that any improvement can be necessarily attributed to improved patient outcomes. Rather it has focussed health information teams to perform more specific data quality checks to ensure that the clinical coding is accurate. The pricing of safety and quality initiatives since 2017-18 were not preceded by targeted trials (with controls) to prove pricing improved outcomes & quality cost-effectively in the Australian context. Given the absence of pre-implementation trials or a review of the pricing strategies, QH is not aware of evidence that improvements have occurred, particularly as a result of the pricing initiatives.

While there have been changes in the prevalence of sentinel events, hospital acquired complications and avoidable hospital readmissions, such changes cannot be presumed to entirely reflect changes in underlying outcomes. Often changes in outcome measures can simply reflect changes in reporting behaviour.

- If funders shift too much risk to providers (risk-averse), providers may respond by lowering quality or ceasing treatment / diverting higher risk patients / decreasing the accuracy of

coding. (As clinicians also generate the data they are assessed on, coding behavioural responses need to be considered seriously.)

- For example, US evidence suggests that following US enactment of its Hospital Readmissions Reduction Program "nearly two-thirds of the reduction in national readmission rates was due to changes in coding practice".
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QH supports IHACPA's intention to review the current safety and quality adjustments to ensure they are meeting their policy objectives.

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?

IHACPA could consider advancing Stephen Duckett's suggestions around better utilising and extending access to care quality registries, as Denmark does, to help monitor quality and safety.

The Commonwealth might consider making its funding of registries conditional on them providing wider access to health services. Detailed registry information on quality might then be routinely linked to administrative data to help monitor quality. For example, the ANZICS Intensive Care Registry contains information on unplanned admissions to ICU, but these data are not routinely available to State Departments of Health.

Duckett's specific registry recommendations were to:

- "Make public funding of registries conditional on the registry enrolling at least 90 per cent of relevant patients (or providing evidence of a valid sampling process)
- Link registry data regularly to other sources, including routine data
- Require registries to extend reporting to all relevant clinicians, managers, funders and accreditors".

Leveraging such data would help IHACPA quantify pricing measures, as well as provide jurisdictions with much richer information with which to monitor quality.

However, consideration does need to be had around which registries are beneficial and ensuring the registries are only capturing information that is of use. There is concern some registries capture too much information that is not of relevance.

IHACPA could also consider the potential use of the Australian Atlas of Healthcare Variation where the report highlights unwarranted clinical variation to identify low value ineffective care that should be disincentivised, eg. unnecessary knee arthroscopies and hysterectomies for certain cohorts. Regarding high-value care, performance payments for evidence-based clinical best practice models of care such as a bundled payment for hip or knee replacements using prothesis that don't lead to high revision rates.

Any new quality and safety initiatives should only be implemented after trial evidence of effectiveness has been demonstrated, noting the below previous concerns around safety pricing:

- ACSQHC literature review has noted "The evidence for the material impact of such [safety pricing] schemes on patient outcomes remains equivocal"
- Stephen Duckett has said "I cannot recall a single recent article which endorses readmissions rate as a P4P measure".

- Harvard Professor Ashish K Jha has suggested the US Hospital Readmissions Reduction Program's "benefits have been small and its costs potentially large".

20. Other issues not raised in the Consultation paper

Proposed new funding model

Queensland notes the draft pricing framework is based on the current national funding model as per the National Health Reform Agreement (NHRA) Addendum 2020-2025, which covers the period 2020-21 to 2024-25.

On 6 December 2023, National Cabinet agreed to some broad parameters for a new national health reform (NHR) funding model to apply under the next NHRA from 2025-26. National Cabinet endorsed:

- The Commonwealth increasing NHR contributions to a Commonwealth contribution rate (CCR) of 45 per cent over a ten-year glide path from 2025-26.
- The current 6.5 per cent funding cap being replaced by a more generous approach that applies a cumulative cap over the period 2024-25 to 2029-30.

The proposal will change the funding formula that determines NHR funding from the current ‘base plus growth’ model under which growth is funded at 45 per cent but the base may be funded at less than 45 per cent, to a new ‘set percentage of activity and price’ model where all activity will be funded at the CCR.

The Commonwealth and States are currently finalising a range of details relating to the new funding model. The new funding model is likely to have a broad range of implications for the pricing framework, the National Efficient Price (NEP) determination and National Efficient Cost (NEC) determination in 2025-26 and subsequent years.

For instance, in the current model back-casting has been used to ensure that changes in in the national funding model from one year to another do not impact on funding outcomes. However, it is not intended that back-casting would apply under the new model. Funding outcomes under the new model will also be more susceptible to fluctuations in the rate of growth in the ‘native’ NEP.

More broadly, the next NHRA Addendum covering the period 2025-26 to 2029-30 is expected to take account of a range of issues discussed in the Final Report of the Mid-Term Review of the NHRA Addendum 2020-2025, including payment reforms and innovation funding. These changes are also likely to have significant implications for the pricing framework.

Once the new funding model and Addendum are finalised, IHACPA will need to work closely with jurisdictions as a matter of priority to analyse the implications for the pricing framework and for the NEP and NEC determinations, with an initial focus on changes required in 2025-26.

Virtual Care

Queensland is experiencing an explosion in emerging new models of virtual care services in the post COVID-19 period. In addition, our government is committed to super-charging virtual models as it allows the State to respond to growing pressures on our health system without needing to build new hospitals. In addition, in our geographically challenged State, virtual models of care reduce the need for consumers to travel to access specialist services that are clustered in the south-east corner. Whilst the benefits to consumers and the health system remain undisputed, we are very concerned that without strict rules defining what constitutes a virtual care admission or a non-admitted encounter, the explosion in virtual care models could impact pricing in outer years and in an activity-based funding system, could encourage low value care. Queensland believes that a new data

collection may be required that is more flexible and adaptable to the emerging new models and neither the admitted or the non-admitted collections are agile enough to accommodate changing practice.