SA Health Response

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

On 8 May 2024 the Independent Health and Aged Care Pricing Authority (IHACPA) released its Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025-26 for public comment. SA Health welcomes the opportunity to provide feedback and is supportive of the continual collaborative improvements to the framework.

The response has been developed following consultation within the Department of Health and Wellbeing and across Local Health Networks (LHNs). Responses to the questions included in the consultation paper are below. Each section refers to the consultation paper.

[redacted]

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

3.3 Emergency care

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?

SA does not foresee and issue with implementing AECC Version 1.1 with no shadowing providing there is acknowledgement that there will be changes to coding practices. These changes, as with any change to a classification, are expected and should not see jurisdictions impacted by retrospective adjustments for perceived unintended consequences.

To enable the state to understand the impact of the change from AECC Version 1.0 to 1.1 it would be welcomed if IHACPA integrate the updated version into the submission portal to enable comparison.

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

One area that clinicians are interested in is the inclusion of certain interventions in the data which would assist in determining complexity of the patient receiving emergency care.

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?

With the continued roll-out of the electronic medical record (EMR) in South Australian public hospitals the ability to collect the required data will improve. Of the smaller sites that run emergency services and still use the UDG classification there is scope for some to be able to transition to AECC over time. However, the structure of some of the small sites may still see limited ability to collect the principal diagnosis appropriately. Date of birth is available where the patient has registered details in EMR.

The Australian Institute of Health and Welfare (AIHW) currently report on patient level data and the shift from aggregate counts to patient level would need to be reviewed in line with their reporting requirements. As a state we work towards a single submission for multiple uses so this change would need to meet both our AIHW and IHACPA requirements.

3.4 Non-admitted care

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

SA is supportive of the current review being undertaken as part of the Non-Admitted Care Advisory Working Group. In particular, the review of the multiple healthcare provider indicator and the investigation into a new 10 series clinic for intravitreal injections.

The continued work on the new non-admitted classification is supported although at this stage South Australia is not able to assist in Phase 2 of the project.

3.5 Mental health care

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?

SA supports the changes in AMHCC v1.1 associated with HoNOS tolerance. These have been requested by clinicians and assist in creating increased comfort in using the classification as it more accurately reflects clinical practice. Admitted mental health is now being collected using the AMHCC so the transition to Version 1.1 will see a move from unknown HoNOS to known thus enabling improved classification.

The move of community mental health to activity based funding has always been supported however the difficulties in collecting the required data has been a much larger hurdle than expected. The limitations are going to be in the quality of the data collected and its reliability to accurately reflect the cost of providing the services.

SA would also like to see continued work looking at including residential mental health in the classification to fully cover the spectrum of care. Also turning focus to other areas of mental health that may not be adequately reflected in the current classification like postpartum care and eating disorders.

As with the introduction of AECC Version 1.1 without shadowing SA expects that there will be changes to coding and these should not be considered unintended consequences that are retrospectively adjusted.

3.6 Teaching and Training

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?

The main barrier to collecting data for teaching and training is the digital systems. There are limited resources to invest in enhancing systems and with the changes to classifications over the last few years and the COVID-19 pandemic priorities have been directed to other areas. Currently community health is the priority for data systems and with the new non-admitted classification being developed this will require resources to ensure the appropriate data is collected.

For South Australia we currently use limited systems to collect different components to support the data for teaching and training. For example FTE data is reviewed from the HR/payroll systems. The medical, nursing, and allied health required FTEs are materially consistent with the payroll classification and associated work level definitions. If additional data is required above the current elementary level that SA already provides then enhancements would be required for the digital systems.

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?

The question raises whether the current classification is the best that we can develop particularly if jurisdictions have difficulty costing the existing national classification noting that it suffers from lack of transparency and benchmarking that could enable its transition to the NEP.

Fundamental to this is that the NHRA requires budgets to be allocated to LHNs and that budgets are capable of being managed.

An alternative approach that may be capable of being benchmarked and be capable of forward projection and therefore support LHN service planning might consider a workforce demand model that recognises:

- Staff age that could predict staff replacement and skill mix renewal rates
- Workforce increases required to address additional activity (eg with the same skill mix)
- Workforce development objectives (for example that could require a teaching and training response to address career structure, education changes and other agreed national initiatives around specialist skills)
- Links to university course expansion and development
- Demands place on the public hospital system to develop staff that may move on to the private and non-government sectors.

Such an approach would need to be capable of withstanding system shocks such as occurred during COVID and during the post-COVID period. It would also need to ensure it does not reward poor management that may lead to inefficient compensatory overstaffing.

The data required to address such a model would potentially be more complex to collect and to apply, noting that the aim is to facilitate the development of standard prices and subsequent budgets.

Some of this data will be available from the AIHW/ROGS collections but would likely be difficult to prepare noting that some hospital services cover both NHRA eligible and in-eligible services (eg RACs). Alignment to patient costing hospitals would also be required and increase data complexity.

Section 4: Setting the national efficient price

4.1 Impact of COVID-19

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?

Activity in South Australia returned to a more business as usual pattern sooner than other jurisdictions but the increased costs have continued due to new protocols, cost of living and need for staff to take more sick leave when coming down with COVID-19.

Long COVID clinics have been integrated into existing clinics so there is less ability to identify the impact on non-admitted services. SA does support the COVID-19 loading being continued in line with the loadings suggested by the data.

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

Some of the principles and processes are already in place, particularly with increased focus on telehealth and virtual care. The work being undertaken in understanding these services will create greater flexibility should there be restrictions on movement in the future due to natural disasters or epidemics.

With the experience of the COVID-19 pandemic and the implemented agreements to cover the change in service provision there should be combined knowledge across jurisdictions to come up with an improved pricing response. The main impacts on the system were less focussed on the pricing of activity and more on the capital, goods and services and staffing requirements. There needs to be consistent application of how the additional resources are accounted for in the pricing so that the data maintains a level of consistency that reduces the need to adjust the pricing model.

4.2 Adjustments to the national efficient price

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?

South Australia continues to support the review of the ICU adjustment and the criteria for sites to qualify for it. In the past SA has recognised the different types of critical care wards between sites with regional sites getting lower payments to recognise the type of care they provided compared to Level 3 ICUs.

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?

The only perceived barrier to having a tiered adjustment would be the methodology used to determine which sites qualify for each tier and if the required data is collected. Otherwise, no this would be no different to the application of the paediatric loading or site remoteness.

Are there any barriers to including a fixed national weighted activity unit (NWAU) adjustment for eligible hospitals, regardless of activity levels?

South Australia does not support a fixed adjustment that is agnostic to activity levels. This would have potential to impact the NWAUs required to meet the funding cap, if in all other cases actual activity is used to determine NWAU then it should also be used for ICU activity.

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?

South Australia has not noticed any significant changes in the recording of patient Indigenous status so any associated costs should be captured in the costing data. Is the change isolated to particular jurisdictions or is it spread evenly?

Section 6: Data collection

6.1 Cost and activity data collection

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?

SA shares IHACPA's concern that the reduced scope of costing data may risk the "evidence based" Pricing Guideline including the concept that "funding should be based on the best available information that is both nationally applicable and consistently reported".

When undertaking a clinical coding audit on a random sample of a fixed proportion of records are selected to adequately reflect the full dataset. This sampling process could also be adopted when it comes to the data collected for the NHCDC. A sampling approach would need to consider what proportion of the full dataset does the costed data represent, is it spread evenly over different peer types, does the lack of data in some areas have a significant impact on derived average costs? Importantly the sample needs to be representative of the national hospital system.

For the larger classes the reduction in costed records should have minimal impact if the sample costed is representative. However, with smaller classes this could have an impact on the derivation of the weight and may require additional years being included to ensure a sufficient sample.

What needs to be monitored closely is the impact that a reduced dataset has on the unavoidable costs (ie loadings) that are set based on this data also. SA undertakes costing for all its ABF sites at a national level and questions if this should be a minimum standard for all jurisdictions.

6.2 Assurance of cost

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?

SA undertakes regular reviews of costed data once completed. One area that may improve the data quality of the NHCDC submission is if jurisdictions are able to run the IHACPA quality reports to identify earlier any issues that may arise.

6.3 National Benchmarking Portal

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

One of the key issues raised regarding the National Benchmarking Portal (NBP) is the timeliness of the data, with 2021-22 being available currently.

SA would like to see the return of the previous NBP for super-users so that health services are able to drill further into the data for benchmarking purposes. With the implementation of the public NBP there was a decrease in its usability as the detailed analyses required were no longer able to be undertaken easily.

Section 9: Pricing and funding for safety and quality

9.5 Evaluation of safety and quality measures

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?

South Australia has been monitoring safety and quality measures as part of monthly performance reporting. With the pricing approaches it is now possible to report on the price impact of these along with the volume. This price impact can then be married up with the costing data to understand the true impact of sentinel events and hospital acquired complications. SA is still to fully implement the avoidable hospital readmissions.

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?

SA believes there will need to be collaboration with the medical/surgical colleges to determine how high quality care is defined. Will this be based on approved models of care only or will patient outcomes be included?

There is support to move in this direction, however there must be consideration on the enhancements required to digital health to measure this impact. If new systems are required to measure this work, then implementation cannot occur unless all jurisdictions are able to run the data themselves or are provided with a suitable alternative.

As with all the new data elements that are required across the system there needs to be a prioritisation of the changes as some jurisdictions will have limited resources and will not be able to implement them all at the same time.

For more information

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