Department of Health, Victoria

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

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Contents

Introduction

Victoria's response includes comments in addition to specific consultation questions. Please note, a response has not been provided to every section or consultation question.

Chapter 3: Classifications used to describe and price public hospital services

3.3 Emergency care

Consultation questions

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?**

Victoria notes that there is significant variation between jurisdictions regarding the definition of admission time for emergency department patients.

In Victoria, admission from the emergency department is defined at the point where the patient leaves the emergency department. However, in other jurisdictions this is based on the time when the clinical decision is made to admit the patient. This results in costs being inconsistently allocated to emergency and admitted episodes.

As a result the costs of care in emergency departments and/or in the admitted patient data collection may not be reflective of costs with regard to the pricing methodology. Victoria recommends consideration be given to providing more definitive guidance on the point of admission regarding the interaction between the AR-DRG and AECC classifications.

2. **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?**

While Victoria has no specific comments at this time, Victoria is undertaking a pilot project exploring the feasibility of small rural health services collecting and reporting patient level data (including principal diagnosis and date of birth). The pilot project is due to conclude in September 2024.

Victoria will share the findings of the project with IHACPA and anticipates these will provide useful insight into progressing an uplift in data to support the future transition of emergency service presentations to be priced using Australian Emergency Care Classification (AECC), in place of Urgency Disposition Groups (UDG).

3.4 Non-admitted care

Feedback from Victorian health services is consistent regarding concerns that the Tier 2 weights are not sufficiently accounting for the following costs:

- multi-disciplinary meetings (MDMs), where often up to 5-6 clinicians are participating
- variations associated with patient complexity
- clinician to clinician discussions where a patient is not present
- diagnostic services associated with medical consultations (20 series).

3.5 Mental health care

Consultation 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?

Victoria considers that there are several barriers to pricing admitted and community mental health care using Australian Mental Health Care Classification (AMHCC) Version 1.1. These are detailed below.

Not allowing concurrent community episodes

- The AMHCC does not allow more than one community episode within a health service entity (across establishments) and across separate health service entities.
- Victorian health services have advised that this approach does not reflect clinical practice as often there are multiple active community episodes by different teams within s within the same health service, as well as across different health services.
- Under the AHMCC model, primary clinical teams are responsible for coordinating the reporting of concurrent episodes across health services. Not only does this approach increase administrative burden, but it also leads to inconsistent funding, as only one provider will be funded for multiple providers delivering care for a single consumer.
- Victoria notes that it is not currently possible for Victorian health services to cost across Local Health Networks and therefore pricing in this way does not allow the price to be reflective of the cost.
- Victoria requests IHACPA work with jurisdictions on pricing options that allow multiple concurrent community episodes to be reported and classified separately.

Not accurately capturing forensic mental health service

- Victoria does not consider that AMHCC accurately captures the complex nature of forensic mental health services and the associated costs.
- Victoria requests that IHACPA work with jurisdictions to understand the costs of forensic services relative to non-forensic services and would ask that until this work is completed, forensic mental health establishments be considered for inclusions in the ‘standalone list of hospitals’.

Requirement for consistent HoNOS across age ranges

- AMHCC groups activity by consumer age, based on age at episode start, and effectively requires the use of a consistent HoNOS instrument to define complexity for each phase of care within the episode.
- However, under the National Outcomes and Casemix Collection (NOCC) protocol, where a consumer transitions between age groups during an episode, the applicable HoNOS instrument will change when they commence a new phase of care. For example, a consumer commencing an episode at 64 years of age requires a valid *adult HoNOS* throughout the entire episode; however, if the consumer turns 65 during the episode, a *HoNOS65* is completed for this consumer when they commence a subsequent phase of care.
- The reporting requirements under the AMHCC will incorrectly result in an unknown HoNOS for all subsequent phases of care following the transition to a higher age group.

- Victoria therefore requests IHACPA further review how the NOCC protocol can be incorporated into the AHMCC.

Price weights for unknown HoNOS end classes

- Under AMHCC Version 1.0, admitted mental health price weights per occupied bed day for NWAU versions 22, 23 and 24 are commonly higher for unknown HoNOS complexity end classes than for those associated with moderate and/or high HoNOS complexity end classes.
- Recent Victorian analysis of phases of care with a net length of stay under 21 days (excluding assessment only and unknown phase end classes) shows that moderate HoNOS complexity end classes attract almost 4% less NWAU24 per occupied bed day than unknown HoNOS complexity end classes. For phases of care with a net length of stay over 40 days (excluding assessment only and unknown phase end classes), high HoNOS complexity and moderate HoNOS complexity end classes attract almost 5% and 10% less NWAU24 per occupied bed day than unknown HoNOS complexity end classes, respectively.
- Community mental health shadow price weights used to calculate NWAU24 appear to have common instances where high and moderate HoNOS complexity end classes attract lower NWAU24 per contact (between 11 and 12% less NWAU24 per contact on aggregate in Victoria, excluding assessment only and unknown phase of care end classes) than unknown HoNOS complexity classes.
- For adult consumers: all end-class associated with known HoNOS complexity attract lower NWAU24 per contact than unknown HoNOS end-classes; for end-classes that use Abbreviated Life Skills Profile (LSP-16) complexity, those with high LSP-16 complexity attract lower NWAU24 per contact than those with moderate LSP-16 complexity.
- For older adult consumers, all phase of care end-classes associated with high HoNOS complexity attract lower NWAU24 per contact than moderate HoNOS complexity, except for functional gain.
- For child and adolescent consumers, the acute phase of care with high HoNOS complexity attracts both lower NWAU24 per contact than acute phases with moderate HoNOS complexity and unknown HoNOS complexity. Only intensive extended end-classes appear to attract expected progressively higher NWAU24 per contact depending on complexity.

Victoria recommends that IHACPA review whether this higher funding of unknown HONOS aligns with the intent of the AHMCC or is an artefact of the reporting issues all jurisdictions have reported over the course of the shadow pricing period.

3.6 Teaching and training

Consultation questions

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?

Victoria has not identified any persisting barriers to the collection of activity data following the COVID-19 pandemic response.

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?

Feedback from the Victorian health sector indicates that it would be challenging to map data driven processes in order to directly link training and teaching to determine their efficient cost. Collecting hours and minutes would also be challenging and create administration burden.

Chapter 4: Setting the national efficient price

4.1 Impact of COVID-19

Consultation questions

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?

Victoria notes the work underway to review the National Health Reform Agreement and recommendations made with respect to addressing the ongoing impact of the COVID-19 pandemic and the need to prepare for future system disruptions.

An analysis of costs per NWAU between 2016-17 and 2021-22, indicates that costs for Victoria and most jurisdictions in any given year, have grown above inflation for a material period.

Some of these costs reflect the need for jurisdictions as system stewards to design and maintain system-wide responsiveness and flexibility. Given a period of system disruption it is also noteworthy that services may initially appear inefficient as models of care transition to a new normal. The impact of such changes will take some time to work through the data collections.

Overall, managing the infection protocols associated with such a virus has placed additional burden on health services that is unlikely to abate over the medium term as COVID-19 infections continue to fluctuate within the community.

In 2022-23 COVID-19 positive patients were managed separately to non-COVID-19 patients. During this period Victoria experienced waves resulting in up to 950 COVID-19 positive patients in hospital across the system at any one time. This meant health services were required to operate parallel wards and Emergency Department pathways, requiring additional equipment and staffing to meet nurse to patient ratios.

As high-risk environments, health services were required to implement transmission-based precautions where COVID-19 was a potential or known risk in addition to standard protocols. Costs related to increased staff absences due to COVID-19 for both ongoing employees and casual employees were also incurred by health services (through paid special leave) when paid personal leave was not available. Victorian public health advice was in 2022-23, and continues to be, that masks should be worn by staff and visitors to healthcare settings. Part of the health services' responsibilities in minimising risk is providing appropriate personal protective equipment (PPE) for their setting such as gloves, gowns, masks, eye protection and respirators.

Such requirements not only increased demand pressures on health services but have led to embedded changes to cost structures. This includes costs associated with PPE, particularly N95 mask supply and Fit Testing for the workforce; Rapid Antigen Tests; paid special leave; and more frequent environmental cleaning.

Feedback from Victorian health services notes there also remain additional costs and operational challenges incurred due to COVID-19 outbreak responses within services. For example, a COVID-19 outbreak in a discrete setting, such as a dedicated sub-acute ward, may see not only the services of the ward impacted but also result in flow on impacts to health service utilisation and increased sub-acute wait lists which in turn lead to increase length of stay in acute beds.

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

As previously communicated to IHACPA, Victoria does not support IHACPA's approach to independently determine when to implement pricing responses to significant disruptions, otherwise referred to as 'normalisation'.

It is acknowledged that it is important for the national pricing model to be able to respond to major events within or across jurisdictions, which may result in data that is not representative of trends (where a return to trend is expected), or may not be equivalent in the year of pricing. However, Victoria considers the use of such policies should only occur in limited circumstances and with the support of the majority of jurisdictions (as per existing IHACPA governance structures).

Victoria therefore recommends a normalisation policy is introduced. In this circumstance, Victoria defines normalisation as an attempt to stabilise cost movements that can be directly attributed to major disruptions (such as natural disasters). Such an approach would support engagement by jurisdictions and enable sustainable pricing responses.

4.2 Adjustments to the national efficient price

4.2.1 Intensive Care Unit adjustment

Victoria considers that the ICU adjustment, introduced in 2012–13, has not kept pace with clinical advancements in the field of intensive care, particularly healthcare system design in a post-pandemic era. While welcoming the engagement of IHACPA on this issue since it was added to their workplan, Victoria remains concerned that the implementation of any solutions is not considered possible until beyond 2025–26.

Consultation questions

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?

Victoria's view is that eligibility for the ICU adjustment should not be restricted to a list of designated hospitals, and that all Victorian health services that provide ICU services should receive an ICU adjustment.

ICU services are part of the wider emergency services system, and their role includes being prepared to respond to an unplanned event. As an emergency service, ICUs parallel other emergency services, such as fire services. Fire services are not funded based on the number of fires fought. Rather, emergency services are funded to provide capability to respond in the event of an emergency. Typical factors taken into account by jurisdictions when planning these services are preparedness, responsiveness, and scalability in case of a widespread disaster along with the likelihood of significant events.

Health services staff maintain ICU readiness through training and deploy their specialist skill and time into other hospital activities when they are not specifically required in the ICU.

Jursidictions, as system stewards plan and invest in ICU services in response to community needs, healthcare system design and the operational need to respond to surges in demand. Jurisdictions

carefully weigh resource allocation decisions to support the commissioning of new ICU services, with a view to responding to the health needs of growing populations. These investments build preparedness, responsiveness and scalability across population centres, but dollars invested translate unevenly in terms of ICU services reported to activity-based funded data collections.

The national model must keep up with changes in clinical care and improve the mechanisms to fund ICUs, recognising these 'fixed costs'. Despite recent developments in clinical care and the pandemic response, the national approach to fund ICU has been largely unchanged since 2011. The volume and the percentage of mechanical ventilation thresholds remain, as does the specified list of health services that can receive the NWAU loading. There has been no retesting of these thresholds and there is a lack of clinical evidence to support their continued use.

Victoria recommends the current criteria to set the list of hospitals as specified ICUs be removed and an interim solution where jurisdictions prospectively 'designate' their ICU services prior to the NEP determination is enacted. This approach while pragmatic, also ensures that jurisdictions do not require the approval of a national body for recognition of ICU services, when the national body has no involvement in the planning or commissioning of these services.

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?

Victoria considers that a tiered payment could be appropriate given the expected resource intensity differential between larger metropolitan and smaller hospitals to deliver ICU services.

If a higher tier payment is to apply to a limited number of hospitals as nominated by Jurisdictional Advisory Committee members, it would be reasonable for IHACPA to provide guiding eligibility principles based on the characteristics of larger and more complex ICU hospitals, as informed by the Australian and New Zealand Intensive Care Society. However, should a list-based approach be maintained, the decision on the final list need be in time to inform the National Efficient Price published in March of each year. The current approach for retrospective application for recognition as an eligible ICU does not align with the timing of investment decisions, nor does it account for preparedness and responsiveness type consideration.

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

Victoria considers that a fixed NWAU adjustment for eligible hospitals is consistent with the fact that activity-based funding volumes alone do not provide an effective mechanism to fund preparedness, responsiveness and scalability.

A fixed component is appropriate to recognise unutilised capacity or availability. Fixed payments are likely to scale between health services expected to play a major role in supporting a statewide emergency response, as compared to smaller hospitals that deliver ICU of lower complexity, with less beds and a lower resource intensity of the specialist staff profile.

4.2.2 Other adjustments and their eligibility criteria

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?

The reduction in the Indigenous adjustment in the National Efficient Price (NEP) in recent years is problematic because Aboriginal community leaders, particularly members of the Aboriginal Health and Wellbeing Partnership Forum, as representatives of their local communities may equate this to less funding for Aboriginal[1] patients. It is not consistent with Closing the Gap.

Presentations to tertiary health services by Aboriginal people are for more acute conditions than the broader population, largely due to a lack of focus and investment on prevention and early intervention. Aboriginal Community Controlled Organisations (ACCO) models of care focus on prevention using a holistic, 'wrap-around' model of healthcare. This means an 'episode of care' is not considered in the same way as the IHACPA's clinical definition of an episode of care. As such, statistical approaches to unit pricing does not capture the range of factors involved in Aboriginal patient care, and further consideration is needed to capture the true cost of Aboriginal patient care.

Victoria notes the inherent risks through the current method of calculating the NEP adjustments, as they disadvantage the Victorian Aboriginal community. For example:

- Victoria has only two small 'remote' areas under the Rural, Remote and Metropolitan Area classification, with very few Aboriginal people living in those areas. Where Victorian data are reported for health conditions, there are no data sourced from 'remote' areas.
- Dialysis and radiotherapy adjustments may help address health conditions of the Australian Indigenous population more broadly, but other chronic conditions such as chronic obstructive pulmonary disease (COPD) and other diseases of the circulatory system are of greater, and increasing concern to Aboriginal Victorians. For example, Aboriginal hospitalisations for diseases of the circulatory system are increasing at a greater rate in Victoria than nationally (105% Victorian change in the last decade compared to 49.3% change nationally).[2]

IHACPA's technical specifications allude to a statistical explanation. That is, the Indigenous adjustment interacts with residential remoteness area, radiotherapy, and dialysis adjustments. If those other adjustments are increasingly better proxies to explain the variation in costs, a decreasing Indigenous loading may have a statistical explanation, albeit the funding for Indigenous patients, all other model parameters accounted for, is most likely increasing. One way to more accurately measure the increase in funding for Indigenous patients is to isolate the impact of Indigenous patients from other adjustments. This could be referenced to funding for non-Indigenous patients. The decreasing loading underscores the risk of misinterpretation of model parameters that are of statistical origins.

Signatories to the NHRA represented through the Jurisdictional Advisory Committee may wish to explore alternatives to the current Indigenous adjustment in the NWAU model, which is based on reported costs, noting that the intent of the adjustment is to account for costs of care that may not be able to be directly attributed to Indigenous patients (such as culturally safe service models). The

[1] Refers to those identifying and Aboriginal and/or Torress Strait Islander people.

[2] AIHW analysis of National Hospital Morbidity Database.

current approach means the adjustments calculated value can change due to varied interactions with other model parameters (some of which are already reasonable proxies for the Indigenous loading). The intent could be to meet a policy objective where the national funding approach is more closely tied to the improvement of Indigenous health outcomes. There is no such requirement at this stage that the Indigenous loading be specifically tied to expenditures on improving Indigenous health outcomes.

In considering an alternative funding mechanism to the Indigenous loading in the NWAU model, the IHACPA may wish to consider the following:

- There is likely no appropriate national mechanism to improve reporting of Indigenous status at local health services. While the national data collection rightly allows for Indigenous status to be reported as 'not-stated/inadequately described' there is an inherent bias in reporting to this category: Indigenous patients that present, but do not wish to identify because they feel culturally unsafe will be over-represented in this category.

  A limited analysis of the Victorian cost data shows the volumes of reporting in the unreported category is a significant proportion of the volume of Indigenous patients. It also has significantly higher cost metrics than non-Indigenous patients, suggesting the 'not stated' cohort is more aligned with Indigenous patients, and not at all aligned with non-Indigenous patients.

  The Victorian experience is that a person is more willing to identify as Indigenous through local initiatives tailored to improve cultural safety that have been consulted on with the local Indigenous leaders that live near that health service.

  The nature of the activity-based funding costing approach means investments in cultural safety are not adequately allocated as costs to Indigenous patients so as to materially impact the Indigenous loading, or as part of a cost ratio analysis.

- A limited analysis of the Victorian cost data shows that the costs for Indigenous patients have been growing over time, which is inconsistent with a decreasing national Indigenous loading (noting a probable statistical explanation). Counterintuitively, the cost per NWAU at the aggregate level is consistently lower than non-Indigenous patients; however, other metrics such as cost per separation, cost per bed day, NWAU per separation, and average length of stay are consistently higher for Indigenous (or non-reporting) patients. This suggests that, at least in Victoria, the NWAU model appears to over-penalise Indigenous patients in relation to costs. This may be explained through inter-related reasons, in that Indigenous patients:
  - may interact with the health system later when their condition is more complex
  - are under-represented in DRGs that have higher funding to cost recovery rates
  - present with a greater rate of comorbidities and as such they are likely to stay longer (so have a higher probability of being a high outlier).

  The efficiencies built into the NWAU model lead to a greater proportion of Indigenous patients as high outlier patients that have lower funding to cost recovery – Indigenous loading as a set percentage is too blunt so as to offset a more complex case-mix and health outcomes narrative (much of that narrative supported that outlined in the Closing the Gap reports).

  Despite a good intention of having an explicit Indigenous loading, the built-in efficiency mechanisms in the NWAU model most likely leads to a claw back that exceeds the Indigenous loading.

- The importance of consulting on and addressing the declining Indigenous adjustment underscores the mismatch between an articulated policy position on an Indigenous adjustment,

versus what a statistical model is intended to do. The NHRA provides for such a policy discussion with Jurisdictional Advisory Committee members.

Victoria suggests IHACPA consider the following options, including a potential combination:

- Policy based adjustment

  Based on feedback and analysis provided by Jurisdictional Advisory Committee members, develop a policy position for an adjustment separate to the cost data. This could be 5%, 10% or greater, but could be based on the relative weighting of jurisdictions current funding towards cultural safety initiatives proportioned out to the activity-based funding envelope. The other statistical adjustments in the NWAU model will still be based on the cost data, but calibrated to take into account this policy position.

- Block fund actual expenditure

  In light of the inadequacy of activity-based funding to pay for tangible initiatives that improve Indigenous health outcomes IHACPA consider removing the Indigenous adjustment from the NWAU model. Instead block fund the actual expenditures incurred by jurisdictions which can be acquitted against investments made at the health service level.

  This would provide the following benefits:

  - Unlike the Indigenous loading in the NWAU model that is not tied to specific initiatives that target the improvement of Indigenous patient outcomes, block funding is tied to specific investments.
  - Addresses the issue that smaller regional hospitals with higher Indigenous populations, do not receive a significant amount of activity-based funding throughput to deliver meaningful investments to improve Indigenous health outcomes.
  - Enhances the link between Commonwealth NHRA funding and the tangible initiatives that support improvement of health outcome for Indigenous communities.

4.3 Accounting for private patients in public hospitals

Victoria notes the intention of this clause is that there be no financial incentive to treat private patients over public patients. As previously expressed during consultation periods, there may be longer-term impacts on rates of private health insurance per population when there is no value seen if attending a public hospital. This is policy issue that largely sits as a consideration for the Commonwealth. However, the expected impact of higher growth in public NWAU over private NWAU is a factor that should continue to be closely monitored and reported on by IHACPA in its quarterly activity reporting, with respect to its impact on the current annual NWAU growth cap.

Victoria considers the private funding neutrality adjustment (PPNA) unreasonable because:

- The current jurisdiction and DRG specific private patient service adjustments (PPSA) will neutralise public to private over the three year cost to pricing cycle. That allows time for a transitioned response from health services that may have in the past delivered a relatively high proportion of private activity for a particular DRG. Granted that if the private funding neutrality adjustment can only be negative (as a liability to jurisdictions) it creates a risk of over-penalty during a period in which the PPSA has already neutralised any residual funding incentive.
- The adjustment is calculated retrospectively to the activity delivered. There is no meaningful way for jurisdictions or health services to respond to the signal inherent in an adjustment, suffice to say an appropriate prospective response signal already exists in the PPSA.

- It is unpredictable and therefore uncontrollable. There is a lack of effective policy mechanisms for jurisdictions and health services to mitigate the financial risk of a retrospective funding adjustment. A patient still has the right to elect to be a private patient which are driven by Commonwealth policy settings: affordability and coverage of individual policies will determine whether a patient elects to be private in public which are not factors able to be controlled by system managers A direction to health services to stop private activities in public hospitals would disrupt service delivery which is contrary to the principles agreed to in the NHRA.

4.4 Harmonising price weights across care settings

Victoria notes IHACPA's intention to harmonise chemotherapy price weights between the admitted and non-admitted setting. The analysis to date has largely focussed on a desktop analysis of the available data. Victoria has previously advised that the reasons underpinning differences in care setting between jurisdictions must be better understood before harmonisation can occur.

Some outstanding questions remain, such as:

- Are the apparent higher costs in the admitted setting for chemotherapy able to be explained due to the bundling of patient services. When comparing costs to a jurisdiction that deliver non-admitted chemotherapy, are there separate non-admitted services (for example diagnostics or pathology) that can help explain the cost differences?
- What are the risks of harmonisation on national reporting? Specifically, will the volume of non-admitted services (chemotherapy and other supporting non-admitted services in-scope of NHRA or in-scope of MBS) likely increase?
- What impact will the harmonisation have on the ability of specialist hospitals to sustainably and safely deliver chemotherapy services, particularly those jurisdictions that currently deliver chemotherapy primarily in the admitted services setting? What thought has been given to support transition?

Victoria is broadly supportive of the IHACPA harmonisation work, but considers that it needs to more effectively account for clinical factors. The expected impact on service reconfigurations should be interrogated prior to harmonisation to better understand system level impacts and avoid unintended consequences.

Chapter 5: Setting the national efficient cost

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

Consideration should be given to specialist forensic mental health services, including Thomas Embling Hospital (Victorian Institute of Forensic Mental Health), as standalone hospitals providing specialist mental health services under future *National Efficient Cost* determinations.

Additionally, the appropriateness of classifying mental health secure extended care units as in-scope for activity-based funding should be assessed. In Victoria, these units are often characterised by admitted episodes spanning years, even decades. As activity-based funding is determined following episode closure, it may be appropriate to consider block-funding criteria within future *National Efficient Cost* determinations for secure extended care units within Victorian public hospitals.

Chapter 6: Data collection

6.1 Cost and activity data collection

Consultation questions

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?

The current activity data submission timeframes imposed by IHACPA are challenging and do not always allow for rigorous auditing and quality assurance processes to be undertaken. IHACPA's proposal to bring forward the submission timeframes for 2025–26 may further reduce the quality of data submitted by jurisdictions.

IHACPA should ensure that health services and jurisdictions have sufficient time to allow for data collection and quality assurance processes to be undertaken.

6.3 National Benchmarking Portal

Consultation 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?

The National Benchmarking Portal (NBP) provides a valuable tool which assists in informing policy decisions, supporting health services research and analysing health system performance. As with any such tool, there are opportunities to enhance user experience. The following suggestions are informed by the department and Victorian sector's experiences.

Hospital Acquired Complications (HAC) activity

- The visual for the number of HACs by complication group does not display data on all HAC groups when filtered on a year other than 2020–21. When a year other than 2020–21 is selected, users are required to select each individual HAC group for the observed and expected number of HACs to appear. It would be useful if this visual always works as it does for 2020–21.
- When two or more HAC groups are selected, the expected number and expected rate of HACs and the comparison from the previous year is not displayed. It would be useful if this functionality is implemented. Similarly, when individual HAC groups are selected, it would be useful if the observed and expected number of HACs are displayed for each discrete HAC sub-classification.
- Summary data on the 14 evaluable HAC groups in the NBP is useful. Though specific diagnoses (ICD-10-AM) ascribed to the complication is of value, as this enables clinicians and health services working in tandem with government agencies to develop targeted HAC prevention initiatives.

  The existing HAC model funds each HAC category as a clinically homogenous group, meaning the amount lost in HAC penalties may not reflect the incremental cost associated with specific complications within that HAC group. For example, the aetiology, pathogenesis, and risk factors for respiratory syncytial virus pneumonia (HAC3.3, J12.1) is different to that of pneumonia due to

Escherichia coli (HAC3.3, J15.5), yet both are condensed to just one HAC grouping in the NBP (that is, HAC3.3). The NBP currently does not enable users to drill down to the ICD-10-AM-level rates within each HAC group. It would be beneficial to consumers that this functionality be considered in future iterations of the dashboard.

- Addition of another measure of jurisdiction-based performance relative to national performance. Victoria proposes the addition of a new visual, or calculation where appropriate, that takes the state or territory HAC ratio (observed/expected) divided by the national HAC ratio. This ratio-to-ratio comparison enables jurisdictions to gauge the difference of their HAC rate compared to what is observed at a national level.

  For example, according to NBP data, in 2020–21, the Victorian HAC ratio for HAC12 (persistent incontinence) was 1.51 (588 observed / 390 expected), whereas the national HAC ratio for HAC12 was 0.86). When applying the ratio-to-ratio rule, 1.51 / 0.86 yields 1.76, indicating that the rate of HAC12 is approximately 1.76-times greater to what is observed nationally.

  This information is of relevance as it provides a more detailed measure of higher HAC rates that may be unique to any state or territory.

- Users can observe HAC activity according to individual local hospital networks (LHN); however, when two or more LHNs are selected, HAC activity is presented for all selected networks combined. It would be useful for consumers and health service administrators to observe HAC rates for each selected LHN to assess performance between comparable LHNs.

HAC trends

- It would assist analysis if the portal presented the count of episodes assigned ≥2 HAC ICD-10-AM codes with opportunities to disaggregate according to the prescribed list of risk factors adopted for each HAC from the IHACPA's logistic regression model. Notwithstanding that for episodes containing >1 HAC that the maximum adjustment is applied for the funding adjustment (regardless of the HAC complexity), provision of more granular information on episodes with ≥2 HACs will support NBP users to identify at-risk and complex case-mixes that may benefit from targeted HAC prevention programs.

- The inclusion of HAC data preceding 2017–18 would enable jurisdictions to understand whether higher HAC rates are a recent phenomenon or a long-standing observation.

Chapter 9: Pricing and funding for safety and quality

9.1 Overview

Victoria faces challenges with the consistency in definitions and variability in reporting sentinel events and hospital acquired complications (HAC). Victoria has not as yet included avoidable readmissions (AHR) adjustments in the Victorian funding model; however, work is underway towards its imminent implementation.

9.2 Sentinel events

There are concerns around definitions, and variability in interpretation of definitions, of the Australian Sentinel Events List categories 1-10. For example, the definition of what life saving surgical and medical treatment is can be widely interpreted and there is no guidance around what is classified as a medication error. This can be seen by the large variation in what is reported across jurisdictions.

IHACPA should continue to work with the Australian Commission on Safety and Quality in Health Care to clarify definitions and categorising events. This will help improve the process for confirming avoidable events. Currently, the process for confirming is not structured or robust. Safer Care Victoria does not sit on the review panels, which means making the assessment on avoidable events is reliant on the information provided. Health service may find it difficult to confirm whether an event should be classified as a sentinel event.

9.3 Hospital acquired complications

1. Alignment with Australian Coding Standards

Victoria notes that for NEP24, diagnostic codes used to define risk factors for HACs have been updated to reflect the latest ICD-10-AM edition. The addition of chronic condition codes (U codes) are welcomed, however there is still existing misalignment with the Australian Coding Standards for supplementary chronic conditions.

Safer Care Victoria has received some feedback from researchers that there is a disconnect between Australian Coding Standards and consensus surveillance criteria for key HACs risks clinical over-coding of HACs and an ill-guided signal of quality and safety. It should be considered whether harmonising clinical definitions with Australian Coding Standards in the context of HACs may provide a more accurate and meaningful measure of patient safety and health service performance.

2. Improving HAC data

Victoria looks forward to working with IHACPA and other jurisdictions to improve the national data collection for HACs and National Benchmarking Portal (NBP).

According to the NBP from 2017-18 to 2020-21, Victoria and the national average show a general trend of improvement with decreasing ratios of actual to expected HACs. However, Victoria's actual to expected HAC ratio remains higher than the national ratio throughout this period. From 2018-19 to 2020-21, Victoria’s actual to expected HAC ratio remained above 1 (suggesting higher than expected rates), while the national ratio decreased to below 1 (indicating lower than expected rates).

Of the 15 evaluable HACs in 2020-21, healthcare-associated infection (HAC03), surgical complications requiring unplanned return to theatre (HAC04),[3] and cardiac complications (HAC14) resulted in the highest statewide prevalence.

The omission of HACs 5 (Unplanned intensive care unit admission) and 16 (Neonatal birth trauma) in the IHACPA's NBP is a notable limitation of the dashboard. This omission limits Victoria's ability to evaluate the burden of all complications in the HAC framework.

3. Improving the HAC model

Victoria requests IHACPA undertake further work with jurisdictions to ensure the HAC adjustments are not resulting in unintended consequences in the quality and mode of health service delivery by disproportionately impacting health service funding.

Victoria is conducting further analysis based on more updated state data to evaluate which hospitals have low HAC ratios and to identify clinically significant factors contributing to these outcomes. This analysis aims to understand the specific characteristics and practices of hospitals with lower HAC ratios, which can then be used to develop targeted interventions and best practice guidelines. By focusing on hospitals that perform well, Victoria can derive valuable insights into effective strategies for reducing HACs and improving overall patient safety and care quality.

While undertaking this analysis it has become apparent that there are health services that are disproportionately exposed to the HAC adjustment. These include specialist health services or hospital peer groups which almost exclusively manage a unique casemix that have a higher risk profile for onset of discrete HACs. These health services may be disproportionately impacted by the funding loss ascribed to HAC-coded admissions. Such may be the case with HAC03 (healthcare-associated infections) among specialist cancer health services managing an immunocompromised casemix.

The adjustments should also take into consideration that some clinical practices may be associated with higher risk for HACs. For example Victoria has observed that hospitals specialising in maternity care experience higher rates of this persistent incontinence (HAC 12). HACs are intended to reflect conditions acquired during the hospital stay, but not necessarily resulting directly from the care provided. For vaginal deliveries, persistent incontinence is a commonly reported condition and the high rate of HAC12 may not always indicate inappropriate care. This distinction is crucial because inappropriate risk adjustment can lead to unjust financial penalties for hospitals that manage inherently high-risk populations.

Victoria therefore recommends a review of the risk adjustment model to ensure it accurately reflects the risk profile of specialist health services (and requests in the first instance maternity hospitals) and to inform adjustments to HAC pricing to ensure appropriate funding. Such a review should involve evaluating the model's sensitivity to the specific complexities of maternity care and making necessary adjustments to avoid penalising hospitals that provide care for high-risk and complex patients.

[3] Note results for HAC4 include false positives, as there is no national data element for unplanned return to theatre.

9.4 Avoidable hospital readmissions

In regard to avoidable hospital readmissions (AHR), Victoria is planning to implement IHACPA's avoidable readmission model. Historically, Victoria has had KPIs related to readmissions, but has identified gaps in defining what constitutes a course of care or period of care. It is crucial that the new model can adopt different models of care, such as Hospital at Home.

Currently, the basic linkage rule used involves looking at the admission source and type to exclude transfer of care. Victoria also uses a 24-hour gap between admission and separation to identify transfers. However, there are limitations with this approach.

There is a need to balance the complexity of coding with the ability to timely reflect new and different models of care.

As Victoria plans to implement the AHR model, the department looks forward to working with IHACPA to improve linkage and defining course of care to enhance the readmission model.

9.5 Evaluation of safety and quality measures

Evaluating safety and quality measures is crucial for ensuring high standards in healthcare delivery.

IHACPA has developed comprehensive models for risk-adjusting AHR and HAC, which integrate safety and quality into hospital pricing and funding. These models use advanced methodologies, such as gradient boosting decision trees, to assign risk scores based on patient characteristics and clinical conditions, encouraging hospitals to improve clinical management and discharge planning.

Victoria plans to fully adopt IHACPA's AHR model, addressing historical gaps in defining the course of care and refining linkage rules to accommodate new care models such as Hospital at Home. The evaluation will consider data from several years. Given the significant impact of COVID-19 careful review is required to ensure accuracy and relevance.

Risk-adjusted rate measures serve as valuable screening tools to identify trends and areas of concern, but they should prompt further investigation rather than act as definitive indicators of quality. Limitations in administrative data collection highlight the need for a comprehensive approach to funding adjustments.

Victoria requests IHACPA to conduct ongoing reviews and stakeholder engagement to refine these models, ensuring fair and accurate assessments that enhance healthcare quality and safety.

Consultation questions

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?

1. Potential longer term reporting impact

There are concerns that introductions of pricing adjustments will impact reporting and reporting quality. While this may be true for less mature health services, by and large this has not been evidenced in Victoria’s data.

A decrease in sentinel event notification reporting has been noted for 2023-24. Year to date, there have been 78 less notified events. It is anticipated there will be approximately 50 less than previous years. For the National category’s 1-10 there has been 14 less notifications (2022-23 had 35 reported category 1-10 versus 21 year-to-date 2023-24).

Victoria will continue to monitor this and feed back to the Australian Commission on Safety and Quality in Health Care.

2. Service delivery impact

There is currently insufficient information to estimate the impact that HAC and AHR funding rules have on public health service delivery. More information will be available once Victoria has implemented IHACPA's AHR model and seen a full year of HAC implementation.

Victoria maintains that the HAC and AHR models emphasise the importance of quality and safety in healthcare. It is crucial that risk adjustment adequately accounts for varying levels of risk. Victoria has used the HAC and AHR models to conduct reviews to identify quality and safety concerns.

3. Data limitations

Feedback from health services indicates that the model is built on administrative data collection, which has limitations. For example, conditions noted in the admission record but not treated during the hospital stay, are not included in the diagnosis codes submitted in accordance with Australian Coding Standard ACS 0002 Additional diagnoses This omission can impact the identification of the complexity of cases, which in turn affects hospital funding. Given these limitations, it is essential to consider the broader context and potential data gaps when using risk-adjusted rate measures for funding decisions.

4. Improvements on risk-adjusted rate measures

Risk-adjusted rate measures are essential tools designed to account for patient variability and provide a more accurate comparison of healthcare outcomes across different providers. However, there are concerns about whether it is sufficient to use these measures to apply funding reductions to health services. Victoria requests IHACPA to continue to work with jurisdictions to improve this approach.

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?

Positive incentives for consumer experience and staff experience measurement would be key. Provide additional funding to health services that receive praise from consumers and who report positive experience, as well as services who have high staff engagement, high safety cultures, and high leadership quality. While this would approach would need consideration on how it may be implemented, these two indicators are the strongest predictors of safety and quality.

Noting, implementing additional indicators to reward high-quality care, while also adjusting for AHRs, sentinel events, and HACs, may create a wider funding gap across hospitals. Therefore, it is important to ensure that health services with poor performance based on contemporary HAC or AHR data also receive sufficient funding to improve their quality of care.

This support can be achieved through program-based funding, enabling health services to develop and expand infrastructure aimed at minimising HACs or AHRs. For example, funding could be allocated for the implementation of high-efficiency particulate air (HEPA) filtration devices on wards to reduce the risk of aerosolised pathogen transmission for hospital-acquired pneumonia (HAC3.3). Additionally, expanding the availability of mobilisation aids for elderly patients could help reduce the risk of hospital-acquired fractures (HAC02).

Short-term investments of this nature will provide health services with limited resources that can be used to provide the opportunity to improve healthcare quality by minimising the risk of HAC acquisition. By focusing on targeted infrastructure improvements, underperforming services can be supported in their efforts to enhance patient outcomes and overall safety.

Other comments on chapter

Victoria is interested in the costing data from virtual care in the national context, particularly in cost-efficiency analysis. This evidence will support informed decisions that will lead to improved healthcare outcomes and sustainability.

IHACPA have previously provided costings for clinical trial activity, and it would be worthwhile to consider updating this information to aid clinical trial conduct, particularly within health services and given the introduction of the National Clinical Trials Governance Framework.