ATTACHMENT A
WESTERN AUSTRALIA'S SUBMISSION TO THE CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2025-26

Introduction

Western Australia (WA) welcomes the opportunity to provide feedback to the Independent Health and Aged Care Pricing Authority (IHACPA) on the *Consultation Paper for the Pricing Framework for Australian Public Hospital Services 2025-26*.

Classifications used to describe and price public hospital services

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

   WA does not see any barriers to pricing without a shadow pricing period for NEP25.

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

   Mental health presentations in emergency care settings pose unique challenges and often require specialised assessment and management. Whilst the AECC includes end classes for mental health, enhancing the classification system to better capture the complexity of mental health presentations and interventions to improve care delivery and resource allocation particularly for Aboriginal populations is suggested.

   One of the proposed refinements mentioned in the consultation paper is complexity of paediatric patients. Could the review be extended to include complexity of Aboriginal patients?

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?***

   WA does not see any barriers or known issues in relation to reporting principal diagnosis and patient's age.

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

   WA notes the work that is currently in progress to develop a new Non-Admitted Care Classification, which would take a few years before a new classification is ready for implementation. It is proposed, in light of the time consideration, that the Tier 2 Non-Admitted Services documentation should be reviewed to:

- Ensure alignment between the Tier 2 Non-Admitted Services Compendium, Tier 2 Non-Admitted Services Definitions Manual and the Metadata Online Registry (Australian Institute of Health and Welfare) resources regarding both multidisciplinary clinics and multidisciplinary case conferences.
- Give clarity on definitions for specialties/professions and what comprises a *unique service.*

It is understood that Voluntary Assisted Dying (VAD) is generally low volume activity but becoming a common practice across Australia. There are also challenges in data reporting due to the confidential nature of the service. Currently the best fit Tier 2 code available for VAD services is 20.13 (Palliative care). A Tier 2 code more specific to VAD services should be considered to enable a more consistent approach to recording and reporting VAD activity, and allay concerns raised by the palliative care community that the use of 20.13 may cause referral pathway errors.

WA is supportive and will continue to participate with the refinement work relating to Tier 2 and the development of a new non-admitted care classification to better describe the capturing patient complexity, treatment of multiple healthcare providers, accounting for changes in care delivery and models of care as more services transition to virtual care and other innovative models of care.

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?*

WA does not see any barriers to pricing admitted and community mental health care services using AMHCC Version 1.1.

WA will continue to work with all jurisdictions particularly the Commonwealth to address funding transition arrangements to ensure service delivery to vulnerable populations is not compromised particularly in rural and remote areas.

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?

Resourcing remains a key barrier to collecting activity data following the COVID-19 pandemic response. Funding for systems and resources that facilitate in collecting activity data would contribute to overcoming these barriers. In addition, WA suggest consideration of public health alerts and/or flags to easily identify activity related to a pandemic or other infectious disease impacts.

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?

From a WA perspective, the current annual activity data being reported to IHACPA based on the Australian Teaching and Training Classification (ATTC) requirements

is not robust enough to determine the efficient cost of teaching and training. WA recommends a review of the ATTC to determine whether it is fit for ABF purposes.

In WA, activity data is fragmented and currently manually collected as there is no central data repository. The structure of the ATTC does not align with the current WA TT(Research) costing methodology, therefore activity cannot be costed.

Setting the national efficient price

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?

The impact of the COVID-19 pandemic on activity and expenditure in 2021-22, as noted in the WA Response to the Consultation Paper for the Pricing Framework 2024-25, persisted into 2022-23 as the state transitioned to living with COVID-19. Evidence demonstrating the persistence of costs and changes to models of care in 2022-23 include:

- Elective Surgery restrictions that occurred in 2021-22 had an impact on 2022-23 service delivery as services were put back online.
- Treating more complex patients because of delayed elective surgeries and the cost of delayed treatment on disease progression.
- Staff furlough and other COVID-19 effects including increased sick leave and 'new normal' levels of sick leave usage impacted the ability to return back to pre-COVID levels of service delivery.
- Additional costs associated with increased Personal Protective Equipment, fit testing, enhanced cleaning regimes, running Fever Clinics, establishment of rapid response teams, vaccinations, and costs related to COVID-19 preparedness persisted in 2022-23.
- Insurance costs including medical treatment liability, worker's compensation, and re-insurance markets.
- Changes in medical vs surgical patient mix.
- Increases in relation to inflationary pressures of all expenditure and costs, including operational guidelines, supply and stockpiling.
- Increase of virtual care services requiring additional support.
- Increased length of stay and bed blockage, associated with an increase in patients that were not able to be discharged in a timely manner due to the availability to manage these patients in a community setting.
- Increase in wages costs, due to a reliance on agency nursing as the COVID-19 pandemic impacted local labour markets in a way that is yet to recover, especially in rural and remote areas.
- Increase in workforce costs related to continuous and ongoing recruitment to increase the workforce and the additional workforce required to support the system associated with increased bed capacity.
- A greater emphasis on disaster and emergency management, and planning procedures has occurred post-pandemic and remains in 2022-23.

As of October 2022, the WA Department of Health requested Health Service Providers (HSPs) to no longer report and identify COVID-19 costs, and hence the visibility of costs have diminished during 2022-23 as HSPs were expected to absorb any COVID related costs.

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

To help identify costs associated with significant disruptions to the health system, principles and guidelines should be established at a Commonwealth level, first to define "significant disruptions", and then to outline what responses are required at a national and jurisdictional level if and when they occur. Considerations for such guidelines might include:

- Agreements between the Commonwealth and States and Territories, as with the National Partnership on COVID-19 Response, to outline how financial assistance may be provided in the case of a significant disruption, acknowledging the responsibility for health is shared between the Commonwealth and States and Territories.
- Funding should be provided within the given year it is required and needed, rather than retrospectively. Consideration should be given to the additional resources required during natural disasters and epidemics, including capital costs.
- As demonstrated during the COVID-19 response, it is important to determine the impact of legitimate and unavoidable costs when delivering health services during significant disruptions, especially when these services are either cancelled or postponed. This was undertaken during COVID-19 when the cost signature was broken down into a pre-COVID-19 performance and a COVID-19 performance. Given the disruption to outpatient services seen during and following COVID-19, WA suggests consideration of complex outpatient appointments and how these might be managed during significant disruptions.
- The creation of a dedicated cost centre and accounts to quarantine identifiable costs arising from the disruptions. Automatic and early implementation of this identification should occur when there is a reasonable expectation that the cost of disruption will exceed some minimum threshold.

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?

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?

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

Comments for questions 10, 11 and 12:

- WA supports review and possible update of the ICU adjustment and how it is derived and applied, plus the eligibility criteria.
- WA would suggest that there be a mechanism that recognises length of time in ICU and the varying level of service, for example the inherent difference in complexity/acuity of a rural ICU compared to a metropolitan ICU.
- As much as possible, leverage data/information that is already collected and reported by jurisdictions to reduce the reporting burden.

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 adjustments, so that it reflects the costs of public hospital services for Aboriginal and Torres Strait Islander (ATSI) peoples across Australia?

- Consideration for "Clinical Yarning" as part of the therapeutic treatment in the actual cost for delivering public hospital service.
- It's possible that patients who identify as Aboriginal may choose not to declare it within a clinical setting. Aboriginal patients are amongst those who experience the highest levels of complications arising from social determinant factors, which are not be captured by the current methodology.

Data Collection

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

When developing costed dataset, IHACPA should allow adequate time for consultation and for jurisdictions to implement changes.

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?***

While WA will continue to provide all data available, improved guidelines and standardised data quality measures would help ensure data collected is 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?

- To improve the quality of data provision to enable the capture of quality data and accurate costing, IHACPA could consider enhancing the ability for jurisdictions to access the IHACPA validated data.
- WA ensures data is compliant with national and state policy and legislation, using a tiered approach – system validation, data analytics and clinical auditing. Dashboards are being used to manage data quality contemporaneously, enabling accurate data collection.

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 could be improved by enabling a user (pending appropriate access) the ability to extract record level data across a particular Diagnosis Related Group (DRG) and peer group sites. Other changes that would enhance user experience and functionality include:

- More detail, including greater longitudinal views (more years to enable better trend analysis).
- Improving the recency of data available.
- Including the date of the last update and when the next update is planned for.
- Further national data associated with the mental health phase of care.
- Greater flexibility in comparing peers, for example the ability to pick top 10 performers for a particular DRG.
- For the future - the ability to introduce predictive Artificial Intelligence technology to be able to have new queries displayed visually for the end-user.

Pricing and funding for safety and quality

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 pricing approach has encouraged greater accountability by Local Hospital Networks (LHNs) into safety and quality initiatives.
- The implementation of these initiatives has led to the introduction of dedicated resources and teams in these program areas to investigate safety and quality related issues and which has assisted in driving the reduction of these incidences occurring. Noting that these programs are an additional cost to the LHNs and will be contributing to higher costs in the system without commensurate funding being received, and with jurisdictions being financially penalised regardless of any improvement.
- It is likely that continuous improvement will become less cost effective as processes and systems within the LHNs adjust and will also become more difficult to justify moving forwards.

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?

WA notes the on-going NHRA Addendum negotiations and any further development in this area will be guided by measures included in the finalised Addendum.

Other comments

- **Virtual care**

WA is participating in the IHACPA virtual care project consultations and looks forward to a national strategy for integrating virtual care models into the national pricing and funding models. The ABF classification systems, in particular the Tier 2 clinic codes, have very limited scope/utility to classify virtual care in non-admitted settings. WA recommends the urgent need to progress the review of classification systems to accommodate virtual care.

Involvement of primary care

The involvement of General Practitioners (GPs) and specialist (in public hospitals) is becoming a common practice in WA. GPs bill Medicare for their services, but the public hospital cannot report their activity via ABF because the interaction in the public hospital only involves a specialist therefore the event could not be classified as a multidisciplinary case conference. Telehealth codes are also not applicable because this is an interaction between a private provider (GP) and public hospital specialist. GP access to a specialist in public hospitals enables GPs to receive timely feedback from specialists to help determine the appropriate management and care pathway for the patient. It reduces waiting time for patients unnecessarily on outpatient waitlists, foster a collaborative working relationship to manage chronic conditions in the primary care setting, and facilitate sharing of knowledge to support primary care education. As an interim measure, it is recommended that IHACPA considers the use of relevant Tier 2 clinic codes provided the activity meets the definition of a service event.

Command centre

Rural and remote sites rely heavily on virtual care (telehealth) to deliver services closer to home via a command centre. A metropolitan service provider is also using a command centre for virtual care. The operational cost of the command centre (i.e., equipment, maintenance, administration etc) and other infrastructure related costs are not captured in the ABF pricing model and WA suggests that this issue be considered as part the IHACPA virtual care project.

- **National Health Reform Agreement (NHRA) Mid-Term Review**

  It is noted that IHACPA will continue to support NHRA negotiations in line with the recommendations made in the Mid-Term Review (MTR). To this end, it is recommended that IHACPA:

  - Review and redesign the NEP and NEC methodologies to address funding challenges faced by smaller jurisdictions and recognise the higher costs and service complexity in rural and remote areas, noting WA is at a particular disadvantage given both its relative size, and service delivery challenges in rural and remote areas;
  - Also review and adjust the calculation of Indigenous, residential and treatment location loadings to ensure smaller jurisdictions are not disadvantaged, consistent with Recommendation 18 of the MTR;
  - Commit to removing the three-year time lag between the NEP/NEC and actual cost of service delivery, consistent with Recommendation 19 of the MTR; and
  - In line with the most recent IHACPA conference, consider how to reward high value care and penalise low value care, consistent with Recommendation 14 of the MTR.

- **Interface between public hospitals and residential aged care services**

  The undersupply of respite and residential aged care services particularly prevalent in rural and remote WA, means that hospitals encounter difficulties in caring for patients who, once admitted, often remain for longer than ideal due to inadequate discharge options. The repercussions of these deficiencies on hospitals, as the provider of last resort, within the hospital pricing framework is significant. This is an independent issue to the pricing of aged care services in aged care facilities.