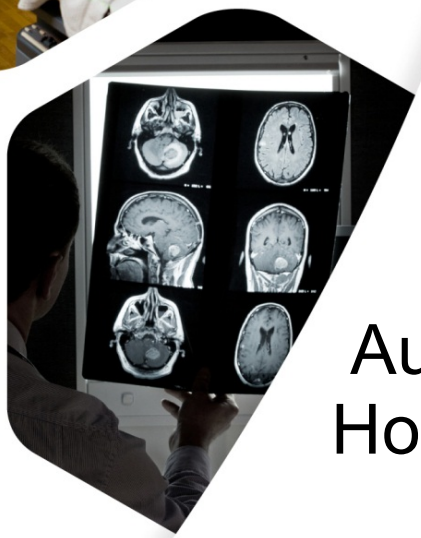
Independent Hospital Pricing Authority

IHPA



The Pricing Framework for Australian Public Hospital Services 2015-16

Independent Hospital Pricing Authority
The Pricing Framework for Australian Public Hospital Services 2015-16

The Hon Jillian Skinner MP
Chair, COAG Health Council
52 Martin Place
SYDNEY NSW 2000

Dear Minister

On behalf of the Independent Hospital Pricing Authority (IHPA), I am pleased to present the *Pricing Framework for Australian Public Hospital Services 2015-16.*

This is the fourth Pricing Framework issued by IHPA. The Pricing Framework emphasises the commitment by IHPA to transparency and accountability and it is the key strategic document underpinning the National Efficient Price (NEP) and National Efficient Cost (NEC) Determinations for the financial year 2015-16. The NEP Determination will be used to calculate Commonwealth payments for in-scope public hospital services that are funded on an activity basis, whilst the NEC Determination covers those services which are block funded.

This being the fourth Pricing Framework, the scope of policy issues considered has narrowed considerably.

Looking forward, IHPA continues to improve the key foundations of activity based funding through further developing classifications, counting rules, data and coding standards as well as the methods and standards for costing data.

The role of states and territories as system managers of public hospitals is vitally important. IHPA also works in partnership with other national agencies, including the Australian Commission on Safety and Quality in Health Care and the National Health Performance Authority. These collaborations ensure that pricing, quality and performance measures for public hospitals are complementary and, together, create a strong national framework for the delivery of public hospital services.

Finally, I would like to affirm the commitment of IHPA to transparency and continuous improvement in how it undertakes its delegated functions, grounded in an open and consultative approach to working with the health sector in the implementation of funding reform for public hospital services.

Yours sincerely

Shane Solomon
Chair
Independent Hospital Pricing Authority

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Glossary

ABF	Activity Based Funding
ACHI	Australian Classification of Health Intervention
AHPA	Allied Health Professions Australia
AHPCS	Australian Hospital Patient Costing Standards
AIHW	Australian Institute of Health and Welfare
AMA	The Australian Medical Association
AN-SNAP	Australian National Subacute and Non-acute Patient classification
APACHE	Acute Physiology, Age, & Chronic Health Evaluation
ARCBS	Australian Red Cross Blood Service
AR-DRG	Australian-Refined Diagnosis Related Groups
ASGS	Australian Statistical Geography Standard
CAC	Clinical Advisory Committee
CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
DRG	Diagnosis Related Group
DSS	Data Set Specification
ECAWG	Emergency Care Advisory Working Group
GEM	Geriatric evaluation and management
HCP	Hospital Casemix Protocol
HEN	Home enteral nutrition
ICU	Intensive Care Unit
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
IHPA	Independent Hospital Pricing Authority
JAC	Jurisdictional Advisory Committee
JWP	Joint Working Party for Safety and Quality
LHN(s)	Local Hospital Network(s)
MBS	Medicare Benefits Schedule
MDCCs	Multi-disciplinary case conferences
NACAWG	Non-Admitted Care Advisory Working Group

NBA	National Blood Authority
NEC	National Efficient Cost
NEP	National Efficient Price
NHCDC	National Hospital Cost Data Collection
NHRA	National Health Reform Agreement
NMDS	National Minimum Data Set
NPHED	National Public Hospital Establishments Database
NWAU	National Weighted Activity Unit
PBS	Pharmaceutical Benefits Scheme
PCCL	Patient Complexity and Comorbidity Level
Pricing Authority	The governing body of IHPA established under the *National Health Reform Act 2011*
RACP	The Royal Australasian College of Physicians
RANZCP	The Royal Australian and New Zealand College of Psychiatrists
SCWG	Subacute Care Working Group
SHPA	Society of Hospital Pharmacists of Australia
The Act	The *National Health Reform Act 2011*
The Commission	Australian Commission on Safety and Quality in Health Care
TPN	Total parenteral nutrition
TTR	Teaching, Training and Research
UDGs	Urgency Disposition Groups
URGs	Urgency Related Groups
VHA	Victorian Healthcare Association

1. Introduction

Under the National Health Reform Agreement (NHRA) of 2011, the introduction of a national activity based funding (ABF) system is designed to improve efficiency, as well as improve the transparency of funding contributions of the Commonwealth and state and territory governments for each Local Hospital Network (LHN) across Australia. To achieve this, the Independent Hospital Pricing Authority (IHPA) is required to determine the National Efficient Price (NEP) that will be used to calculate Commonwealth payments for in-scope public hospital services that are funded on an activity basis and the National Efficient Cost (NEC) which is used to determine the Commonwealth funding for those services which are block funded.

IHPA has previously completed three rounds of pricing public hospital services under the NHRA, for the 2012-13, 2013-14 and 2014-15 financial years.

On 13 May 2014, the Commonwealth Treasurer delivered the Commonwealth Government's Budget 2014-15. The Commonwealth Government announced its intention to work with states and territories during 2014-15 with the intention to create a new Health Productivity and Performance Commission. Subject to consultation, the new Health Productivity and Performance Commission would be formed by merging the functions of the Australian Commission on Safety and Quality in Health Care (the Commission), the Australian Institute of Health and Welfare (AIHW), IHPA, the National Health Performance Authority, the National Health Funding Body and the Administrator of the National Health Funding Pool.

Whilst the Government undertakes these consultations, IHPA will continue to deliver the program of work laid out in the IHPA Work Program 2014-15, including the Determination of the 2015-16 NEP (NEP15) and NEC (NEC15).

In June 2014, IHPA released a consultation paper on key issues that IHPA would consider in the preparation of the *Pricing Framework for Australian Public Hospital Services 2015-16* (Pricing Framework). The consultation paper is IHPA's primary consultation mechanism as it informs the development of the Pricing Framework. The Pricing Framework details the key principles, scope and approach adopted by IHPA to inform the NEP and NEC Determinations.

IHPA received submissions from 30 organisations that have informed the Pricing Framework, including all state and territory governments and the Commonwealth. These submissions are available on the IHPA website except where submissions have been provided in-confidence.

These submissions have been carefully considered by the Pricing Authority and incorporated into the Pricing Framework where appropriate.

The 2015-16 Pricing Framework builds on the three previous Pricing Frameworks (*2012-13 Pricing Framework*, *2013-14 Pricing Framework* and *2014-15 Pricing Framework*). For simplicity, where IHPA has reaffirmed a previous principle, the supporting argument has not been restated in this year's paper.

IHPA has issued the Pricing Framework prior to releasing the NEP and NEC Determinations, which will be publicly available in March 2015. This provides an additional layer of transparency and accountability by making available the key principles, scope and approach adopted by IHPA to inform the NEP and NEC Determinations.

2. Pricing Guidelines

2.1 Understanding this element of the Pricing Framework

All nine Australian governments agreed to establish IHPA to provide independent advice about the efficient cost of public hospital services and to determine the NEP and NEC of public hospital services throughout Australia. This advice is evidence-based, drawing on technical knowledge and expertise about the classification, costing and funding of public hospital services. Nonetheless, IHPA must also balance a range of national policy objectives including improving the efficiency and accessibility of public hospital services. This role requires IHPA to exercise judgement on the weight to be given to different policy objectives.

In order to be transparent about how it makes decisions that involve policy choices, IHPA has developed a set of Pricing Guidelines. These Pricing Guidelines are used to explain the key decisions made by IHPA in this Pricing Framework. The Pricing Guidelines may also be used by governments and other stakeholders to evaluate whether IHPA is undertaking its work in accordance with the explicit policy objectives included in the Pricing Guidelines.

The Pricing Guidelines signal IHPA's commitment to transparency and accountability in how it undertakes its work (refer to Box 1).

Feedback received

Submissions were generally supportive of the current Pricing Guidelines. However, Tasmania indicated that the Pricing Guidelines were more complex than what is required to determine the NEP. Victoria argued that IHPA should manage changes in the underlying cost data between years to support continuity and predictability in pricing. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) were concerned that the Pricing Framework favoured hospital-based public hospital services over services delivered in other settings.

IHPA amended the Pricing Guidelines in 2014-15 to include recognition of the need to consider the administrative impact on hospitals and system managers from the national ABF system and does not consider that further amendments to the Pricing Guidelines are necessary. IHPA promotes pricing stability and predictability for LHNs and hospital managers through adjusting for instability in the year-on-year price weights and adjustments. This approach is outlined in the IHPA *National Efficient Price Stability Policy*. IHPA's approach to the pricing of public hospital services recognises in-scope services regardless of the setting they are provided in, and IHPA is satisfied that the RANZCP concerns are addressed through the current Pricing Guidelines.

IHPA's decision

IHPA has developed, and will use, a set of Pricing Guidelines (specified in Box 1) to guide its decision-making where it is required to exercise policy judgement in undertaking its legislated functions. IHPA has not made changes to the Pricing Guidelines for 2015-16.

Next steps and future work

IHPA will actively monitor the impact of the implementation of ABF. This will include monitoring changes in the mix and distribution of public hospital services, consistent with its responsibilities under Clause A25 of the NHRA. IHPA will continue to work with the Jurisdictional Advisory Committee (JAC) and the Clinical Advisory Committee (CAC) to analyse these changes.

The first phase of the evaluation of the national implementation of ABF has commenced. An independent consortium, which includes academics, has been engaged to design the evaluation framework and establish the baseline data. The findings of the evaluation will allow IHPA to monitor any impacts that the introduction of a national ABF system may have on the delivery of public hospital services.

Box 1: Pricing Guidelines

The Pricing Guidelines comprise the following overarching, process and system design guidelines.

Overarching Guidelines that articulate the policy intent behind the introduction of funding reform for public hospital services comprising Activity Based Funding (ABF) and block grant funding:

- **Timely–quality care:** Funding should support timely access to quality health services.
- **Efficiency:** ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.
- **Fairness:** ABF payments should be fair and equitable, including being based on the same price for the same service across public, private or not-for-profit providers of public hospital services.
- **Maintaining agreed roles and responsibilities of governments determined by the NHRA:** Funding design should recognise the complementary responsibilities of each level of government in funding health services.

Process Guidelines to guide the implementation of ABF and block grant funding arrangements:

- **Transparency:** all steps in the determination of ABF and block grant funding should be clear and transparent.
- **Administrative ease:** Funding arrangements should not unduly increase the administrative burden on hospitals and system managers.
- **Stability:** the payment relativities for ABF are consistent over time.
- **Evidence based:** Funding should be based on best available information.

System Design Guidelines to inform the options for design of ABF and block grant funding arrangements:

- **Fostering clinical innovation:** Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.
- **Price harmonisation:** Pricing should facilitate best-practice provision of appropriate site of care.
- **Minimising undesirable and inadvertent consequences:** Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.
- **ABF pre-eminence:** ABF should be used for funding public hospital services wherever practicable.
- **Single unit of measure and price equivalence:** ABF pricing should support dynamic efficiency and changes to models of care with the ready transferability of funding between different care types and service streams through a single unit of measure and relative weights.
- **Patient-based:** Adjustments to the standard price should be, as far as is practicable, based on patient-related rather than provider-related characteristics.
- **Public-private neutrality:** ABF pricing should not disrupt current incentives for a person to elect to be treated as a private or a public patient in a public hospital.

3. In-scope public hospital services

3.1 Overview

Making decisions about what is, or is not, a public hospital service for the purpose of determining eligibility for Commonwealth funding is one of the important tasks assigned to IHPA under the NHRA.

In August 2011, Australian governments agreed to be jointly responsible for funding growth in 'public hospital services'. As there was no standard definition or listing of public hospital services at that time, the Council of Australian Governments (COAG) assigned IHPA the task of deciding which services will be ruled 'in-scope' as public hospital services, and therefore eligible for Commonwealth funding.

The NHRA refers to 'public hospital services', not public hospitals. Many public hospitals provide some services, such as residential aged care services, that are not generally regarded as public hospital services. In addition, organisations other than public hospitals may provide 'public hospital services'. For example, this happens if governments or public hospitals contract out the provision of some public hospital services to private hospitals and non-government organisations.

3.2 Scope of Public Hospital Services and General List of Eligible Services

Each year, IHPA publishes the 'General List of In-Scope Public Hospital Services' (General List) which, in accordance with Section 131(f) of the *National Health Reform Act 2011* (the Act) and Clauses A9–A17 of the NHRA, defines public hospital services eligible for Commonwealth funding to be:

- all admitted programs, including hospital in the home programs;
- all emergency department services; and
- non-admitted services that meet the criteria for inclusion on the General List (see Box 2 below).

In previous years IHPA also published the 'A17 List' of public hospital services that are eligible for Commonwealth funding under the NHRA as part of the NEP Determination. The A17 List is based on Clause A17 of the NHRA which provides a form of grandparenting, in that a service not already captured within the General List and which is not eligible for Commonwealth funding under Clause A10 of the NHRA will be eligible for Commonwealth funding for a specific hospital if that service was purchased or provided by that hospital during 2010.

Services proposed by states and territories to be in-scope for Commonwealth funding are assessed based on a set of criteria and interpretative guidelines which are refined annually.

The most recent criteria and interpretative guidelines were published in the *IHPA Annual Review of the General List of In-Scope Public Hospital Services Framework* Version 2.1. The key change from previous years was the removal of the eligibility criterion that provided for non-admitted services reported in the 2010 National Public Hospital Establishments Database (NPHED). This change recognised reporting in the 2010 NHPED was relevant for the A17 List and not relevant for the annual General List update process which accounts for changes in the way in which public hospital services are delivered.

The criteria and interpretive guidelines are presented in Box 2. The 2015-16 General List, including the A17 List, will be published as part of the NEP15 Determination in March 2015.

Feedback received

Western Australia was of the view that the use of provisions relating to the 2010 NPHED in establishing in-scope public hospital services (the A17 List) creates inequities between states and territories. The requirement for grandparenting is included as part of the NHRA (Clause A17) so some inequity is inevitable.

Many stakeholders advocated for the inclusion of child and adolescent community mental health services on the General List. As published in the *Pricing Framework for Australian Public Hospital Services 2014-15*, the Pricing Authority determined that there was insufficient evidence to support the inclusion of these services on the basis that there is only a low level of interaction between people enrolled in these services and hospitals; nor was there sufficient evidence that these services provided significant reductions in admissions amongst the enrolled patient groups. Evidence provided to date by jurisdictions shows that the admission rates from these programs are considerably lower than for adult and older persons' specialist community mental health programs. IHPA assesses the level of interaction between people enrolled in the service and hospitals as a distinguishing feature between in-scope public hospital services and out-of-scope community based services.

IHPA's decision

IHPA does not propose any changes to the definition or criteria for determining in-scope public hospital services that are eligible for Commonwealth funding under the NHRA in 2015-16.

Full details of the public hospital services determined to be in-scope for Commonwealth funding will be provided in the 2015-16 NEP Determination.

Next steps and future work

The annual review of the General List provides a mechanism for jurisdictions to apply to IHPA for additional services to be included or excluded from the General List.

Box 2: Scope of Public Hospital Services and General List of Eligible Services

In accordance with Section 131(f) of the Act and Clauses A9–A17 of the NHRA, the scope of "Public Hospital Services" eligible for Commonwealth funding under the Agreement are:

- All admitted programs, including hospital in the home programs and forensic mental health inpatient services;
- All emergency department services; and
- Non-admitted services as defined below.

Non-admitted services

This listing of in-scope non-admitted services is independent of the service setting in which they are provided (e.g. at a hospital, in the community, in a person's home). This means that in-scope services can be provided on an outreach basis.

To be included as an in-scope non-admitted service, the service must meet the definition of a 'service event' which is:

> "An interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record".

Consistent with Clause A25 of the NHRA, the Independent Hospital Pricing Authority will conduct analysis to determine if services are transferred from the community to public hospitals for the dominant purpose of making those services eligible for Commonwealth funding.

There are two broad categories of in-scope, public hospital non-admitted services:

A. Specialist Outpatient Clinic Services; and
B. Other Non-Admitted Patient Services.

Category A: Specialist Outpatient Clinic Services – Tier 2 Non-Admitted Services Classification – Classes 10, 20 and 30

This comprises all clinics in the Tier 2 Non-Admitted Services classification, Classes 10, 20 and 30, with the exception of the General Practice and Primary Care (20.06) clinic, which is considered by the Pricing Authority as not to be eligible for Commonwealth funding as a public hospital service.

Category B: Other Non-Admitted Patient Services and non-medical specialist outpatient clinics (Tier 2 Non-Admitted Services Class 40)

To be eligible for Commonwealth funding as an Other Non-Admitted Patient Service or a Class 40 Tier 2 Non-Admitted Service, a service must be:

- directly related to an inpatient admission or an emergency department attendance; or
- intended to substitute directly for an inpatient admission or emergency department attendance; or
- expected to improve the health or better manage the symptoms of persons with physical or mental health conditions who have a history of frequent hospital attendance or admission.

Jurisdictions were invited to propose services that will be included in or excluded from Category B “Other Non-Admitted Patient Services”. Jurisdictions were required to provide evidence to support the case for the inclusion or exclusion of services based on the three criteria above.

The following clinics are considered by the Pricing Authority as not to be eligible for Commonwealth funding as a public hospital service under this category:

- Commonwealth funded Aged Care Assessment (40.02);
- Family Planning (40.27);
- General Counselling (40.33); and
- Primary Health Care (40.08).

Interpretive guidelines for use

In line with the criteria for Category B, community mental health, physical chronic disease management and community based allied health programs considered in-scope will have all or most of the following attributes:

- Be closely linked to the clinical services and clinical governance structures of a public hospital (for example integrated area mental health services, step-up/step-down mental health services and crisis assessment teams);
- Target patients with severe disease profiles;
- Demonstrate regular and intensive contact with the target group (an average of eight or more service events per patient per annum);
- Demonstrate the operation of formal discharge protocols within the program; and/or
- Demonstrate either regular enrolled patient admission to hospital or regular active interventions which have the primary purpose to prevent hospital admission.

Home ventilation

A number of jurisdictions submitted home ventilation programs for inclusion on the General List. The Pricing Authority has included these services on the General List for 2015-16 (10.19 – Ventilation - home delivered) in recognition that they meet the criteria for inclusion, but will review this decision in the future once the full scope of the National Disability Insurance Scheme is known.

4. Classifications used by IHPA to describe public hospital services

4.1 Overview

In determining the NEP for ABF funded public hospital services, IHPA must first specify the classifications, counting rules, data and coding standards as well as the methods and standards for costing data.

4.2 Classification systems

Classification systems are a critical element of any activity based funding system. They group patients who are clinically relevant (i.e. have similar conditions) and resource homogenous (i.e. cost similar amounts per episode) together.

4.3 Australian-Refined Diagnosis Related Groups

For NEP14 IHPA used the Australian-Refined Diagnosis Related Groups classification (AR-DRG) Version 7.0 to group and price admitted acute patient services with the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) and the Australian Classification of Health Interventions (ACHI) 8th edition used for the underlying diagnosis and procedure coding.

In 2013 IHPA appointed an independent consultant to develop AR-DRG Version 8.0 for implementation from 1 July 2016 and for use in pricing for NEP16. The development of AR-DRG Version 8.0 will also be informed by the findings of the Patient Clinical Complexity Level (PCCL) review and will include the 9th edition of the ICD-10-AM and ACHI due for release in early 2015.

Feedback received

There was broad stakeholder support for the development of the AR-DRG Version 8.0. The Commonwealth and the Victorian Healthcare Association (VHA) noted the importance of the review of the PCCL system to the successful development of AR-DRG Version 8.0.

The review of the AR-DRG classification system case complexity process will inform AR-DRG Version 8.0 development. The new approach to case complexity more accurately quantifies individual patient complexity, particularly through better recognising the impact of the principal diagnosis and other patient-based factors on overall case complexity.

IHPA's decision

IHPA has determined that ICD-10-AM 9th Edition and Australian-Refined Diagnosis Related Groups Version 7.0 will be used in setting the NEP in 2015-16 for admitted acute services.

Next steps and future work

IHPA will implement the new AR-DRG case complexity process in the development of AR-DRG Version 8.0. AR-DRG Version 8.0 will be used for pricing in NEP16.

4.4 Australian National Subacute and Non-Acute Patient classification

In 2013 IHPA engaged an independent consultant to develop the Australian National Subacute and Non-Acute Patient classification (AN-SNAP) Version 4.0 to reflect current and evolving clinical practice in subacute services such as rehabilitation, palliative care and geriatric evaluation and management (GEM) services. The development process involves close consultation between IHPA and the Subacute Care Working Group (SCWG) which is composed of senior clinicians and jurisdictional representatives.

The development of AN-SNAP Version 4.0 will be completed in late 2014. In assessing the available data, the consultant has identified some issues with the availability of subacute care data with both clinical variables and costing information. This is particularly the case for the GEM care type in relation to clinical assessment tools for cognition. IHPA is undertaking a targeted study to source the necessary data on cognitive impairment for GEM patients to enable further improvements in the GEM care type.

However, AN-SNAP Version 4.0 will not be available for pricing by 1 July 2015 as the updated version requires the capture of some data elements that are not currently captured in the national data sets, most notably individual Functional Independence Measure scores. The use of AN-SNAP Version 4.0 in pricing has been deferred to 1 July 2016 and IHPA will price subacute and non-acute services in NEP15 using AN-SNAP Version 3.

For NEP13 and NEP14 IHPA determined prices for both AN-SNAP grouped activity data and per-diem rates for ungrouped subacute services at the care type level (i.e. rehabilitation, palliative care, GEM and psychogeriatric services all had different per diem prices).

As foreshadowed in previous Pricing Frameworks, subacute and non-acute services will be priced using only AN-SNAP grouped services from 1 July 2015.

Feedback received

The Commonwealth supported the development of AN-SNAP Version 4.0 for use in NEP15. The Commonwealth and Allied Health Professions Australia (AHPA) identified that further improvements in the GEM care type is an important focus area. New South Wales and Queensland do not support the use of AN-SNAP Version 4 for use in NEP15 due to the new classification being underdeveloped and the lack of robust data for some of the new classes.

New South Wales, Queensland, Western Australia, South Australia and Tasmania all expressed concern regarding the decision to price only AN-SNAP grouped services from 1 July 2015 and cease per diem pricing for episodes of care where the care type definition is not met. Tasmania argued that removing the per diem payments will impose a cost and administrative burden on hospitals and system managers. Western Australia argued that services not able to be grouped to AN-SNAP should be based on DRG pricing, whilst New South Wales and Queensland were concerned about the impact on small facilities of collecting data to support grouping services to AN-SNAP classification. IHPA notes that service providers are required to meet the subacute care type definitions in the Admitted Patient Care National Minimum Data Set (NMDS) in order for the patients to be recorded as subacute patients.

Furthermore, IHPA foreshadowed the decision to cease per diem payments for subacute and non-acute patients in the 2013-14 and 2014-15 Pricing Frameworks and considers that jurisdictions have had sufficient lead time to implement system changes to accommodate this decision.

New South Wales recommended that care type per diems be retained for paediatric subacute activity in 2015-16 as AN-SNAP Version 3 does not include paediatric classes.

IHPA agrees that the delay in the implementation of AN-SNAP Version 4 means that paediatric classes are not yet available and will determine paediatric per diem prices for subacute activity for 2015-16.

As such, IHPA will proceed with pricing subacute and non-acute services using only AN-SNAP grouped services from 1 July 2015.

IHPA's decision

Subacute and non-acute services for NEP15:

- will be priced using only the AN-SNAP classification;
- will use AN-SNAP Version 3; and
- will retain paediatric per diem prices.

Next steps and future work

IHPA will continue the development of AN-SNAP Version 4 for its use in pricing for NEP16. As AN-SNAP Version 4 will include paediatric price weights, paediatric subacute activity will be priced using only AN-SNAP grouped services from 1 July 2016. IHPA is also undertaking a targeted study to source the necessary data on cognitive impairment for GEM patients to enable further improvements in the GEM care type in future versions of AN-SNAP.

4.5 Tier 2 Non-admitted patient classification

In 2013 IHPA commissioned a study to review existing non-admitted patient care classifications for ABF purposes. The review found that the existing Tier 2 classification system is not ideal for the longer term, and found no classifications in use internationally that were considered suitable for adapting to the Australian setting. The review recommended the development of a new Australian non-admitted patient classification.

The outcomes of the review have in-principle support from the JAC, CAC and Non-Admitted Care Advisory Working Group (NACAWG).

During 2014-15 IHPA will continue to develop a new non-admitted care classification noting that introducing a new classification will have resource implications for jurisdictions. A key feature of a new non-admitted classification includes transitioning non-admitted care data from clinic level to patient-centred data.

For NEP15 IHPA will continue to use the Tier 2 classification for pricing non-admitted services. It is anticipated only minor amendments will be made to the Tier 2 classification as work begins on the new non-admitted classification.

Feedback received

The Commonwealth, New South Wales, Queensland, South Australia, the Royal Australasian College of Physicians (RACP) and Allied Health Professions Australia (AHPA) supported IHPA's approach to develop a new non-admitted care classification. The Commonwealth, New South Wales and South Australia argued that IHPA should only make minimal updates to the Tier 2 classification whilst the new classification is developed. Tasmania went further to suggest that no refinements to the Tier 2 classification are made until it is replaced by a new classification.

Stakeholders suggested a range of refinements to the Tier 2 classification and these have been referred to the NACAWG for consideration.

The development of a new non-admitted classification system is a staged process over several years. In the meantime, refinements of the Tier 2 classification, such as introducing additional classes where necessary, ensures that IHPA is better capturing current non-admitted service delivery. Each of these refinements will in turn inform the development of the new classification.

A number of stakeholders advocated for the recognition of multidisciplinary clinics within the Tier 2 classification on the basis that this reflected contemporary clinical practice for non-admitted services in many cases. IHPA will introduce an additional data element in the non-admitted data sets to capture service events provided by multiple providers for 2015-16, with a view to building an understanding of the costs of these multidisciplinary clinics in order to price them in NEP15 if it is feasible to do so. The final approach will be confirmed in the NEP15 Determination.

New South Wales and the Northern Territory identified the need to consider re-defining Aboriginal and Torres Strait Islander peoples health clinic (40.01) in the Tier 2 classification. The Tier 2 class 40.01 Aboriginal and Torres Strait Islander peoples health clinic was developed prior to the inclusion of patient-level identification for Aboriginal and Torres Strait Islander patients in national data collections. IHPA has determined that the few services which are still being reported to the clinic would be more appropriately classified elsewhere with the use of the Aboriginal and Torres Strait Islander identification flag. For example, an Aboriginal Infant and Maternal Health non-admitted service may be more appropriately classified to the non-admitted class 40.28 Midwifery and maternity, whilst attracting an Indigenous loading referred to in section 9.2. For this reason, IHPA has removed the Aboriginal and Torres Strait Islander peoples health clinic (40.01) from the Tier 2 classification.

Women's Healthcare Australasia requested that IHPA consider whether additional classes in the Tier 2 non-admitted patient classification system are required to capture more complex pregnancy and post-natal services for women and babies at high risk of ill health or complication. IHPA agrees that the current approach that includes a single obstetrics class does not reflect current best practice models of care. IHPA will create additional women's health and maternity services classes after further consultation with expert clinical groups.

IHPA's decision

IHPA will use the Tier 2 non-admitted services Version 4 classification for pricing non-admitted services for NEP15.

Next steps and future work

In 2014-15 IHPA will continue the program of work to develop a new non-admitted care classification.

4.6 Emergency care classification

IHPA uses the Urgency Related Groups (URGs) and Urgency Disposition Groups (UDGs) classifications to describe presentations to emergency departments and emergency services for ABF purposes.

In 2013 IHPA commissioned an independent review of the emergency care classifications which assessed that the URG and UDG classification systems require improvement for classifying emergency care in the medium to long term. The main weaknesses of the emergency care classifications include the lack of stakeholder support for the ongoing use of triage status as a classification variable and the need for a classification with a stronger emphasis on patient factors such as diagnosis.

Feedback received

The Commonwealth, New South Wales, Victoria, Queensland, South Australia, Tasmania, the Northern Territory, the Australasian College for Emergency Medicine (ACEM) and the VHA supported the need for a new emergency care classification.

The Commonwealth expressed support for the development of a classification with a stronger emphasis on patient diagnosis and stated that IHPA should prioritise work on standardising the reporting of diagnoses in emergency care. New South Wales considers that a new emergency care classification is a high priority area within the program of classification development. Victoria called for further development on the relationship between patient complexity and diagnosis made following an emergency admission. The Northern Territory supported the development of an emergency care classification that is simple to use by the treating practitioner and is nationally comparable. The VHA advocated for the new emergency care classification to identify suitable measures of severity and complexity that would replace using the disposition variable (that is, whether the patient is admitted or returns home at the end of the emergency department visit). ACEM went further to suggest that measures of quality of care, and staffing requirements should be considered as well.

IHPA has referred this feedback to the Emergency Care Advisory Working Group (ECAWG) for consideration in the development of a new emergency care classification.

Some stakeholders recommended that IHPA consider Emergency Telehealth Service an in-scope public hospital service for NEP15. This is a stand-alone service that facilitates emergency specialist services through telehealth to emergency departments across rural and remote areas. IHPA will consider this issue for NEP16.

IHPA's decision

For NEP15 IHPA will price emergency activity using the URG Version 1.4 and UDG Version 1.3 classifications.

Next steps and future work

IHPA will continue to work with jurisdictions primarily through the ECAWG to develop a new emergency care classification for use across all Australian emergency departments and emergency services in the coming years.

4.7 Australian mental health classification

As foreshadowed in previous Pricing Frameworks, IHPA has commenced developmental work for a new mental health classification for the purposes of ABF. The new classification is expected to improve the cost predictability of the classification system and to support the new models of care being implemented in all states and territories. IHPA has committed to pricing mental health services using the new classification from 1 July 2016.

IHPA has commissioned a consultancy to undertake a six-month prospective mental health costing study across a sample of Australian public hospitals, community mental health services and private hospitals.

IHPA has also commenced work with jurisdictions and other key stakeholders to develop a data set specification (DSS) to underpin the new mental health classification, using existing data collections and definitions where feasible. It is intended that this will be ready in time for data collection to commence from 1 July 2015.

This work is guided by IHPA's Mental Health Working Group, which includes clinicians, consumer and carer representatives and jurisdictional representatives. It is intended that the new classification will be applied across the admitted, non-admitted and community mental health settings.

As foreshadowed in the 2014-15 Pricing Framework, the mental health care type will be included in the Admitted Patient Care NMDS and the Non-Admitted Patient DSS. This was due to have occurred from 1 July 2014, however it has been delayed until 1 July 2015 to allow additional time for changes to be made to jurisdictional data systems.

Feedback received

With three exceptions, there was broad support amongst stakeholders for IHPA continuing the program of work to develop a new classification for mental health care.

Western Australia identified the mental health care classification development as a high priority for that jurisdiction. Mental health classification development is also a priority for Queensland who identified that mental health care is a major expenditure area in Queensland operating in the absence of a national classification system based on patient complexity. Furthermore, the Commonwealth suggested that IHPA consider prioritising mental health care classification development and ensure that a robust data collection for the mental health care type is feasible from 1 July 2015 in order to meet the implementation date of pricing using ABF from 1 July 2016.

The Northern Territory suggested that social factors should be considered (e.g. homelessness) in the development of the classification as they are key drivers of mental health services. The Northern Territory also suggested that the alcohol and drug service classification should be refined to reflect the burden of this disease on mental health services.

On the other hand, Tasmania argued that developing a mental health care classification is a low priority compared to amending the AR-DRG classification. Victoria and Western Australia argued for longer timeframes to develop the mental health care classification.

IHPA is well progressed with its work on the new mental health classification. States and territories are participating in the six-month prospective mental health costing study which will inform the development of the new classification. It is intended that the new classification is trialled in 2015-16 ahead of pricing from 2016-17.

IHPA's decision

IHPA's approach to pricing admitted acute mental health services in the National Pricing Model in 2015-16 remains unchanged from 2014-15.

This arrangement is anticipated to continue until the Australian Mental Health Care classification is introduced in 2016.

Next steps and future work

IHPA will continue with the comprehensive program of work to develop the new Australian Mental Health Classification.

4.8 Teaching, training and research

The NHRA requires that IHPA provide advice to the COAG Health Council (formerly the Standing Council on Health) on the feasibility of transitioning funding for teaching, training and research (TTR) to an ABF system by 30 June 2018.

To implement ABF there are certain classification, counting and costing requirements to be met. Although these are not yet in place for TTR, IHPA has commenced a substantial program of work over the past two years to inform IHPA's advice to the COAG Health Council regarding a nationally consistent approach to funding TTR. As part of this program, IHPA has established the Teaching, Training and Research Working Group to progress each of these requirements.

Milestones achieved in the past two years have included:

- developing definitions of TTR for ABF purposes;
- preparing a DSS for data collection from 1 July 2014;
- an investigative study into the cost drivers of these activities; and
- early classification development.

IHPA will also undertake a comprehensive teaching and training costing study in the first half of 2015, subject to the participation of the states and territories. The outcomes of the costing study in early 2015 will also enable a better understanding of the component of teaching and training and research activities.

IHPA considers that further work is required to determine the feasibility of ABF for research and is investigating potential data collections that may assist with better understanding the components of research expenditure and the measurement of research outputs.

Feedback received

The Australian Medical Association (AMA), the RACP and RANZCP all expressed their support for continuing to progress the TTR program of work as a priority. The Commonwealth supported the TTR costing study to be undertaken in the first half of 2015.

On the other hand, New South Wales, Queensland, Victoria, South Australia and Tasmania argued that TTR is a lower priority than other classification development and that IHPA should consider deferring this program.

IHPA's decision

In 2015-16 IHPA will determine block funding amounts for teaching training and research activity based on jurisdictional advice.

Next steps and future work

IHPA will advise the COAG Health Council on the feasibility of ABF for TTR shortly.

Meanwhile, IHPA will progressively work on classifying, counting and costing TTR, with the aim of establishing a Teaching and Training Classification and, possibly, a Research Classification for use in the future.

5. Costing and counting rules

5.1 National Hospital Cost Data Collection

The National Hospital Cost Data Collection (NHCDC) is the primary data collection that IHPA relies on to develop the NEP and price weights for the ABF of public hospital services.

In 2014 IHPA worked with stakeholders, including all jurisdictions, to address actions from the Strategic Review of the National Hospital Cost Data Collection (Strategic Review).

The Strategic Review found that through stronger governance and compliance frameworks; better communication and transparency; an agreed understanding of the key purpose of the collection; greater industry involvement and some improvements in methodology, the NHCDC will continue to serve an important role in Australia's health system. Recommended priorities include establishing an NHCDC Advisory Committee with both jurisdictional and industry members; rationalising data specifications to reduce duplication of morbidity data elements between the NHCDC and other NDMS; and developing Version 3 of the Australian Hospital Patient Costing Standards (AHPCS).

As part of this, IHPA will release Version 3.1 of the AHPCS in late 2014 for use in costing in Round 18 of the NHCDC.

IHPA remains committed to continually improving the robustness of the NHCDC collection and has commenced work on developing Version 4 of the AHPCS, guided by the NHCDC Advisory Committee.

Feedback received

IHPA received detailed feedback from several jurisdictions regarding priority areas for AHPCS Version 4. Western Australia recommended that AHPCS Version 4 should give greater guidance on how blood products are treated. New South Wales recommended that the costing standards should consider how best to cost models of care, such as stroke services, because coding and classification development lags behind clinical practice. The Commonwealth recommended that IHPA develop supporting materials to assist staff undertaking costing activities in public hospitals which would deliver greater consistency and improve comparability for future rounds of NHCDC data.

IHPA will release Version 3.1 of the AHPCS in late 2014. Most jurisdictions indicated they will be able to comply with most aspects of the new standards for Round 18 of the NHCDC, and approach full compliance from Round 19. Work has commenced to develop Version 4 of the AHPCS. IHPA has referred the detailed feedback to the NHCDC Advisory Committee for consideration.

IHPA's decision

Version 3.1 of the APHCS will be published in late 2014 for use in Round 18 of the NHCDC.

Next steps and future work

Over the coming year IHPA will continue to develop Version 4 of the APHCS in conjunction with the NHCDC Advisory Committee.

5.2 Additional costing studies to inform the development of NEP15

Consultation in relation to the *Pricing Framework for Australian Public Hospitals 2014-15* identified a number of issues in relation to the counting and costing of Indigenous patients, Culturally and Linguistically Diverse (CALD) patients, and patients receiving home-delivered ventilation, total parenteral nutrition (TPN), home enteral nutrition (HEN) or home-delivered dialysis services.

Initial data reviews conducted in 2013 on CALD patients indicated that no adjustment was warranted for this group but significant data limitations were noted that led IHPA to conclude that this issue requires further analysis in 2014 for NEP15.

To inform the development of NEP15, IHPA has commissioned the following work:

- A review of the extent to which the costs associated with the treatment of Indigenous patients are identified and correctly allocated in hospital costing systems;
- A review of the extent to which data on "language spoken at home" would be a better indicator to ascertain whether an adjustment is warranted for CALD patients or certain subgroups of CALD patients (such as for patients receiving mental health or geriatric services);
- An investigative study to ascertain the costs associated with the delivery of home-delivered ventilation, TPN and HEN services; and
- A review of existing data to estimate the costs of delivering home-based haemodialysis and peritoneal dialysis.

These costing studies will allow IHPA to determine the actual cost of service delivery for these services to inform the determination of the price weights for these services for NEP15.

Feedback received

The Northern Territory suggested that existing approaches to costing Indigenous patients, especially remote Indigenous patients, inadequately captures the additional time service providers spend with Indigenous patients compared to other patients.

IHPA will consider the approach to capturing service provider time in the Indigenous Costing Study.

IHPA's decision

IHPA will consider the outcome of these costing studies in the development of NEP15.

5.3 Non-admitted telehealth counting rules

In submissions to the *2014-15 Pricing Framework Consultation Paper*, stakeholders recommended that IHPA change the counting rules for telehealth in order to record services at the service provider end of the consultation, usually a metropolitan ABF hospital. The Pricing Authority adopted this approach in the 2014-15 Pricing Framework.

In both 2013-14 and 2014-15, many stakeholders continued to advocate for IHPA to recognise and count both ends of the telehealth consultation. To accommodate that request, IHPA would have to create and price a Tier 2 Clinic for the receiving end. IHPA sought stakeholder feedback on the feasibility and support for this option through the Consultation Paper.

Feedback received

Seven jurisdictions and four other stakeholders supported the proposal to recognise the cost incurred at the receiving end of a non-admitted telehealth service.

The Commonwealth argued that it is the role of system managers to make decisions regarding the delivery of specific services, including outreach or telehealth services and was concerned to ensure that any patient-location clinic for a non-admitted service would be carefully developed to avoid double counting.

In the 2014-15 Pricing Framework IHPA decided to count telehealth activity at the service provider end and signalled its intention to investigate the most appropriate counting arrangements for these services in future years. IHPA accepts the need to count telehealth at both ends of the consultation and considers that there is significant support to create a dedicated clinic in the Tier 2 classification for the patient-end of the non-admitted telehealth service.

IHPA is working with jurisdictions, CAC, TAC and NACAWG to develop an appropriate clinic definition in the Tier 2 classification system for the patient end of a non-admitted telehealth service and associated counting rules.

IHPA is investigating options for pricing these services for NEP15, however if adequate cost data is not available, pricing for these services will not commence until NEP16.

IHPA's decision

For NEP15 IHPA will update the Tier 2 patient classification system in order to price the patient end of a non-admitted telehealth service. IHPA will confirm its approach to pricing these services in the NEP15 Determination.

5.4 Multi-disciplinary case conferences where the patient is not present

Multi-disciplinary case conferences (MDCCs), otherwise referred to as multi-disciplinary team meetings or multi-disciplinary meetings, are an important, and rapidly developing, feature of evidence-based care and treatment. Across a number of service areas, and particularly in cancer care, there is evidence to show that patients who have their case discussed at an MDCC experience better outcomes than patients who do not.

Some MDCCs do not meet the service event definition as they are conducted in the absence of a patient. This group of MDCCs are however an input to providing health care and as such the costs are reflected in the price weight assigned to the Tier 2 Clinic.

In 2013-14, IHPA discussed the counting of MDCCs where the patient is not present with a range of stakeholders, including the CAC and JAC, and commissioned an independent assessment on the feasibility of counting, costing and pricing those services.

Whilst counting, costing and classifying MDCCs where the patient is not present was deemed possible, jurisdictions agreed this would create additional complexity and burden in ABF data collection. Several jurisdictions also noted that their systems were patient centric and would be unable to report data for these services at this time.

Feedback received

IHPA received submissions from New South Wales, Victoria, Queensland, Tasmania and the RACP that outlined their support for MDCCs where the patient is not present to be considered in the development of a new non-admitted care classification.

IHPA's decision

MDCCs where the patient is not present will be considered in the development of a new non-admitted care classification.

5.5 Alternative approaches to pricing chronic disease services

IHPA was approached in early 2014 by a stakeholder organisation regarding the counting of home-delivered dialysis services. The stakeholder organisation was particularly concerned with the burden on service providers imposed by the current requirement that individual service events need to be recorded each time that services occur.

The current definition of a non-admitted service event presents a number of issues to be addressed for this proposal to be considered. The definition is *"an interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record."*

Specifically, the proposal presents a challenge to the requirement for a dated entry in the patient's medical record. An alternative mechanism may need to be considered for verifying that the service was delivered on the number of occasions claimed.

Temporal care bundling as an alternative approach to pricing chronic or long term care services

IHPA believes that there are a number of chronic or long term care models that are amenable to an ABF model that spans longer time periods than a single service event, such as through bundled pricing. IHPA's approach to bundled pricing refers to setting temporal price weights based on the underlying cost data and average number of services provided in a defined time period.

These services are high-volume, predictable, regular, usually ongoing, delivered within a defined period and with increasing demand.

Through the Consultation Paper IHPA identified some preliminary examples of services IHPA may consider for temporal care bundled pricing including:

- HEN, TPN, home-delivered dialysis and home ventilation – for example, set a price weight equivalent to 28 days of service delivery;
- Maternity (non-complicated) – for example, a single payment for pre- and postnatal non-admitted services and admission for birth;
- Hip and knee replacements – for example, a single payment for non-admitted, admitted, and sub-acute services; and
- Stroke – for example, bundle ABF payments across care types and weight for complexity.

Temporal care bundled pricing is in line with several IHPA Pricing Guidelines, particularly:

- **Single unit of measure and price equivalence:** ABF pricing should support dynamic efficiency and changes to models of care with the ready transferability of funding between different care types and service streams through a single unit of measure and relative weights.
- **Fostering clinical innovation:** Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.
- **Efficiency**: ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services. Bundling encourages technical and allocative efficiency
- **Timely–quality care:** Funding should support timely access to quality health services.
- **Administrative ease:** Funding arrangements should not unduly increase the administrative burden on hospitals and system managers.
- **Price harmonisation:** Pricing should facilitate best-practice provision of appropriate site of care.

In its Consultation Paper, IHPA sought feedback regarding whether temporal care bundled pricing should be further investigated and developed.

Feedback received

The concept of temporal care bundled pricing received broad stakeholder support during the consultation process. The Commonwealth argued that "the potential benefits of bundling prices of services are increased incentives to maximise efficiency and timely, quality care of patients who have relatively predictable courses of treatment. Such an approach is also likely to foster clinical innovation and enhance price harmonisation."

The Commonwealth, Queensland, Victoria, the AMA, the RACP, AHPA and the Dietitians' Association of Australia all supported further exploring the bundled pricing options. They particularly identified HEN, TPN, home-delivered dialysis and home ventilation services as candidates for NEP15.

Stakeholders also expressed concerns regarding IHPA's interpretation of a bundled price and various implementation issues. Although South Australia offered in principle support for temporal care bundled pricing, this support was conditional on resolving technical issues such as establishing clinical pathways. New South Wales did not support temporal care bundled pricing for NEP15 for HEN, TPN, home-delivered dialysis and home ventilation services and sought further detail on the bundled pricing mechanism and to assess the underlying cost data.

IHPA's approach to bundled pricing refers to setting temporal price weights based on the underlying cost data and average number of services provided in a defined time period. It is intended in the first instance to improve efficiency through reducing the administrative cost of delivering these targeted services. It is not intended that a clinical pathway is required before determining a bundled price.

IHPA's decision

IHPA's intention is to develop temporal care bundled price weights for Home Enteral Nutrition, Total Parenteral Nutrition, home-delivered dialysis and home ventilation for NEP15, subject to satisfactory cost data being available from the current costing studies, and will confirm its approach in the NEP15 Determination.

Next steps and future work

IHPA will work with jurisdictions, the CAC, SAC and other stakeholders to further develop a bundled pricing approach that considers additional targeted services for future years.

6. The National Efficient Price for Activity Based Funded Public Hospital Services

6.1 Overview

Having determined the classifications, counting and costing data, the critical question is the approach to setting the value of the NEP.

A key objective of the NHRA is to improve public hospital efficiency through the use of ABF based on a NEP. The key to maximising efficiency is to design the most appropriate incentives so that the health system is delivering the right service in the right way and at the best price.

Since 2014-15, the Commonwealth funding for public hospital services funded on an activity basis has moved from a 'capped' basis (a known quantum of funding) to an 'uncapped' basis (funding will vary in response to changes in activity and the cost of public hospital services as represented through the NEP). The approach and formulae used to calculate Commonwealth funding from 2014-15 onwards are specified in the NHRA (Clauses A3, A5, A34-A40 and A67-A79). In simple terms, in 2014-15 to 2016-17 the Commonwealth will:

- pay 45 per cent of the NEP for 'growth' in the volume of services relative to the previous year; and
- recognise changes in the NEP. It will pay a price adjustment calculated by multiplying the previous year's volume of services by the change in the NEP relative to the previous year multiplied by 45 per cent.

While the NEP determines Commonwealth funding for public hospital services, it does not require the states and territories to fund those services at the NEP. Under the NHRA (Clauses A59-A66), states and territories have autonomy as to the level of funding they choose to invest in public hospital services. States and territories "meet the balance of the cost of delivering public hospital services and functions over and above the Commonwealth contribution". States and territories may choose to provide a higher or lower share of the NEP.

6.2 Purpose and use of the National Efficient Price

The NEP provides a price signal or benchmark about the efficient cost of providing public hospital services and is an important driver of change. A transparent NEP facilitates states and territories, LHNs and public hospitals making choices about the range and mix of accessible, efficient, equitable and high quality public hospital services they provide.

Through successive Pricing Frameworks, IHPA has determined two key purposes of the NEP. Firstly, in 2015-16, the NEP is one of the major determinants of the growth in Commonwealth funding of public hospital services; the other factor determining Commonwealth expenditure is the volume of public hospital services provided. Secondly, the NEP provides a price signal or benchmark about the efficient cost of providing public hospital services. This price signal is an important driver of change because:

- It allows states and territories in their capacity as system managers to determine the level of state or territory funding provided, and the approaches that will be implemented to support public hospitals in improving efficiency;
- It encourages LHNs and public hospitals to benchmark their cost structures against the efficient cost of providing public hospital services and identify options for improvement; and

- It promotes transparency so that states and territories, LHNs and public hospitals can make choices (within the context of state or territory health plans and service agreements) about the range of public hospital services they provide, the models of care and the settings in which care is provided that are consistent with accessible, equitable and high quality public hospital services provided on an efficient basis.

As outlined in successive Pricing Frameworks, the following definition of the NEP sets out IHPA's expectations so that a public hospital service operating at the NEP will:

- be able to provide episodes of patient care (on average, across all types of care, as measured using agreed classifications) and other services (including teaching, training and research) at or below the national benchmark price;
- be able to respond to evidence based initiatives to improve patient care including new technologies;
- be able to provide services at a quality level consistent with national standards, and to minimise negative consequences that fall on patients (including those attributable to poor quality and safety) or on other parts of the service system; and
- be able to make choices about how best to deliver services to ensure that people receive the 'right care at the right time in the right setting'.

In adopting this definition, IHPA is seeking to convey that the NEP:

- is a benchmark of efficiency. It is not the price at which public hospital services can be provided most cheaply or at the lowest cost;
- is the price that allows for the provision of public hospital services at a quality level consistent with national standards. It is not the price at which public hospital services can be provided with no regard for the quality and safety with which those services are delivered;
- will move in response to changes in how care is delivered. The 'value' of the NEP will not be eroded over time; instead it will move in response to changes in the costs of delivering public hospital services; and
- will provide a price signal that will allow choices to be made by governments, by LHNs, and by public hospitals about how best to provide public hospital services.

6.3 Determining the NEP

Through successive Pricing Frameworks, IHPA has considered and balanced three of the Pricing Guidelines, namely:

- **Timely-quality care:** Funding should support timely access to quality health services. In other words, the NEP should support public hospital services being widely accessible, in a manner that allows care to be provided at the right time and at a quality level that meets national standards;
- **Fairness:** ABF payments should be fair and equitable. The NHRA indicates that IHPA should "consider the actual cost of delivery of public hospital services in as wide a range of hospitals as practicable" (Clause B12 (b)); and
- **Efficiency:** ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.

In 2012–13, 2013–14 and 2014-15, IHPA set the NEP based on the arithmetic mean cost at the patient level. In adopting this position, IHPA was mindful of a number of issues:

- The maturity of the national ABF system (including the underpinning classification systems and activity and cost data collections);
- The arithmetic mean cost provided a significant incentive to states and LHNs to examine their underlying cost structures, particularly in the jurisdictions where LHN costs were predominantly above the average; and
- There are significant efficiency benefits for the public hospital system as a whole if high-cost LHNs move their cost base towards the average.

In the 2014-15 Pricing Framework IHPA stated:

> "In 2014-15, IHPA has decided to maintain this approach. However, in the coming year, IHPA will begin to explore other approaches that will "provide a relevant price signal" to states and LHNs. This work will be underpinned by rigorous examination of the existing cost data and will involve significant consultation with a range of stakeholders including all jurisdictions."

The Consultation paper included a preliminary set of hypotheses and options to inform the national discussion, including:

- Scenario 1: setting the price at the average sends a strong price signal to hospitals that are more expensive than the NEP with the associated option to continue setting the NEP at the average cost;
- Scenario 2: setting the NEP at the average inflates an efficient price as it includes costs of highly inefficient hospitals with the associated option to exclude high cost (potentially inefficient) hospitals when setting the NEP; and
- Scenario 3: there are significant avoidable costs in the system that should not influence the setting of the NEP with the associated option to exclude "avoidable costs" when setting the NEP.

IHPA presented analyses of the three scenarios showing that these options are all capable of delivering improved efficiency in the public hospital system.

Continuing to set the NEP at the average cost (Scenario 1)

Under scenario 1, IHPA carefully analysed the cost profile of public hospitals which report data to the NHCDC. The analysis showed significant variation in costs per national weighted activity unit, with some hospitals approximately 30 per cent below the national average, and others almost 30 per cent above the national average. It is expected that setting the NEP at the average will send a strong price signal to those hospitals placed well above the NEP.

IHPA estimates that if the highest cost quartile hospitals in the acute admitted setting were able to reduce their costs to the mean of the second highest cost quartile, the NEP would be around four per cent lower, resulting in improved efficiency to the public hospital system of $870 million annually on a national basis.

Excluding high cost (potentially inefficient) hospitals when setting the NEP (Scenario 2)

Under scenario 2 IHPA estimated that high-cost hospitals (high-end outliers) significantly impact the average cost at the national level. High-cost hospitals are identified on the basis of their cost ratio which is defined as their actual cost divided by their modelled cost based

on the NEP. Data analysis conducted by IHPA showed that excluding the acute admitted high-end cost outliers (cost ratios greater than 1.3) or the top ten per cent of cost ratios would reduce NEP14 by respectively 1.26 per cent and 2.04 per cent. This would result in improved efficiency to the public hospital system of $250 million and $400 million per annum respectively on a national basis.

Excluding "avoidable costs" when setting the NEP (Scenario 3)

Under scenario 3 IHPA examined the impact of excluding "avoidable costs" from influencing the setting of the NEP and applied the Grattan Institute approach[1] to the IHPA context.

The Grattan Institute defines 'unexplained costs' as the difference between the average cost per weighted separation at a given hospital when compared with the best performer in the state or territory. Avoidable costs are further defined as the average cost per weighted separation for hospitals that are above the average unexplained cost in a given state or territory after adding an allowance for data limitations.

If the Grattan Institute approach was implemented and the analysis was limited to accounting for existing Pricing Authority approved adjustments in the acute admitted stream, then NEP14 would have decreased by 3.8 per cent moving from $5,007 to $4,815.This would result in approximately $770 million per annum in improved efficiency to the public hospital system on a national basis.

Feedback received

The issue of exploring future directions for pricing approaches received a significant amount of interest through the public submissions process.

All jurisdictions that provided submissions and five other stakeholders supported continuing the approach of setting the NEP based on the average cost. Consistent with the feedback received from other jurisdictions, South Australia argued that the "average is a well-accepted measure of central tendency and will more accurately reflect hospitals costs as ABF matures over time".

Western Australia stated their opposition to any change in the setting of the NEP that resulted in reduced Commonwealth funding. New South Wales were concerned that the approach to setting the NEP was cognisant of the requirement in the NHRA for continuity and predictability in prices (Clause B12(e)).

In discussing scenario 1, the Commonwealth highlighted the degree of variation in cost per National Weighted Activity Unit (NWAU) and argued that reducing the existing variation was the first avenue to explore before considering any alternative approaches to setting the NEP.

Stakeholder feedback also discussed alternative price setting approaches. The Commonwealth and New South Wales argued that alternative pricing approaches may require further years of underlying data to ensure the empirical evidence is sufficiently robust to support the change. Victoria did not support either of the alternative scenarios. The Society of Hospital Pharmacists of Australia (SHPA) indicated that IHPA should investigate scenario 2, particularly excluding high-cost outliers, if further efficiencies are to be pursued. Queensland disagreed with the concept of avoidable costs saying that an unexplained cost does not necessarily lead to the cost being avoidable. Separately, New South Wales

[1] Stephen Duckett and Peter Breadon, *Controlling Costly Care: a billion-dollar hospital opportunity, Brain and Spinal* March 2014, Grattan Institute.

considered that the pricing hypotheses and options could be extended to examine the impact of setting the NEP at the median cost.

Transition and implementation challenges were also raised by the AMA and the Commonwealth as issues for IHPA to have regard to in the event that an alternative approach was to be further considered. The AMA suggested that transition challenges and lead times for implementation have the potential to affect the amount of additional efficiencies identified in the analyses produced for the scenarios. The Commonwealth argued that system managers should be given at least one year's notice prior to any changes being made.

Indexation

For previous NEP Determinations IHPA developed an indexation methodology to account for the time lag between the costing data used and the price to be set (for example, NEP14 was based on 2011–12 cost data). The methodology uses the average growth in the past five years' cost data to estimate the expected growth in costs over the three year time lag. In NEP14 this methodology included data from over 170 hospitals across all states and territories.

IHPA has reviewed the indexation methodology again in preparation for determining NEP15, and has decided that there is no cause to alter this methodology.

Pricing very long stay patients

In the *Pricing Framework for Australian Public Hospital Services 2014-15* IHPA included a decision that admitted patients with a length of stay of more than 200 days at 30 June of each year, but had yet to be discharged from hospital, would be eligible to be assigned a provisional NWAU value. This NWAU value would be based on the average high outlier per diem rate for the care type that the patient is admitted under (i.e. acute or subacute). On discharge, the provisional NWAU value assigned to the patient in previous years would be subtracted from the actual NWAU value calculated at the time of discharge.

This approach to very long stay patients was requested by a number of states and territories. Since that time the Administrator of the National Health Funding Pool has identified some difficulties with the implementation of this approach.

In 2015-16 IHPA will continue to work with the Administrator and jurisdictions to reconcile the position of the Pricing Authority with the issues raised by the Administrator.

IHPA's decision

For NEP15 IHPA will continue to set the NEP based on the arithmetic mean cost at the patient level.

In 2015-16 IHPA will continue to work with the Administrator of the National Health Funding Pool and jurisdictions to reconcile the position of the Pricing Authority with the issues raised by the Administrator.

Next steps and future work

IHPA will work with jurisdictions and other stakeholders over the next twelve months to explore the most effective options for achieving further efficiencies in the public hospital system.

6.4 Technical Improvements

The Consultation Paper included a range of possible technical improvements to the cost models for NEP15 that jurisdictions submitted to IHPA for consideration.

Feedback received

New South Wales, Queensland, Western Australia, ACEM and South Australia, with some exceptions, supported the proposals identified in the Consultation Paper.

The Commonwealth did not support the proposals for the acute admitted model as the "proposed technical improvements would have little material impact on the price whilst significantly increasing the complexity of the model and are considered unnecessary at this stage."

IHPA's approach to considering additional technical improvements to the cost models is to balance the materiality of the changes against the added complexity such changes would introduce to the models. IHPA has analysed the proposed technical improvements against this criterion.

Better recognising the high cost of very long-stay patients

Jurisdictions requested that IHPA investigate whether there are DRGs which have an unusual distribution of long stay patients which do not have their costs adequately reflected in the national pricing model.

In line with the Pricing Guidelines, IHPA will not adjust the national pricing model if it undermines appropriate incentives to improve public hospital efficiency through length of stay reductions.

IHPA has analysed the data and has identified a small number of DRGs where a small number of long-stay patients have costs that are material, are not adequately recognised by the national pricing model and are unlikely to be due to inefficiency.

For NEP15 IHPA will adjust the methodology for calculating the inlier boundaries for these specific DRGs to better reflect the costs associated with the high cost of their long-stay patients.

IHPA's specific approach will be confirmed in the NEP15 Determination and accompanying Technical Specifications.

An improved model for the pricing of subacute patients

Some jurisdictions have previously raised concerns that the price weights and inlier boundaries for the subacute pricing models were potentially outdated. These price models were developed in the 1990s and use a mix of episodic payments and per diem payments for inlier patients.

IHPA has developed an updated subacute pricing model based on the latest cost and activity data. The model uses a modified approach to setting the inlier boundaries for length of stay when compared to the acute admitted approach. The new model will provide greater incentives for improved efficiency in subacute services.

For NEP15 IHPA will use the updated model for the pricing of subacute patients and IHPA will confirm the approach taken in the NEP15 Determination.

IHPA's decision

IHPA will implement additional technical improvements to the costs models if the materiality of the change outweighs the cost from the added complexity in the models.

IHPA's final approach to the proposed technical improvements will be confirmed in the NEP15 Determination.

Next steps and future work

IHPA continues to be receptive to suggestions for technical improvements to the cost models and will analyse the underlying data as required.

7. Setting the NEP for Private Patients in Public Hospitals

7.1 Overview

The NHRA requires IHPA to set the price for admitted private patients in public hospitals, accounting for payments made by other parties including private health insurers (for prosthesis and the default bed day rate) and the Medicare Benefits Schedule (MBS).

7.2 Costing private patients

The collection of private patient medical expenses is problematic in the NHCDC. For example, there is a common practice in some jurisdictions of using Special Purpose Funds to collect associated revenue (e.g. MBS) and reimburse medical practitioners.

These funds generally do not appear in hospital accounts used for costing in the NHCDC. This leads to an under-attribution of total medical costs across all patients, as costs associated with medical staff are applied equally across public and private patients.

In NEP14 IHPA corrected for this issue by inflating the cost of all patients by 1.7 per cent to account for these missing costs. This correction factor was determined by comparing reported patient costs in the NHCDC versus the reported payments on behalf of private patients in the Hospital Casemix Protocol (HCP) collection. IHPA will continue this approach in NEP15.

IHPA sought feedback from stakeholders through the Consultation Paper regarding a reasonable timeframe for hospitals to change practices to ensure that all admitted private patient costs are consistently captured. More accurate data will improve the precision of the pricing methodology and enable IHPA to phase out this correction factor in future years.

7.3 Pricing private patients

For NEP14 IHPA adopted a significantly improved methodology for pricing private patients compared to previous years by using HCP data to identify actual payments made by insurers and the MBS. These payments are deducted at the DRG level to reflect the revenue the public hospital receives from these private patients. Revenue is deducted to prevent the hospital being paid twice for each private patient – once by the revenue source and a second time by the Commonwealth under the NHRA. IHPA will continue this approach for NEP15.

IHPA works with jurisdictions to regularly review activity data to examine the utilisation of public hospitals by private patients in order to detect any emerging trends. IHPA notes that the growth in private patient utilisation of public hospitals has not varied significantly from the historical growth trend prior to the introduction of the national ABF model.

Feedback received

Stakeholders were broadly supportive of IHPA phasing out the correction factor that accounts for private patient costs missing from the NHCDC. Phasing out the correction factor is dependent on the implementation of AHPCS Version 3.1. New South Wales, Victoria, South Australia and Tasmania were concerned that public hospitals in these states would not be able to fully implement the private patient costing standards in Round 18 of the NHCDC. However, Victoria was also opposed to the change arguing that private practice arrangements are confidential agreements between doctors and LHNs.

IHPA will release Version 3.1 of the AHPCS in late 2014 for use in costing Round 18 of the NHCDC and considers that the standards will lead to significant improvements in the way private patient costs are captured. IHPA will review the data collected in Round 18 of the NHCDC with the intention of phasing out the correction factor from NEP16 onwards.

IHPA's decision

For NEP15 IHPA will continue to utilise the methodology from NEP14 for pricing private patients.

IHPA will review the data collected in Round 18 of the NHCDC with the intention of phasing out the private patient correction factor in future years.

Next steps and future work

IHPA will continue to monitor the growth in private patient utilisation of public hospitals.

8. Treatment of other Commonwealth programs

8.1 Overview

The NHRA requires IHPA to discount funding that the Commonwealth provides to public hospitals through programs other than the NHRA to prevent the hospital being funded twice for the same service. The two major programs are blood products (through the National Blood Agreement) and Commonwealth pharmaceutical programs including:

- Highly Specialised Drugs (Section 100 funding);
- Pharmaceutical Benefits Scheme (PBS) – Herceptin: Early Stage Breast Cancer (Section 100 funding);
- Pharmaceutical Reform Agreements – PBS Access Program; and
- Pharmaceutical Reform Agreements – Efficient Funding of Chemotherapy (Section 100 funding).

8.2 Blood and blood products costs

Through their submission in the 2014-15 Pricing Framework consultation process, the Australian Red Cross Blood Service (ARCBS) identified a multi-stage approach to capture the full cost of blood products in the NHCDC. IHPA has held preliminary discussions with the National Blood Authority (NBA) regarding the feasibility of costing blood products in future years.

In 2014-15, IHPA commenced a process with the NBA, the ARCBS and jurisdictions to progress the foundation work to further examine blood costs to improve the approach to costing blood and blood products in future years. IHPA has held preliminary discussions with one jurisdiction with the intention of undertaking a pilot project in 2014-15. Any changes to the pricing of blood products will require a decision of the COAG Health Council to amend the National Blood Agreement, so IHPA cannot act alone in this matter.

As such, IHPA is not amending the existing approach of removing blood and blood products costs from the NHCDC prior to determining NEP15.

8.3 Commonwealth funded pharmaceutical programs

In NEP14 IHPA significantly improved the way in which Commonwealth pharmaceutical programs were accounted for by removing them from the cost data prior to calculating the price weights. This meant that for DRGs and Tier 2 Clinics in which there was a high use of Commonwealth funded drugs (e.g. chemotherapy), a higher discount was applied than those in which there was a lower use of those drugs.

IHPA worked with its CAC to map individual drugs to DRGs and Tier 2 Clinics where they were most likely consumed, which resulted in a substantially improved degree of confidence in the accuracy of the discounts at the DRG and Tier 2 Clinic level.

Feedback received

The Commonwealth and South Australia support IHPA's intention to match actual Commonwealth pharmaceutical payments to the NHCDC at the patient level. Tasmania and Victoria stated in-principle support.

The SHPA does not support IHPA's proposed approach as it does not believe that information currently available to IHPA is sufficiently detailed, accurate or robust to enable this approach.

For NEP15 IHPA has received patient-level Commonwealth pharmaceutical programs payment data from the Department of Health for in-scope services. This data has allowed IHPA to accurately identify pharmaceutical program payments and t he particular service setting in which they were delivered.

The result is increased precision in the pricing approach and IHPA considers there is benefit from utilising this patient-level data on an ongoing basis.

IHPA's decision

IHPA will maintain the existing approach of removing blood costs from the NHCDC prior to determining NEP15.

IHPA will make deductions for in-scope Commonwealth pharmaceutical program payments by matching actual in-scope Commonwealth pharmaceutical payments to the NHCDC at the patient level.

Next steps and future work

IHPA will continue to work on developing an improved approach to the treatment of blood and blood products costs and in-scope Commonwealth pharmaceutical program funding in future years.

9. Adjustments to the national efficient price

9.1 Overview

The Act gives IHPA the role of determining "adjustments to the NEP to reflect legitimate and unavoidable variations in the costs of delivering health care services" (Section 131(1)(d)). The NHRA provides an additional specification indicating that IHPA "must have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery including hospital type and size; hospital location, including regional and remote status; and patient complexity, including Indigenous status" (Clause B13).

On an annual basis IHPA tests whether there are empirical differences in the cost of providing public hospital services in order to determine whether there are legitimate and unavoidable variations in the costs of service delivery that may warrant an adjustment to the NEP. Decisions are based on national data sources but will be informed by data held by states and territories.

IHPA will examine patient-based characteristics in the cost of providing public hospital services as a first priority before considering hospital or provider-based characteristics. This approach supports the principle that funding should follow the patient wherever possible.

In 2013, IHPA established a framework to assist jurisdictions in making applications to have legitimate and unavoidable variations which affect the costs of service delivery recognised by IHPA. Jurisdictions may continue to propose potential unavoidable cost variations under this framework for IHPA to consider. To date, IHPA has received one application which has been assessed for NEP15.

In NEP14, the Pricing Authority determined to apply these evidence based adjustments:

- Paediatric Adjustments for a person who is aged up to and including 16 years and is admitted to a specialist paediatric hospital for admitted acute patients or treated in any facility for admitted subacute patients;
- Specialist Psychiatric Age Adjustment for a person who has one or more psychiatric care days during their acute admission, with the rate of adjustment dependent on the person's age;
- Patient Remoteness Area Adjustment for a person whose residential address is within an area that is classified as being outer regional, remote, or very remote in the Australian Bureau of Statistics' Australian Statistical Geography Standard (ASGS), with the rate of adjustment dependent on the person's specific geographical classification;
- Indigenous Adjustment for a person who identifies as being of Aboriginal and/or Torres Strait Islander origin;
- Intensive Care Unit (ICU) Adjustment for patients who:
    - Were admitted to an ICU that met the criteria defined by IHPA (provided more than 24,000 hours of ICU care, at least 20 per cent of which involved mechanical ventilation); and
    - Were in a DRG where less than 50 per cent of patients are admitted to an ICU;
- Radiotherapy Adjustment for a person with a specified ICD-10-AM 8th edition radiotherapy procedure code recorded in their medical record; and
- Private Patient Service Adjustment and Private Patient Accommodation Adjustment for admitted private patients.

Paediatric Adjustment

The review of the clinical complexity methodology, particularly the Patient Clinical Complexity Levels (PCCLs), should have a significant impact on how well the costs of specialist paediatric hospitals are explained. The clinical complexity methodology was reviewed as part of the development work for AR-DRG Version 8.0 which is scheduled to be implemented from 1 July 2016 and used for pricing in NEP16. The new approach to case complexity will more accurately quantify individual patient complexity, including paediatric patients, through better recognising the impact of the principal diagnosis and other patient-based factors on overall case complexity.

As such, IHPA will continue the same approach to the specialist paediatric adjustment as was applied for NEP14.

Specialist Psychiatric Age Adjustment

IHPA currently applies a specialist psychiatric age adjustment to acute admitted patients with one or more specialist psychiatric care days recorded in the admitted patient data collection. The level of adjustment varies according to age group to reflect the different costs associated with the provision of specialist mental health care services to these different patient cohorts.

New South Wales requested that IHPA consider whether these current levels of adjustment are adequate for patients between 18 and 64 years with one or more specialist psychiatric care days and where their primary diagnosis was not mental health-related.

IHPA has re-examined the current adjustment approach and has determined that the costs attributed to patients who receive one or more specialist psychiatric care days, but do not have a mental health primary diagnosis, are not adequately reflected in the national pricing model.

IHPA has therefore revised its specialist psychiatric care adjustment methodology for NEP15 to better recognise the costs of these patients.

Intensive Care Unit Adjustment

The current ICU adjustment reflects the high cost of unexpected intensive care treatment for these patient groups.

In NEP14 patients in DRGs where more than 50 per cent of patients were admitted to an ICU do not receive an additional payment because ICU costs for these patients are bundled in the unadjusted DRG price weight.

In the 2014-15 Pricing Framework IHPA advised of its intention to work with jurisdictions and other stakeholders to explore alternative patient-based mechanisms for determining the ICU Adjustment. New South Wales and South Australia have supported the re-examination of the threshold for bundling ICU costs.

For NEP15 IHPA has re-examined the 50 per cent threshold for bundling ICU costs to ascertain whether this provides the best statistical fit for the pricing model.

IHPA's analysis indicates that the unbundling of ICU costs would improve the national pricing model as it would better reflect costs incurred by hospitals for providing ICU services.

For NEP15 IHPA will unbundle ICU costs. This means that all patients admitted to an eligible ICU will receive the ICU Adjustment.

IHPA is also carrying out further analysis of Acute Physiology, Age, & Chronic Health Evaluation (APACHE) score data to determine if this can be further adapted to provide a patient level indicator of ICU need and patient complexity for potential implementation in future years

Western Australia is not supportive of APACHE scores being used as an indicator of ICU need as it claims that it does not reflect contemporary practice in ICUs. Tasmania also does not consider APACHE data sufficiently robust for determining an ICU adjustment and considers there is more merit in considering the outcome of the AR-DRG case complexity review.

IHPA is also working with its CAC to explore the feasibility of considering whether inotrope use may be worth investigating as a modifier for ICU adjustments. National data sets do not collect data on inotrope use because the administration of medication (except chemotherapy) is not coded for admitted patients. Before such a significant change in coding practice were considered there would need to be some information gathering to determine if inotrope use would be a suitable measure for complexity. IHPA is therefore exploring avenues to access additional data sets to undertake this analysis, including discussing the feasibility of AORTIC data held by the Australia and New Zealand Intensive Care Society.

9.2 Adjustments to be evaluated for NEP15

IHPA has reviewed the empirical evidence for a number of potential adjustments for NEP15. Stakeholder feedback on these areas is discussed below.

Feedback received

New South Wales, Victoria, Western Health and AHPA support IHPA's review of the evidence for whether an adjustment is warranted for CALD patients, particularly in mental health and GEM services.

New South Wales, the RACP and the Australian Association of Developmental Disability Medicine suggested considering adjustments for children, adolescents and adults with intellectual disability more generally, and not just among mental health patients with concomitant intellectual disability.

Queensland suggested that analysing hospitals by peer group status may indicate that there are higher costs incurred by principal referral hospitals (using AIHW peer groups) compared to other hospitals and that these costs are not already recognised in the National Pricing Model. IHPA considered this issue in previous NEPs and found no significant difference according to peer group status once the full adjustment regime is applied. Nonetheless, this issue will be considered in the development of NEP15, noting that it will need to be established that the National Pricing Model does not already sufficiently recognise these costs.

IHPA's approach to considering additional adjustments is to balance the materiality of the changes against the added complexity such changes would introduce to the models. IHPA has analysed the proposed adjustments against this criterion.

Dialysis Adjustment

New South Wales, Western Australia and the Northern Territory have requested that IHPA consider a dialysis adjustment for patients who receive haemodialysis whilst admitted to hospitals for other causes (and as such are not assigned to the AR-DRG L61Z Haemodialysis).

The Northern Territory considered this a priority area for further investigation because a significant proportion of Northern Territory patients have end-stage chronic kidney disease

and are dependent on dialysis. By contrast, Tasmania's view is that the requirement for haemodialysis is a complication that should be captured in the classification.

IHPA has examined whether the costs for patients receiving dialysis who are not assigned to the AR-DRG L61Z are higher than the price they receive under the national pricing model. These patients were found to be under-priced by up to 22 per cent.

For NEP15 IHPA will introduce an adjustment for acute admitted patients receiving dialysis services who are not assigned to the AR-DRG L61Z Haemodialysis.

Stability of adjustments

As advised in the 2014-15 Pricing Framework IHPA reviewed the stability of the adjustments applied to the NEP over previous years. For NEP14, adjustments were determined on a rolling average where historical data was available in order to maximise stability of these adjustments. IHPA is continuing this approach for NEP15.

IHPA's decision

For NEP15 the Pricing Authority has determined to apply these evidence based adjustments:

- Paediatric Adjustments for a person who is aged up to and including 16 years and is admitted to a specialist paediatric hospital for admitted acute patients or treated in any facility for admitted subacute patients;
- Specialist Psychiatric Age Adjustment for a person who has one or more specialist psychiatric care day during their acute admission, with the rate of adjustment dependent on the person's age;
- Patient Remoteness Area Adjustment for a person whose residential address is within an area that is classified as being outer regional, remote, or very remote in the Australian Bureau of Statistics' Australian Statistical Geography Standard, with the rate of adjustment dependent on the person's specific geographical classification;
- Indigenous Adjustment for a person who identifies as being of Aboriginal and/or Torres Strait Islander origin;
- Intensive Care Unit Adjustment for all patients admitted to an eligible Intensive Care Unit;
- Dialysis Adjustment for a person who receives haemodialysis whilst admitted to hospital for other causes (and are not assigned to the AR-DRG L61Z Haemodialysis);
- Radiotherapy Adjustment for a person with a specified ICD-10-AM 9th edition radiotherapy procedure code recorded in their medical record; and
- Private Patient Service Adjustment and Private Patient Accommodation Adjustment for admitted private patients.

Specific details for these and any additional adjustments will be confirmed in the NEP15 Determination.

Next steps and future work

IHPA will continue to review the application of adjustments, with an aim to discontinue adjustments associated with input costs (e.g. radiotherapy and dialysis adjustments) and facility based adjustments (e.g. specialist paediatric adjustment), as the AR-DRG classification continues to be refined in future years.

IHPA will continue to undertake a program of ongoing work to establish the factors resulting in legitimate and unavoidable variations in the costs of providing public hospital services.

10. Pricing for Safety and Quality

10.1 Overview

This section provides an update on the ongoing work between IHPA and the Commission to consider whether to incorporate quality considerations in the NEP in the future.

The NHRA states that in setting the NEP, IHPA must "have regard to ensuring reasonable access to public hospital services, clinical safety and quality, efficiency and effectiveness and financial sustainability of the public hospital system" (Clause B12(a)). The NHRA does not specify, nor does it constrain, how IHPA might seek to give effect to this broad set of responsibilities. Clause B12(a) indicates that IHPA should not only be guided by the efficiency of the public hospital system, but it must also have regard to other important policy objectives such as quality and access as it undertakes its price-setting role.

10.2 IHPA and the Commission collaboration

IHPA and the Commission are undertaking a joint program of work to explore options for incorporating quality and safety in the NEP. A Joint Working Party (JWP) of senior clinicians nominated by both agencies was established to inform this collaboration.

In 2013-14 the agencies commissioned research on high volume and high variation AR-DRGs to determine the impact on case complexity and cost for patients who develop complications with an onset during their stay in hospital, also known as hospital-acquired diagnoses. In 2014 additional work was undertaken to better understand how patient-level information regarding clinical safety is currently provided to clinicians and its potential to improve patient outcomes and care pathways. Available on the Commission website, a number of reports were produced to detail this work, including the:

- *Literature Review - Integrating Quality and Safety into Hospital Pricing Systems;*
- *Analysis of hospital-acquired diagnoses and their effect on case complexity and resource use report;*
- *Identify, specify and group a national set of high-priority complications which occur in hospital for routine local review report that was informed by a clinician driven process to identify the high-priority complications;* and
- *Environmental Scan - Use of Coded Hospital Administrative Data for Reviewing, Reporting and Improving the Safety and Quality of Health Care.*

The agencies have progressed the work seeking to better understand how providing patient-level information regarding clinical safety to clinicians improves quality. In 2014 the agencies commenced a Proof of Concept in selected hospitals to:

- identify whether the draft national set of hospital-acquired complications is clinically meaningful, feasible to monitor and useful to clinicians; and
- assess the accuracy and level of completeness of the set of complications within coded inpatient morbidity datasets against manual audit.

Related work is also underway to improve how patient-level information is documented and recorded. Specifically, data reporting will be improved by:

- developing guidelines for clinicians and coders detailing how health services can better document and code a selected set of high-priority hospital complications; and
- developing new data elements for 'Unplanned return to theatre', 'Unplanned admission to an intensive care unit', and 'Medical Emergency Team call' for potential inclusion in national admitted patient care data sets.

In 2014, the JWP established a sub-committee to investigate and advise the JWP on potential approaches to best-practice pricing and provision of safety and quality data in Australian public hospital services.

10.3 Options for pricing quality and safety

IHPA has foreshadowed a national consultation on pricing for quality and safety in previous Pricing Frameworks. In early 2014 the agencies commenced this process by seeking feedback from jurisdictions on a preliminary set of potential mechanisms for integrating safety and quality into pricing public hospital services. IHPA considered that it was important to include jurisdictions' feedback on the preliminary set of options before undertaking a public consultation process.

The results of the jurisdictional consultations were reported to both agencies' governing bodies in 2013-14. IHPA has also undertaken to consult the COAG Health Council on the outcomes of the consultation process prior to making any decision on safety and quality pricing. Further consultation may occur following the jurisdictional consultation process.

As such, IHPA is not proposing to make any adjustments to NEP15 for safety and quality.

Feedback received

New South Wales, Private Healthcare Australia and the Consumers Health Forum were strongly supportive of incorporating safety and quality mechanisms in the NEP. Western Australia cautiously supported best-practice pricing as one safety and quality mechanism for further investigation.

Meanwhile, Victoria, Queensland and Tasmania were strongly opposed to any national program of work to consider safety and quality mechanisms in pricing. Queensland believes that safety and quality is a matter for system managers and Tasmania highlighted that the evidence base to support safety and quality pricing is equivocal. The Commonwealth submission did not express a view.

IHPA's decision

IHPA will not make any adjustments to the NEP for safety and quality for 2015-16.

Next steps and future work

IHPA will continue to work with the Commission to consider options on pricing for safety and quality. To support the Commission and IHPA in its work, the JWP will provide advice on the options for the consideration of safety and quality in the pricing of public hospital services in Australia.

11. The Evaluation of the National Implementation of Activity Based Funding

11.1 Overview

IHPA is undertaking an independent evaluation of the implementation of national ABF for in-scope Australian public hospital services. The main objective of the evaluation is to learn about the impacts of ABF implementation to better enable IHPA to continuously improve the national ABF system. The evaluation has been split into two phases:

- Phase 1: development of an evaluation framework methodology and the establishment of a baseline; and
- Phase 2: undertaking the evaluation using the criteria and baseline established in Phase 1 as a basis for the evaluation.

Focusing on the first four years of national ABF implementation (2012-13 to 2015-16), the evaluation is expected to assess changes arising from the implementation of ABF such as:

- Efficiency and effectiveness of health services (service delivery costs, activity levels, patient flow);
- Efficient allocation of resources (hospital funding levels, resource usage, use of ABF as a management tool at jurisdictional and hospital level);
- Quality, safety and appropriateness of care (quality of care indicators, length of stay, morbidity and co-morbidity rates, patient safety);
- Access to integrated health care (access to health care services including in terms of time, equity of access especially by locality and socio-economic groups, impact on small and rural hospitals); and
- Identification of possible expected and unexpected incentives (changes in practices, changes in provision of care).

Drawing on existing data sources and performance information, the evaluation will also examine the impacts on data collections and use of data that have resulted from the adoption of a national ABF model.

IHPA has engaged an independent consultant to undertake Phase 1 of the evaluation. Phase 1 commenced in mid-2014 and is expected to be completed in mid-2015.

An ABF Evaluation Steering Committee has been established to support the project and provide a forum for jurisdictions and key stakeholders to inform Phase 1 of the evaluation.

It is noted that Clause 18 of the NHRA requires a review of the NHRA in 2015-16. This proposed evaluation is separate and independent from any review referred to in Clause 18 of the NHRA.

Feedback received

The Commonwealth, Victoria and South Australia expressed support for undertaking the evaluation and Western Australia expressed in-principle support.

Victoria and Queensland noted that accurately evaluating the effects arising from the national implementation of ABF will be difficult in view of the range of other health system reforms that have occurred simultaneous to this process.

The AMA suggested that the evaluation should identify and assess the impact of ABF, including changes in the mix, distribution and location of public hospital services.

The first phase of the evaluation of the national implementation of ABF has commenced. An independent consortium, which includes academics, has been engaged to design the evaluation framework and establish the baseline data. IHPA has established an ABF Evaluation Steering Committee with representatives from all jurisdictions and the IHPA Stakeholder Advisory Committee.

The findings of the evaluation will also allow IHPA to monitor any impacts that the introduction of a national ABF system may have on the delivery of public hospital services.

IHPA's decision

IHPA will refer the suggestions to the ABF Evaluation Steering Committee for consideration in developing the methodology for Phase 1 of the evaluation.

Next steps and future work

IHPA will work with the ABF Evaluation Steering Committee and other stakeholders to develop an evaluation methodology and establish a baseline.

12. Setting the National Efficient Cost

12.1 Overview

In the 2013-14 Pricing Framework IHPA established the criteria for block funding eligibility and provided these to COAG for approval (which has yet to be provided) in accordance with the NHRA. Without pre-empting the decision of COAG, IHPA applied these criteria in making the first two NEC Determinations (NEC13 and NEC14).

The criteria included specific 'low volume' thresholds to determine if a small hospital was eligible for block funding. At the time the criteria were proposed by IHPA they were based on admitted acute NWAU only, as robust figures for non-admitted and subacute activity were not available.

The Pricing Authority provided the following draft Block Funding Criteria to COAG for consideration:

Public hospitals, or public hospital services, will be eligible for block grant funding if:

1. The technical requirements for applying ABF are not able to be satisfied.
2. There is an absence of economies of scale that mean some services would not be financially viable under ABF.

IHPA also determined 'low volume' thresholds that form part of the draft Block Funding Criteria for 2013-14 and 2014-15. Under these thresholds, hospitals were eligible for block funding if:

- they are in a metropolitan area (defined as 'major city' in the Australian Statistical Geography Standard (ASGS)) and they provide ≤ 1,800 acute inpatient NWAU per annum; or
- they are in a rural area (defined as all remaining areas, including 'inner regional', 'outer regional', 'remote' and 'very remote' in the ASGS) and they provide ≤ 3,500 acute inpatient NWAU per annum.

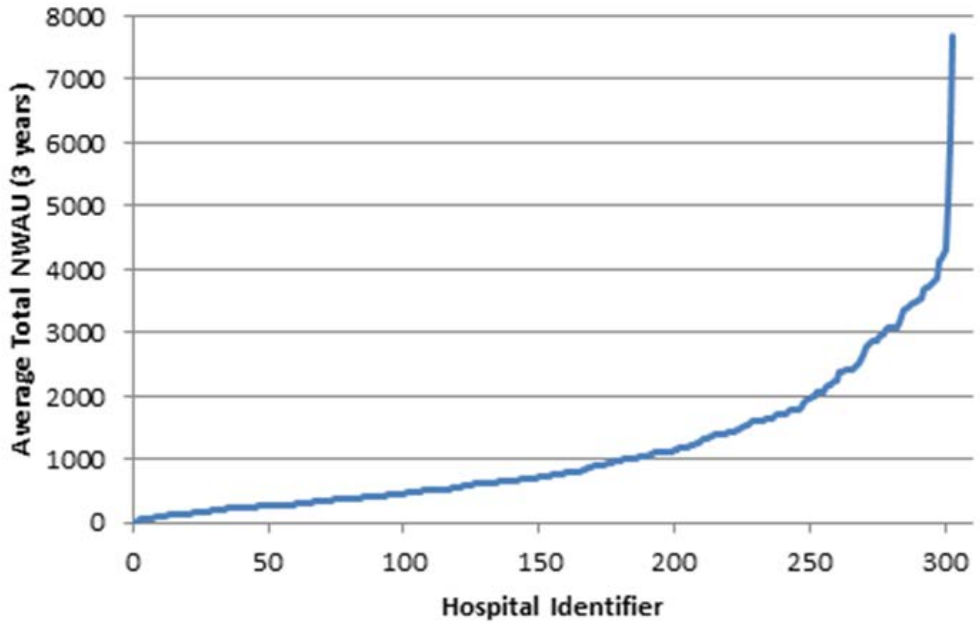
The block funding price model for small rural hospitals assigns each hospital an efficient cost on the basis of the size and location of the hospital. This efficient cost is the average cost of all the hospitals in the same size and location grouping.

12.2 National Efficient Cost 2015-16

When the 'low volume' thresholds were originally proposed by IHPA, these were calculated on the basis of admitted acute NWAU only. This was due to the fact that IHPA had not developed price weights for admitted subacute activity at that time, and also due to the activity data for non-admitted services in block funded hospitals being less robust than the current data supplied by states and territories.

However, the size dimension of the current block funding price model uses total NWAU across all activity streams. This means that some hospitals with very large non-admitted or emergency departments cause a significant skew to the size profile of block funded hospitals, as can be seen in Figure 1. This makes it very difficult to design sensible groupings of hospitals for which the efficient cost can be determined, and contributes to the volatility that many stakeholders have commented on in the past two NEC Determinations.

Figure 1: Average total NWAU – inner and outer regional hospitals



Through the Consultation Paper IHPA proposed that the low volume thresholds are revisited for NEC15. This approach is consistent with clause A31 of the NHRA which states that "in 2015-16 and every three years thereafter, COAG will reconsider those aspects of the IHPA's block funding criteria that require revision…"

IHPA proposed to count all NWAUs per annum in the 'low volume' thresholds for hospitals in 'inner regional', 'outer regional', 'remote' and 'very remote' areas in the ASGS (rural hospitals). IHPA proposed two options for setting the new low volume threshold for rural hospitals. Under the proposed thresholds rural hospitals would be eligible for block funding if they provide:

- ≤ 3,500 total NWAU per annum, which would result in 18 rural hospitals that are currently eligible for block funding no longer meeting the criteria in future years (Option 1); or

- ≤ 2,500 total NWAU per annum, which would result in 42 rural hospitals that are currently eligible for block funding no longer meeting the criteria (Option 2). This would effectively transition all rural hospitals in Group G (as shown in table 1) to ABF and address the significant increase in funding currently observed between Group F and Group G.

Additionally, IHPA also proposed to explore alternative approaches to determining the efficient cost of each small rural hospital such as through various forms of regression analysis, data trimming and examining the calculation of the fixed availability payments for all block funded hospitals.

These proposals seek to improve the stability and predictability within and between groupings and across years accounting for the block funded hospitals' region, role (e.g. the provision of surgical and obstetric services) and size.

Feedback received

There was broad support amongst stakeholders for IHPA's proposals to update the block funding criteria and to develop alternative approaches to determining the NEC.

The Commonwealth, Queensland, Western Australia, South Australia, Tasmania and the National Rural Health Alliance broadly support the need to update the block funding criteria, particularly to include all NWAU in the calculation of the low volume thresholds. These stakeholders identified that the benefits from the proposed updates to the criteria include increased stability in the NEC model and greater accuracy in determining hospital eligibility for block funding from year to year. In South Australia's case, the proposals would offer better funding outcomes for block funded small rural hospitals while larger rural hospitals would be better-off being funded on an ABF basis.

By contrast, New South Wales, Victoria and the Northern Territory did not support the proposed block funding criteria updates. New South Wales did not support any changes to the criteria, particularly because 21 of the 42 affected rural hospitals identified in the 2,500 total NWAU option (Option 2) are in that state. Queensland supported the 3,500 total NWAU threshold (Option 1) and also raised concerns if the threshold was reduced to 2,500 total NWAU per annum (Option 2). Victoria supported the proposed criteria changes in-principle, but requested that they should not occur until NEC16 at the earliest.

Although there was mixed reaction on the low volume threshold, there was broad consensus on the need to establish an alternative methodological approach to determining the NEC for block funded hospitals and services.

IHPA considers that the underlying data is now sufficiently robust to include all activity in the low volume threshold and not just the admitted acute activity. IHPA is also mindful of stakeholder concerns expressed regarding the volatility in the existing NEC model. IHPA considers that setting the low volume threshold for rural hospitals to 3,500 total NWAU per annum and establishing an alternative methodology will address these concerns.

IHPA recognises that the updated block funding criteria will need to be provided to COAG for approval and IHPA will provide these criteria to COAG shortly.

12.3 Teaching Training and Research

In 2013-14 and 2014-15 IHPA determined block funding amounts for teaching, training and research activity in ABF hospitals based on jurisdictional advice. IHPA will continue this approach for 2015-16 and until such time that an ABF model is implemented for teaching and training or research.

The Commonwealth considers that the approach used for the 2013-14 and 2014-15 determinations of the efficient cost of TTR services lacked rigour and suggested it is essential that IHPA employ a more robust approach for the calculation of the efficient cost of TTR for 2015-16, and to work with jurisdictions to identify the composite values of the 'teaching and training' and 'research' components so that these can be identified separately in the NEC15 Determination.

IHPA is working with jurisdictions to develop block funding guidelines that include detail on reporting teaching, training and research expenditure as well as block funded non-admitted mental health services.

12.4 Non-admitted mental health services

The NEC13 and NEC14 Determinations advised that non-admitted mental health services were block funded for 2013-14 and 2014-15.

The Pricing Authority has decided to retain the current block funding approach for these services in 2015-16 whilst work continues to design appropriate classification, counting and costing systems for mental health. This arrangement is anticipated to continue until the Australian Mental Health Care classification is introduced in 2016.

IHPA's decision

Without pre-empting the decision of COAG, for NEC15 IHPA will apply the new low volume thresholds to the block funding criteria, particularly that hospitals will be eligible for block funding if they are:

- in a metropolitan area (defined as 'major city' in the Australian Statistical Geography Standard (ASGS)) and they provide ≤ 1,800 acute inpatient NWAU per annum; or
- in a rural area (defined as all remaining areas, including 'inner regional', 'outer regional', 'remote' and 'very remote' in the ASGS) and they provide ≤ 3,500 total NWAU per annum.

IHPA will further refine the methodology for determining the National Efficient Cost and confirm the approach taken in the NEC15 Determination.

For NEC15 IHPA will continue to block fund teaching, training and research expenditure in ABF hospitals and non-admitted mental health services.

Next steps and future work

IHPA will provide the updated block funded criteria to COAG for their consideration shortly.

IHPA will work with jurisdictions to establish the alternative methodology for determining the NEC.

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