Pricing Framework for Australian Public Hospital Services 2020–21

Department of Health Submission to the IHPA

Queensland Health (QH) welcomes the opportunity to provide feedback on the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021–22* (the Framework), released on 9 September 2020 by The Independent Hospital Pricing Authority (IHPA) for public feedback.

In order to provide representative feedback on the Framework, the Department of Health consulted with all areas of QH including the department's divisions and 16 Hospital and Health Services (HHSs).

The 2020 Queensland State General Election will be held on Saturday 31 October 2020 and therefore the Queensland Government enters the caretaker period prior to the October 9 deadline for submissions. This has resulted in an abbreviated consultation period. HHSs were advised to provide feedback directly to IHPA if unable to meet the constraints of the shortened consultation.

QH responses to the questions, included in the consultation paper on the Framework, are below. QH notes that topics in the consultation paper on the Framework, including important reforms to private patient neutrality, and the points raised in Chapter 8 on the collection of non-admitted activity data, were not accompanied by questions. QH feedback on these important issues has been included at the end of this submission.

1. *What changes have occurred to service delivery, activity levels and models of care as a result of COVID-19?*

The coronavirus disease 2019 (COVID-19) pandemic response led to significant changes in the way health services across Queensland were organised and delivered.

The initial stages of the response included a period of reduced activity due to suspension of elective services, a refocus on the planning and delivery of COVID-19 safe practices, as well as a public health response on education and testing.

Elective non-admitted services were halted, or where possible, delivered via telehealth and remote patient monitoring technologies.

Although there was a reduction of in-hospital activity, there was a significant increase in the delivery of 'Hospital in the Home' to enable patients to receive COVID-19 or non-COVID-19 related treatment in their own homes and thus reduce the risks of transfer of the disease.

QH has established an expert panel to understand the changes arising out of the COVID-19 pandemic. The final report is being considered by the Queensland Deputy Premier and Minister for Health and therefore cannot be made publicly available at this stage. The group did however note the pricing model should support and be flexible around different models of care.

2. How will these changes affect the costs of these services in the short and long term?

Looking broadly at all hospital services, it is expected that costs per National Weighted Activity Unit (NWAU) will be significantly higher in 2019-20 as hospital activity declined to create capacity for an expected influx of COVID-19 patients. However, there was no commensurate reduction in costs. As such caution will be needed using the 2019-20 and likely the 2020-21 cost data in future National Efficient Price (NEP) and National Efficient Cost (NEC) determinations.

Longer term it is expected that service costs will remain elevated due to the ongoing need for COVID-19 safe work practices, such as increased use of Personal Protective Equipment, increased regular diagnostic COVID-19 testing and higher nursing ratios to deliver safe care. There may be some offsetting price reductions through increased use of telehealth. However, this may not necessarily lead to a cheaper option to in-person care due. For example, there are potentially significant costs associated with clinical staff presence at either end of the consultation, additional administrative support, training, technical support, and specialised software and other equipment.

QH suggests that IHPA will need to continue to work with jurisdictions to understand the extent of COVID-19 impacts on hospital costs. Given the speed at which change has occurred, QH suggests IHPA establish a COVID-19 working group reporting directly to the IHPA Technical Advisory Committee (TAC).

3. What aspects of the national pricing model will IHPA need to consider adapting to reflect changes in service delivery and models of care?

The Addendum to the National Health Reform Agreement 2020-2025 (the Addendum) includes guidance on paying for value and outcomes. The Addendum calls for funding flexibility and governance arrangements to support these. The trend to value-based healthcare is likely to accelerate following the pandemic, and IHPA will play a critical role in supporting this.

One change which appears likely to remain in place has been the acceleration in telehealth service events. Consideration must be given to ensure pricing for telehealth (including email and telephone modalities as well as video calls) reflects the resources required to effectively deliver care in this form (as outlined under Question Two) and whether it is appropriate to maintain provider centric pricing for recipient-end telehealth or moving to specialty specific pricing for all telehealth services. Ongoing discussions with jurisdictions will be required to understand how the pandemic response progresses. It is still too early to conclude we are in the 'new normal' and further isolated outbreaks remain a risk.

4. Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?

QH supports the use of a set of guidelines to provide direction and transparency for IHPA's role in pricing Australian public hospital services.

To maintain recency and better reflect policy evolution, the following changes are suggested:

- A review of the Guidelines to consider the NHRA Addendum, that cites under 'Paying for Value and Outcomes,' a call for a focus on the outcomes that matter to patients, not just clinical outcomes.
- Under "ABF pre-eminence" we suggest the following change: *ABF should be used for funding public hospital services except where it is neither practicable nor appropriate*. This change would align the pricing guideline with clause A3 of the NHRA Addendum:

A3. Commonwealth funding will be provided on the basis of activity through Activity Based Funding (ABF) except where it is neither practicable nor appropriate.

For significant changes to the pricing and funding model, QH considers that IHPA should make explicit reference to the pricing guidelines and how any proposed change meets each of the guidelines.

5. Does the change to the public-private neutrality pricing guideline accurately reflect the intent of the Addendum?

The wording of the public-private neutrality pricing guideline should reflect the clauses of the Addendum to the NHRA. Specifically, Clause A13 does not refer to funding neutrality 'for the service provider' but rather 'funding models will be financially neutral with respect to all patients'.

To more accurately reflect the intent of the Addendum, the pricing guideline should be changed to:

'ABF pricing should ensure that there is funding neutrality with respect to all patients, regardless of whether patients elect to be treated as a private or a public patient in a public hospital'.

QH notes there are ongoing discussions through IHPA's Technical and Jurisdictional Advisory Committees regarding the implementation of private patient neutrality required under the Addendum (noting the consultation paper on the Framework does not include questions relating to this).

6. What should be included in online education for new editions of ICD-10-AM/ACHI/ACS?

Online education for new editions of the International Classification of Diseases and Health Related Problems, Tenth Revision, Australian Modification (ICD-10-AM) / Australian Classification of Health Interventions (ACHI) / Australian Coding Standards (ACS) is supported however this format also needs to be flexible enough to enable a component of real-time, interactive delivery (such as live Q&A sessions or interactive 'chat'), thus providing participants with the opportunity to ask questions and / or seek further clarification.

Potentially there is a need for targeted education for State / Territory and HHS Educators. This could be offered in a 'train the trainer' format to ensure education is passed onto coders in a consistent manner.

At a more specific level education needs to provide the following:

- Easy to access lists of new and deleted codes.
- Explanations of components such as the complication index points allocated to each code and how they contribute to patient grouping and Diagnosis Related Group (DRG) allocation.
- Exercises / tutorials that are representative of real hospital documentation.
- Challenge exams that are robust and difficult enough to accurately assess comprehension and application of knowledge.

7. How should AR-DRG education be delivered and what should it include?

Education on the Australian Refined Diagnosis Related Groups (AR-DRG) would be most appropriately delivered online. There is a strong preference for education to be ongoing and not just delivered upon the release of a new edition.

Per the response to Question Six, education on the AR-DRG needs be delivered in a flexible format, with opportunities for real-time and interactive sessions.

At a more specific level education needs to provide the following:

- Varying levels of education ranging from introductory to advanced levels.
- An explanation of the methodology used on the classification.
- Education explaining the difference/relationship between ICD-10-AM / ACHI codes and DRGs, and how ICD-10-AM / ACHI / documentation influences DRGs.
- Explanation of how cost weights are determined.
- How Major Diagnostic Categories (MDC) and Enhanced Service Related Groups (ESRG) sets fit around DRGs.
- How are base DRGs differentiated, using proxies for severity.
- Clear documentation of the changes between previous and new editions, and why these changes were made.
- Summation of the impacts from previous versions e.g. complexity scores at the code level.

8. What improvements to the content and format of the electronic code lists could be made to enhance their utility?

The Electronic Code List provides the International Classification of Diseases (ICD), ACHI and Block Code and description, however, inclusion of the following to the reference list would provide a comprehensive and complete code list:

1. **ICD**

- Chapter
- First level – block e.g. A00-A09 Intestinal infectious diseases, A15-A19 Tuberculosis etc.

2. **ACHI**

- Chapter
- First level – anatomical site e.g. Skull, Meninges and Brain, Spinal canal and spinal cord structures etc.
- Second level – intervention type e.g. Examination, Incision, Excision etc.

3. **Diagnosis Complexity Level (DCL) values**

9. *Is there support to replace the hard copies of the AR-DRG Definitions Manual and ICD10-AM/ACHI/ACS with electronic versions?*

QH supports the ongoing availability of hard copies of the AR-DRG Definitions Manual and ICD-10-AM / ACHI / ACS to support the electronic versions.

There is still a requirement to have hard copies available. This is particularly so in the hospital setting where a coder may need to consult with clinicians regarding appropriate codes and realistic pathway expectations. The hard copy also provides definitive proof of code choice and pathways and can be referred to retrospectively (even after the Edition or Version has been superseded).

10. *Are there other suggestions for approaches or measures to assess impact and readiness of ICD-11 for use in the classifications used in admitted care, or more widely?*

Although ICD-11 appears to offer numerous improvements and flexibility from previous versions, there needs to be a thorough understanding of the requirements and impact of implementation.

QH fully supports IHPA in the exploration of readiness of ICD-11 for implementation in admitted care across Australia.

Consideration to determining the relationship of ICD-11 to the AR-DRG classification is also welcome.

Early engagement with state and territory governments, as well as the private sector, is paramount to the assessment of readiness.

There are potentially significant impacts on state health department Patient Administration Systems and downstream reporting that must be taken into consideration. Appropriate lead times are essential to enable system changes to be adequately costed and implemented.

11. *Are there any other factors that should be considered for the addition of pain management and exercise physiology classes in the clinic nurse specialist/allied health led services of classes in the Tier 2 Non-Admitted Services Classification?*

See comments below (Question Twelve).

12. *How would activity that falls under these proposed new classes previously have been classified?*

Consultation with HHSs indicates variation with reporting of activity that would fall under the proposed new class for exercise physiology.

Some services indicated this activity would be reported under the Tier 2 Non-Admitted Services Classification 40.12 Rehabilitation class, whereas others indicated this would be reported under 40.58 Hospital avoidance programs.

This discrepancy indicates that definitions and inclusions / exclusions need to be very clear, prior to implementation, to ensure correct reporting.

Health services were consistent in stating that pain management, undertaken in nurse specialist / allied health led clinics, would be reported under 40.12 Rehabilitation.

13. *What has been the impact on emergency department data since IHPA commenced shadow pricing using the Australian Emergency Care Classification (AECC) Version 1.0?*

QH has previously advised IHPA that Emergency Department (ED) data collected by the Department of Health is used for a variety of purposes, including funding. The ED information systems used across QH are not designed to be limited to the ICD-10-AM principal diagnosis short list developed by IHPA. In order to improve compliance with the short list, it has been necessary for QH to map reported principal diagnoses, both Systematized Nomenclature of Medicine Clinical Terms (SNOMED-CT) and ICD, to the short list.

Where an external cause code is used to describe the reason for presentation to an ED, it is not possible to map these to a shortlist principal diagnosis code. External cause codes account for around four per cent of total episodes. Ongoing education on the impacts of the diagnosis deficit will be needed across QH. IHPA has advised that under the AECC, ED presentations where a valid AECC end class cannot be derived will not generate NWAU. This is a departure from the current approach whereby presentations that cannot be grouped to a valid Urgency Related Group will be assigned an Urgency Disposition Group and generate activity accordingly.

14. *Are there any barriers to implementing pricing using the AECC Version 1.0 for emergency departments for NEP21?*

QH does not support pricing of AECC Version 1.0 for NEP21. Per the requirements of the NHRA Addendum, the classification should be shadowed for a period of two years.

QH needs to continue to refine mapping of ED presentations where an external cause code is used to improve compliance with the national short list of principal diagnosis codes.

Furthermore, QH considers that IHPA should agree through its committees with jurisdictional representation, exactly what shadow pricing should involve. IHPA has stated that the AECC has been shadowed for 2020-21 as the price weights were published in the NEP20 determination. However, to fully understand the impact of the new classification, jurisdictions require access to both the AECC grouper and price calculator, to run historic activity data through the model and thus make comparisons with existing classifications. At this stage the Department of Health, nor any of the health services, have had visibility of the shadow priced data and therefore cannot make a judgement on the readiness to transition the AECC to full pricing for NEP21.

15. *How can IHPA further support development of pricing for community mental health services using AMHCC Version 1.0 to transition to shadow pricing?*

QH has consistently stated through various working groups, committees, and previous pricing framework consultations, the pricing of community mental health services using the Australian Mental Health Care Classification (AMHCC) is not supported at this time. The underlying data, particularly phase of care, is not robust or comprehensive enough to reliably price. The costing of services outside of the admitted patient component is new. Although there has been an increase in data from other jurisdictions, this is not sufficiently robust to commence shadow pricing. This is evidenced in papers provided by IHPA to the TAC, citing approximately fifty percent of episodes, in two major jurisdictions, grouped to an unknown phase. A significant number of episodes were also unable to be grouped.

If community mental health services were to be shadow priced for NEP21, QH suggests a minimum two-year shadow period with a transition to full pricing once all jurisdictions are comfortable the model is robust and consistent nationally.

During the shadow period IHPA should focus on appropriately finalising the phase of care clinical refinement to provide assurance to states and territories regarding the future stability of the model.

There is also the need for enhanced alignment between the requirements for the AMHCC and the underlying / source data used by the AMHCC. For example, there is a disconnect between the AMHCC requirements and the base protocol for the National Outcomes and Casemix Collection, which is a key source of data supporting the AMHCC. This disunity compromises the ability to effectively price community mental health services.

16. Are there any impediments to pricing admitted mental health care using AMHCC Version 1.0 for NEP21?

QH considers that the classification is not fully developed to transition to full pricing for NEP21. The primary issue is that the phase of care remains unsupported by mental health clinicians with poor inter-rater reliability. As the phase of care continues to be refined the classification should continue to be shadow priced.

There are significant variations in models of care between jurisdictions and the bundling process does not consider the fact that multiple mental health teams based in different facilities may treat the same patient during the same period.

17. Do you support the adjustment IHPA has proposed for NEP21?

QH strongly supports adjustments for patient transport in rural areas and has previously requested IHPA commission a study into pricing for patient travel as part of the annual nomination of legitimate and unavoidable cost variations. QH is willing to assist in providing costing data necessary to facilitate the calculation of this adjustment.

18. What evidence can be provided to support any additional adjustments that IHPA should consider for NEP21?

QH has previously raised, through the Fundamental Review of the NEP conducted in 2019, that it supports the adoption of a percentile-based approach to setting DRG length of stay inlier bounds. Whilst the existing L3H3 methodology produces a reasonable distribution of inliers and outliers across all DRGs, the results at the individual DRG level are significantly different.

19. Are there any obstacles to implementing the proposed harmonisation of prices for dialysis and chemotherapy for NEP21?

In general, QH is supportive of price harmonisation where there is strong evidence that the cost of care and resources for the same product / administration route are the same across admitted and non-admitted settings.

QH supports harmonisation of prices for dialysis but has concerns about harmonisation of prices for chemotherapy.

Whilst the delivery of some classes of intravenous chemotherapy may hold significant clinical risk and / or be administered over a period of hours, other forms of chemotherapy may be administered subcutaneously or orally with minimal clinical time requirements and at lowered risk.

IHPA needs to provide further information to enable clear differentiation between resources across settings but also various types of chemotherapy administration routes and the duration that the patient is undergoing active treatment.

Under NEP20, the price for same-day admitted chemotherapy is significantly higher than the non-admitted price ($1,273 admitted against $414 non-admitted). This suggests there is a substantially different resource use between the settings. There is potentially a difference in the patient treatments between admitted and non-admitted that cannot be explained in the non-admitted data.

Treating cancer has become an increasingly sophisticated field requiring additional specialised support facilities and expertise given to patients during and post chemotherapy such as pharmacists, oncologists, medical emergency team response and specialised care units.

The process of price harmonisation is too simplistic for the cancer patient cohort, and effectively will provide an equal weighting to the non-admitted price which is driven by one jurisdiction and appears to be subject to variations in costing or counting service events.

Prior to harmonising these prices, it is recommended that IHPA provide more complete evidence that the services are the same across settings and investigate the variation in costing between settings to understand the discrepancy where the service provision is allegedly the same. At a minimum, if introduced for chemotherapy, IHPA would apply its stability policy to the harmonised price so it does not move more than 20 per cent from the same-day admitted price. The proposed harmonised price under NEP20 of $738 represents a 42 per cent decline from the same-day admitted price of $1,273.

20. Are there other clinical areas where introducing price harmonisation should be considered?

Minor surgical procedures such as colonoscopy or nasendoscopy.

21. Is there any objection to IHPA phasing out the private patient correction factor for NEP21?

No, QH has previously supported the phasing out of the private patient correction factor.

22. Are there refinements to the 'fixed-plus-variable' model that IHPA should consider?

QH has no further refinements to suggest at this stage.

23. What comments do stakeholders have regarding the innovative funding models being considered by IHPA?

QH supports the investigation of innovative funding models by IHPA, particularly capitation type payments for patients with chronic conditions. QH acknowledges the potential benefits of bundled payments, however such funding models suffer from the lack of a universal patient identifier. There is the need for a nationally agreed care plan, and the administrative complexity of determining funding splits between multiple providers, including those in the primary care setting.

24. What innovative funding models are states and territories intending to trial through bilateral agreements under the Addendum?

QH has two current funding model developments that will be shadow modelled in the 2021-22 year. These are outlined below.

- The Advancing Kidney Care Collaborative, that aims to:
    - Standardise approaches to care pathways with the aim of supporting equitable service access and reducing variation in service provision and outcomes;
    - Develop a strategy to better enable clinicians and Queensland Health to collect and report information on kidney patients, and the provision of kidney services across the state;
    - Develop a state-wide funding model of public kidney services that links funding to patient outcomes and service effectiveness.
- Developing bundled payments for planned care patients in Ear, Nose and Throat (ENT), Orthopaedics, Gastroenterology and Ophthalmology.

As these initiatives evolve, they will be assessed for suitability for consideration as a trial under the NHRA Addendum.

25. Are there other factors that IHPA should consider in its analysis to determine which patient cohorts or ADRGs are amenable to certain funding models?

Patients with chronic disease have many interactions with health care providers across hospital and community settings. The capacity to link patient activity between hospital and primary health care providers (General Practitioners) would provide valuable clinical and costing information to progress innovative and multi-sector initiatives. Is there an opportunity to commence a cross sectoral working group to consider which conditions would best be suited to a whole of system approach? In the absence of a national approach that brings sectors together, States and Territories will develop models in isolation. This has the potential to lead to an inconsistent and piece meal approach that may not achieve outcomes that are important to the patient.

26. What other strategic areas should IHPA consider in developing a framework for future funding models?

As noted above, QH supports the work IHPA is conducting in relation to future funding models and will continue to work collaboratively with IHPA as areas are identified in state activities.

27. Apart from the IHI, what other critical success factors are required to support the implementation of innovative funding models?

For bundled payments, a nationally agreed best practice pathway is required in order to calculate the total service payment. Where services within a 'bundle' are delivered across multiple facilities / HHSs and even states, an administratively simple fund-sharing and adjustment arrangement needs to be established.

28. Do you support IHPA's proposed pricing model for avoidable hospital readmissions, under funding option one at a jurisdiction scope level?

In principle, QH supports the rationale for adjusting avoidable hospital readmissions. In particular QH is pleased to see that IHPA has taken on board concerns raised by jurisdictions and changed the model to exclude transfers as readmissions. QH also supports the changes to exclude insignificant variables in the risk adjustment model and have a separate set of explanatory variables to adjust for

each readmission group. However, HHSs have highlighted the importance of being able to replicate, report on, and audit readmissions data at the HHS level as being a key factor in building frontline clinician engagement.

QH believes that Option 1 is the most transparent approach, with a relatively even funding impact across HHSs. However, the requirement to link patient episodes across the jurisdiction presents a challenge.

Although IHPA has agreed to address these concerns by pseudo-linking the Medicare Personal Identification Number (PIN) and common patient identifiers for replication and reconciliation of data, facilities are dependent on IHPA providing this data following quarterly activity submissions, any re-admissions outside the same hospital will not be identified until 3 to 6 months after event. The time delay may weaken the relationship between the re-admission and the financial adjustment.

QH suggests that should IHPA decide to pursue Option 1, that the scope of readmissions initially be limited to the facility until such time that facilities have confidence that results can be accurately replicated, or a unique patient identifier is available in national datasets. Note that QH supports the scope of readmissions at the jurisdiction level and the initial approach of limiting to facility would be only an interim step.

QH has previously expressed concerns that Option 3 disproportionately impacts smaller regional and rural hospitals. Modifications to the risk adjustment model and the removal of patient transfers appears to have reduced this impact somewhat, though there still remains a bias. However, it is not clear whether this is simply the result of a high rate of readmissions in these hospitals which would justify a disproportionate funding impact.

The benefit of Option 3 is that it aligns with the thinking that some readmissions are not preventable and accounts for this by using expected rates. Under Option 1 (and Option 2) it assumes that all readmissions are preventable. The Australian Commission on Safety and Quality in Health Care has defined an avoidable hospital readmission as having the potential to be avoided through improved clinical management and / or appropriate discharge planning in the index admission. There will always be a level of readmissions that aren't preventable.

29. Are there any refinements to the risk adjustment model and risk factors that IHPA should consider?

QH has previously raised concerns about including indigenous status as a risk adjustment variable. It is important that the need for better care for indigenous people is highlighted and not risk adjusted away. Although it is true that indigenous people are more prone to readmissions, and the variable will naturally show statistical significance. The inclusion of indigeneity as a risk factor indicates acceptance that nothing can / should be done to work with this group to prevent readmissions.

Also, of concern is the inclusion of the number of readmissions in the past year. Although it is acknowledged this is potentially an indicator of how sick a patient is, it may also be a direct reflection of admission policies and practices.

30. What additional aspects does IHPA need to consider when implementing a funding adjustment for avoidable hospital readmissions?

QH has no additional aspects to propose at this stage.

Other issues not included in consultation questions

Private Patient Financial Neutrality

QH has raised concerns with IHPA regarding the proposed methodologies to implement the private patient neutrality clauses. QH to provide specific feedback to each proposed methodology. Key concerns include (but are not limited to):

- QH requires a comprehensive impact statement prior to accepting a methodology, including the approach to back-casting.
- There appears to be a move to a pricing approach from a funding approach. This creates considerable uncertainty and is not practical.
- QH does not determine state funding to HHSs at the episode level – making collection of the state funding amount paid per patient very difficult / not possible.
- The Queensland Efficient Price is different from the NEP as it includes all sources of funds (NHRA, State, private patient revenue, other revenue sources such as compensable patients) and patients not in scope of the NHRA. However, this does not mean that HHSs are paid more for private patients as private patient revenue is used as a funding source in service agreements.
- Complexity it adds to the funding model and potential need for it to be tailored to each HHS.
- Hospital Casemix Protocol (HCP) data is not available to jurisdictions, making jurisdictions unable to comment to its quality, including the match rate and correctness.

Queensland will continue to work collaboratively with IHPA to find a practical and fair methodology.

Phasing out aggregate non-admitted data reporting

QH notes that Chapter 8 of the Consultation paper included some quite significant proposals to amend national datasets and also a proposal by the Administrator of the National Health Funding Pool (Administrator) to amend national public hospital funding policy.

Firstly, it would appear to be a breach of the NHRA for the Administrator to unilaterally decide not to fund in-scope public hospital activity due to a desire to phase out aggregate activity reporting. QH will raise this matter separately with the Administrator.

With regard to IHPA proposing to establish a national minimum data set for non-admitted patient level data from 2021-22, QH notes that this is not the role of IHPA. This would require agreement from all states and territories through the National Health Data and Information Standards Committee. QH has previously advised IHPA via the Non-Admitted Care Working Group that Queensland is working towards transitioning all sites to patient level data, but this will not be completed by July 2021. As such, QH does not support transition from a National Best Endeavours Data Set to a National Minimum Data Set.

Pharmaceutical Benefits Scheme (PBS) price weights in all Tier 2 clinics

QH has identified that some Tier 2 clinics, which in practice would not receive funding for PBS-listed medications, still have a PBS price weight, (e.g. allied health). Officer-level discussions with IHPA confirmed that this is due to a practice of allocating residual PBS costs, which could not be linked to a non-admitted service event, across all Tier 2 clinics. QH recommends this practice should exclude non-admitted clinics that would not receive funding for PBS-listed medications. This will ensure the price weight is only associated with services with prescribing rights.

Proposed transfer of Roma Hospital and Thursday Island Hospital to ABF

QH acknowledges that Roma hospital has recorded activity in excess of the limit for block funded hospitals for four years, but requests that Roma Hospital remain block funded on the basis that activity is projected to fall due to a shift towards greater community care (noting QH request that Multi-Purpose Health Services activity be regarded as in-scope for block funding), combined with projected decline in the catchment population.

- **Change in activity with $112M new Roma Hospital Build and subsequent changes in model of care** (integration of several offsite services into integrated service configuration). The reduction in projected activity is driven by a change in models of care. The Roma Hospital will transition into providing more community services and treating patients in the home. This model of care is aligned to the South West Hospital and Health Service (SWHHS) Strategic Plan, and state and federal government priorities. SWHHS has increased focus on Telehealth and there is a targeted project underway in 2020-21 to enable this model of care for community which will further reduce acute presentations.
- **SWHHS and Roma projected population decline** – most recent Roma (Maranoa) data reports a six per cent decrease in population over the forward years to 2026. All surrounding local government areas also reduce significantly, with Roma specifically. SWHHS has a significant percentage of potentially preventable hospital admissions, which if addressed as planned, will again result in decreased activity.

Attachment 1 expands on the points listed above.

Thursday Island Hospital has previously been classified as an ‘other standalone hospital’ as it did not fit either the ABF or block funded models. QH considers that this has not changed, with the hospital servicing a population with a high proportion of indigenous patients with very high healthcare needs and additional operating costs due to the remoteness of the facility.

Attachment 1- Reported Activity for NWAU Threshold - Roma Hospital

For the past four years Roma Hospital has reported activity over the 3,500 NWAU threshold (NWAU19), however there is trending decline over the period (refer Table 1).

The data integrity for Roma Hospital is impacted through the inclusion of Allied Health activity for all sites in SWHHS. This over-states the NWAU performance at Roma Hospital. When removing this activity, the nett NWAU reported falls to, or below, the 3,500 NWAU threshold (refer Table 2).

As such, and with the other factors described below including potentially preventable hospitalisations (PPHs), acuity and the social and economic factors, it is unlikely that Roma Hospital will be able to achieve the threshold of NWAU activity to be classified as ABF.

Table 1. Cases and NWAUs (NWAU19) by Purchasing Group and Year – Roma Hospital

Purchasing Group	2015-16 Activity	2015-16 NWAU	2016-17 Activity	2016-17 NWAU	2017-18 Activity	2017-18 NWAU	2018-19 Activity	2018-19 NWAU	2019-20 Activity	2019-20 NWAU
1 Inpatient	2,863	1,573.49	3,126	1,779.20	2,951	1,917.12	3,274	1,814.51	3,160	1,734.51
2 Outpatient	16,728	411.57	21,760	520.44	22,746	551.18	22,723	469.15	26,328	529.92
3 Procedures and Interventions	231	101.96	300	140.54	304	141.88	357	160.23	314	137.39
4 Emergency Department	9,209	940.47	8,894	929.20	9,494	972.25	8,517	918.48	8,771	936.56
5 SNAP	111	238.83	92	308.42	100	284.48	91	268.49	104	293.12
6 Mental Health	50	39.33	41	29.30	45	29.00	38	24.64	72	45.71
Unknown	1,695								31	
Total Activity	**30,887**	**3,305.65**	**34,213**	**3,707.10**	**35,640**	**3,895.92**	**35,000**	**3,655.50**	**38,780**	**3,677.20**
Average Acuity		0.1070		0.1084		0.1093		0.1044		0.0948
Percentage change in acuity				1.24%		0.89%		-4.46%		-9.21%

Table 2. Allied Health Cases and NWAUs (NWAU19) by Year – Reported in Roma Hospital

Purchasing Group	2015-16 Activity	2015-16 NWAU	2016-17 Activity	2016-17 NWAU	2017-18 Activity	2017-18 NWAU	2018-19 Activity	2018-19 NWAU	2019-20 Activity	2019-20 NWAU
2 Outpatient – Allied Health	6,060	202.39	6,091	200.46	6,341	212.23	5,262	168.25	4,985	177.98
Average Acuity		0.0334		0.0329		0.0335		0.0320		0.0357
Percentage change in acuity				-1.46%		1.70%		-4.47%		11.66%

Purchasing Group	2015-16 Activity	2015-16 NWAU	2016-17 Activity	2016-17 NWAU	2017-18 Activity	2017-18 NWAU	2018-19 Activity	2018-19 NWAU	2019-20 Activity	2019-20 NWAU
Totals excluding Allied Health	**24,827**	**3,103.26**	**28,122**	**3,506.64**	**29,299**	**3,683.69**	**29,738**	**3,487.25**	**33,795**	**3,499.23**
Average Acuity exc Allied Health		0.1250		0.1247		0.1257		0.1173		0.1035
Percentage change in acuity				-0.24%		0.83%		-6.73%		-11.70%

Further, there are other factors influencing the activity reported, including:

Ophthalmology services. SWHHS operates a distinctive Elective Surgical Ophthalmology Service operated exclusively by one specialist Visiting Medical Officer (VMO). The service viability is contingent on the contractual arrangement remaining in place in future years, to guarantee ongoing activity levels. This is the strongest NWAU activity for inpatient services at Roma Hospital, representing over 12 per cent of Inpatient NWAUs. When including Outpatient activity this service accounts for almost 7 per cent of total NWAUs. Ophthalmology is considered to be an outlier in the data capture and without this service, Roma Hospital activity would reduce and would be unlikely to be above the annualised performance threshold of 3,500 NWAU (refer Table 3).

The heightened activity during 2017-18 FY was investment by SWHHS to manage Ophthalmology weight lists and improve service access. In addition, activity in all years includes patients referred from the Darling Downs HHS catchment, effectively artificially increasing Roma Hospital activity levels.

Table 3. Ophthalmology cases and NWAUs (N19/20) by Year – Reported in Roma Hospital

Purchasing Group	2015-16 Activity	2015-16 NWAU	2016-17 Activity	2016-17 NWAU	2017-18 Activity	2017-18 NWAU	2018-19 Activity	2018-19 NWAU	2019-20 Activity	2019-20 NWAU
1 Inpatient – Ophthalmology	377	146.31	613	288.14	551	294.60	502	197.94	470	211.86
2 Outpatient – Ophthalmology	1,132	34.06	1,407	31.61	1,237	28.48	1,235	25.04	1,385	31.93
Total Activity	**1,509**	**180.37**	**2,020**	**319.7**	**1,788**	**323.09**	**1,737**	**222.97**	**1,855**	**243.79**
Average Acuity		0.1195		0.1583		0.1807		0.1284		0.1314
Percentage change in acuity				32.43%		14.15%		-28.96%		2.38%

Roma Hospital has historically reported high PPHs. There has been a deliberate and focused strategic move to increasing primary care services. This includes investment in promoting healthy communities and reducing the burden on acute services. The activity from PPHs would be redirected into primary care services and reducing the NWAU performance at Roma Hospital.

The Roma Hospital is reporting an average of 349 PPHs over the past five years contributing to the annual activity (refer Table 4). Over half of these relate to diabetes complications.

Targeted activities are occurring at a local level to reduce PPHs, with focus on strengthening access to primary care services and promotion of healthy communities. The impact from reducing PPHs to Roma Hospital activity, even if only diabetes related (est. 125 NWAU) PPHs would reduce the NWAU performance at Roma Hospital. The relevance is that Roma Hospital activity that is generated from PPHs would reduce, further constraining Roma Hospital's ability to exceed the NWAU threshold.

The pivot to a primary health care model has not been implemented as quickly as expected due to the need to ensure sufficient resources will be available, the need to ensure appropriate consultation with community members and affected staff, and the necessary focus on the need to ensure that the redeveloped Roma Hospital will support the primary care model.

Table 4. Potentially Preventable Hospitalisations by Year – Reported in Roma Hospital

Condition	2015-16	2016-17	2017-18	2018-19	2019-20
Angina	12	8	11	14	8
Asthma	17	23	13	13	17
Bronchiectasis	2	2	3		
Congestive cardiac failure	28	16	16	14	14
COPD	48	35	24	27	32
Dental conditions		1	1		
Diabetes complications	160	211	197	188	150
Hypertension	4	4	3	4	1
Influenza and pneumonia vaccine-preventable			1	1	2
Iron deficiency anaemia	15	27	32	36	31
Nutritional deficiencies		2			1
Perforated / bleeding ulcer		1	4	1	3
Pneumonia (not vaccine-preventable)	1				1
Urinary tract infections, including pyelonephritis	17	27	24	36	31
Cellulitis	19	28	24	23	34

Condition	2015-16	2016-17	2017-18	2018-19	2019-20
Grand Total	**323**	**385**	**353**	**357**	**325**

Table 5. Potentially Preventable NWAUs (NWAU19) by Year – Reported in Roma Hospital

Condition	2015-16	2016-17	2017-18	2018-19
Angina	4.620	4.106	5.646	7.186
Asthma	3.586	6.872	3.884	3.884
Bronchiectasis	1.950	1.950	2.925	0.000
Cellulitis	7.878	18.382	15.756	15.100
Congestive cardiac failure	15.388	12.958	12.958	11.339
COPD	14.166	21.557	14.782	15.398
Dental conditions	0.000	0.676	0.676	0.000
Diabetes complications	41.926	163.820	152.951	144.410
Hypertension	0.740	0.986	0.740	0.986
Influenza and pneumonia	0.294	0.000	0.294	0.294
Iron deficiency anaemia	27.569	53.168	63.014	68.922
Nutritional deficiencies	0.000	3.938	0.000	0.000
Perforated / bleeding ulcer	0.000	1.484	5.938	1.484
Urinary tract infections	5.828	14.305	12.715	19.073
Grand Total	**123.943**	**304.203**	**292.279**	**288.076**

(note – 2019-20 NWAU data not yet available)

Other Influences

There are known influences which impacted on the Roma Hospital inpatient NWAU activity in 2019-20 and will continue in future financial years:

Future Activity

- A contractual arrangement with Mater Hospital in the provision of specific Gynaecological procedure will be managed through a new model. This reduces the inpatient NWAU for these procedures.
- Roma Hospital has reduced overnight admitting bed numbers to align with the new Roma Hospital redevelopment project. Roma Hospital reports 25 available overnight beds and 22 bed alternatives. The overnight admitting beds has reduced from 31 in 2016-17 (refer Table 6).
- New Roma Hospital reduces to 22 beds plus 2 bed alternatives (cots).

Table 6 – Roma Hospital Overnight Admitting Bed Numbers by Year

Roma Hospital	2015-16	2016-17	2017-18	2018-19	2019-20
Overnight Admitting Beds	31	31	25	25	25

Acuity

The Roma Hospital is a level three (3) hospital within the Clinical Services Capability Framework (CSCF). The Clinical Services Capability Framework defines the level of complexity for inpatient care a hospital is able to provide. A level three (3) service provides low to moderate risk inpatient and ambulatory care.

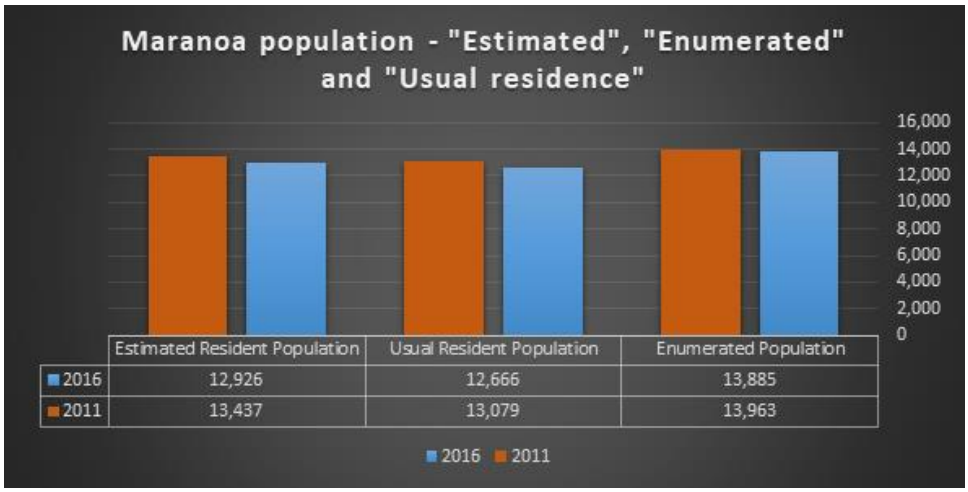
Service provision at Roma Hospital, must be within scope of the CSCF risk assessment level, which impacts on the level of acuity for inpatient care provided. There is no scope for changes in the models of care delivered at Roma Hospital to increase the level of complexity in care. Therefore, the limitations on providing complex care will continue to exist at Roma Hospital in future years. This will impact on the ability to increase NWAU performance levels.

As noted in Tables 1 and 2, overall acuity is decreasing.

Roma - Population and Economic Background

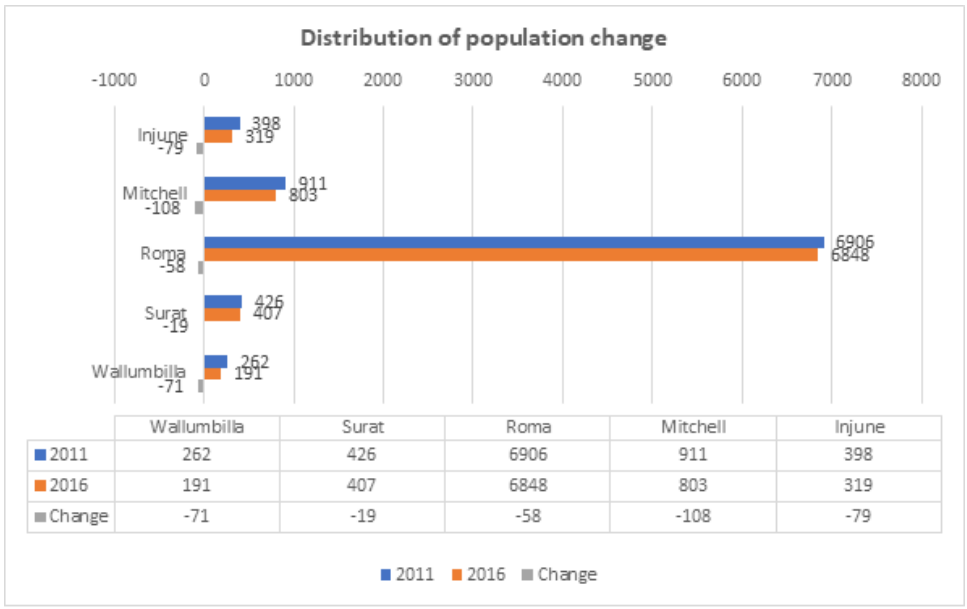
Roma's population characteristics and trends are fundamental to direction setting in an ABF model. The population for Roma between 2011 and 2016 census experienced a decline of 58 residents, reporting a -0.8 per cent decline (ref: Draft Economic and Community Development Plan, Maranoa Regional Council). The population has declined across the entire Maranoa region, impacting on the capacity to grow activity as a hub and spoke model at Roma Hospital.

Graph 1



	Estimated Resident Population	Usual Resident Population	Enumerated Population
2016	12,926	12,666	13,885
2011	13,437	13,079	13,963

Graph 2



	Wallumbilla	Surat	Roma	Mitchell	Injune
2011	262	426	6906	911	398
2016	191	407	6848	803	319
Change	-71	-19	-58	-108	-79

The economic foundations in the region include Agriculture, forestry and the gas industry. The impacting factors to population decline include the reduction in oil and gas activities in the region, along with the extended periods of drought.

The local economic climate in 2016-17, for the Maranoa (LGA) reported a loss of 44 businesses compared to 2014-15. There was a loss of businesses from the region in all employment size categories. This included a loss of 13 businesses that previously operated between 20 and 199 employees, which is significant impact to the economy in the region.

Roma experienced short burst of population increase that outpaced housing supply. There is a strong correlation between ‘Estimated Resident Population’ and Median House Prices as shown below:

Graph 3

Estimated Resident Population (Maranoa LGA) v Median House Prices (Roma SA2)

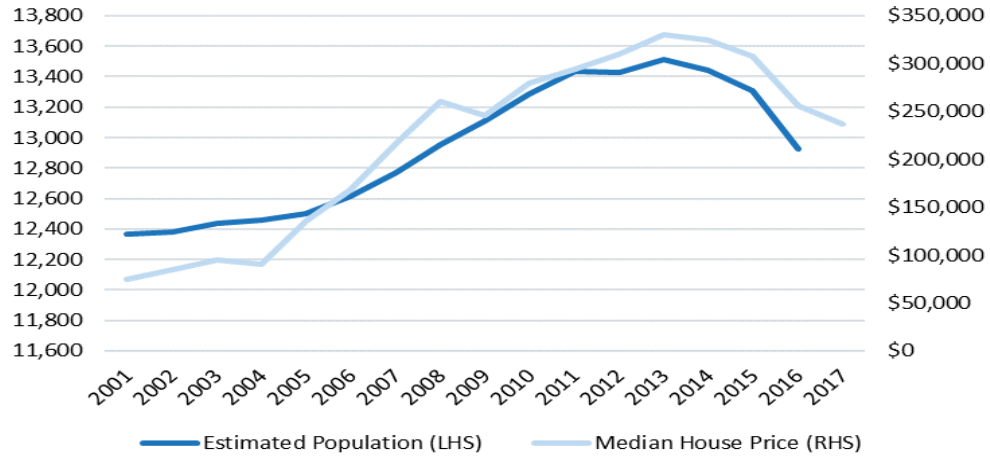


Figure 30

Note: Estimated resident population is to June 2016.

Source: ABS (2017c) & QGSO

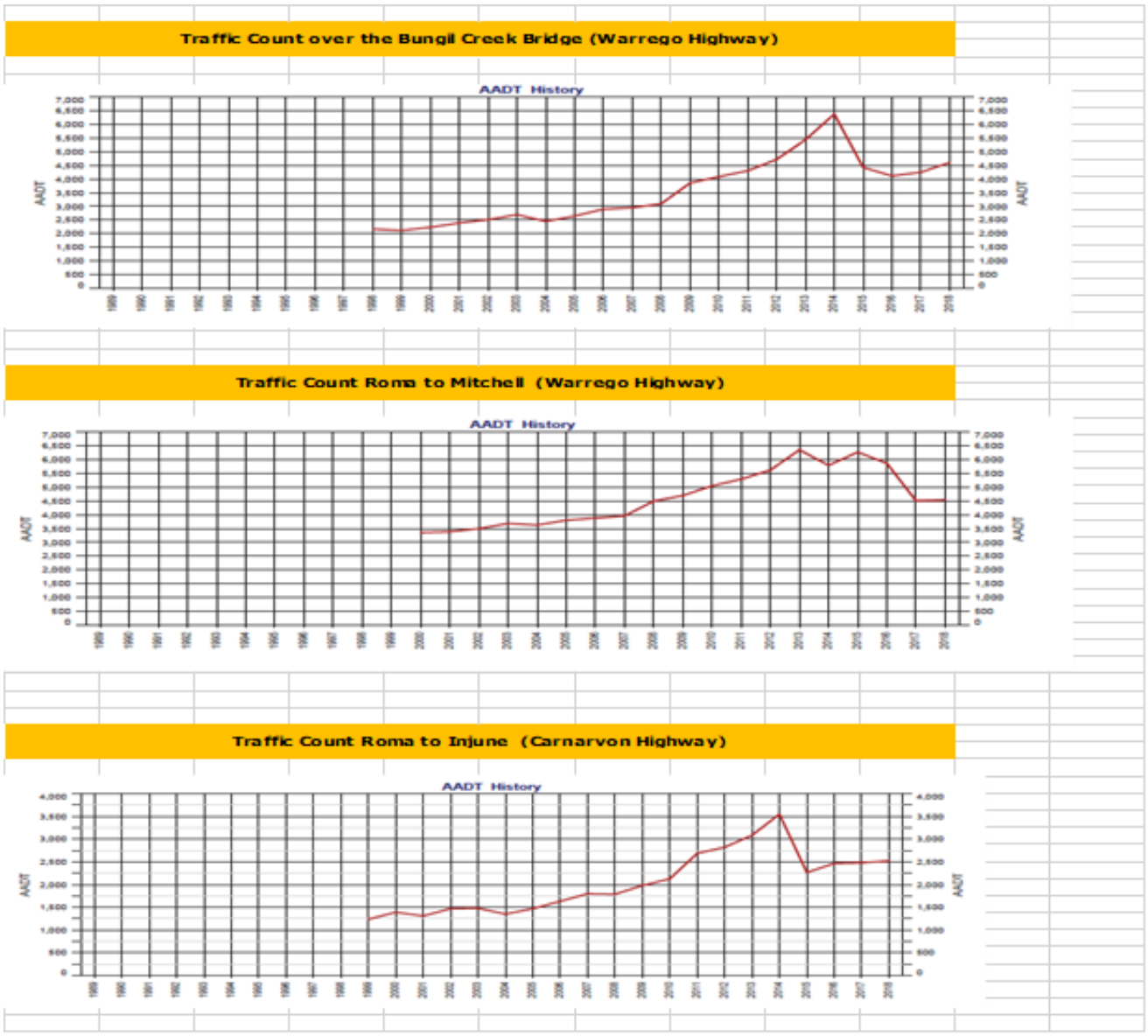
The annual number of house sales in Roma has declined steadily each year since 2004, except during a spike in 2012.

Roma - Traffic figures

Roma Annual Average Daily Traffic - (Please note this is a bidirectional count of traffic)

- Warrego Highway (Bungil Creek Bridge) has reported a decline of 3.06 per cent of traffic growth over the last 5 years.
- Warrego Highway (Roma to Mitchell) has reported a decline of 7.22 per cent of traffic grown over the last five years.
- Carnarvon Highway (Roma to Injune) has reported a decline of 3.56 per cent of traffic growth over the last five years.

Graph 4



References:

Maranoa Regional Council, 'Draft Economic and Community Development Plan – Background Data, 27 March 2019.

University of Queensland, 'Research Project: Cumulative socioeconomic impacts of CSG Development in Queensland', 11 May 2016.