



IHACPA

Pricing Framework for Australian Public Hospital Services 2023-24

Consultation Report

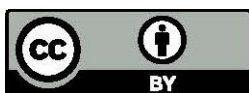
December 2022

Independent Health and Aged Care Pricing Authority

**Pricing Framework for Australian Public Hospital Services 2023-24 – Consultation Report
December 2022**

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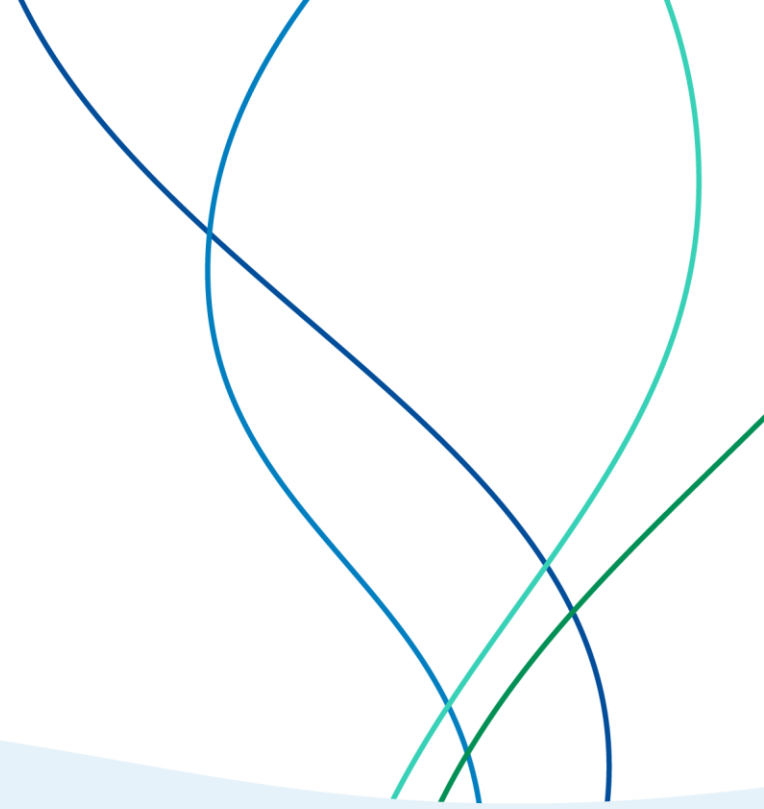
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1



Introduction

1. Introduction



1.1 About IHACPA

The Independent Hospital Pricing Authority (IHPA) was established under the *National Health Reform Act 2011* (NHR Act) to improve health outcomes for all Australians.

Its primary responsibility has been to enable the implementation of national activity based funding of public hospital services through the annual determination of the national efficient price (NEP) and national efficient cost (NEC). These determinations play a crucial role in calculating the Commonwealth funding contribution to Australian public hospital services and offer a benchmark for the efficient cost of providing those services as outlined in the National Health Reform Agreement.

On 12 August 2022 amendments to the NHR Act came into effect changing IHPA's name to the Independent Health and Aged Care Pricing Authority (IHACPA) and expanding its role to include the provision of aged care costing and pricing advice to the Commonwealth Government.

1.2 About this Consultation Report

The Pricing Framework for Australian Public Hospital Services (the Pricing Framework) is IHACPA's key policy document and underpins the approach adopted by IHACPA to determine the NEP and NEC for Australian public hospital services.

IHACPA conducted a public consultation on key issues to be included in the Pricing Framework 2023–24 through the [Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24](#) (the Consultation Paper).

The consultation period ran from 8 June 2022 to 8 July 2022 and invited submissions from the Commonwealth, state and territory health departments, professional health organisations, private health industry and other interested members of the Australian public.

IHACPA received 36 submissions to the Consultation Paper 2023–24 from a diverse range of stakeholders. Key themes arising from the consultation feedback are summarised in this report, corresponding with the chapters in the Pricing Framework 2023–24. This stakeholder feedback has informed the development of the Pricing Framework 2023–24, including the decisions that underpin the NEP and NEC Determinations for 2023–24.

IHACPA has included some of its own general feedback within this report and will respond to stakeholders directly where specific issues were highlighted relevant to that organisation. The key decisions for the NEP Determination 2023–24 and the NEC Determination 2023–24 are outlined in the Pricing Framework 2023–24.

All submissions have been made available on [IHACPA's website](#), unless they were marked confidential for commercial or other reasons.

IHACPA released the [Towards an Aged Care Pricing Framework Consultation Paper](#) in August 2022, noting the *Pricing Framework for Australian Aged Care Services 2023–24* will be published in early 2023. The feedback included in this Consultation Report relates to IHACPA's remit of pricing public hospital services only and a separate Consultation Report will be developed to reflect feedback received in response to the *Towards an Aged Care Pricing Framework Consultation Paper*.

2

Impact of COVID-19

2. Impact of COVID-19

? Consultation question

- Are there any specific considerations IHACPA should take into account for assessing COVID-19 impacts on the 2020–21 data in the development of NEP23?

Feedback received

Stakeholders were supportive of the Independent Health and Aged Care Pricing Authority's (IHACPA) proposed approach to assess the impact of coronavirus disease 2019 (COVID-19) on the 2020–21 activity and cost data in the development of the National Efficient Price (NEP) Determination 2023–24 (NEP23), and recommended the following areas for review:

- account for the differing impact of COVID-19 between states and territories
- consider inconsistent national reporting of COVID-19 costs and the potential limitations of relying on historical data
- investigate the assumptions developed for the NEP Determination 2022–23 (NEP22) and whether pre-COVID-19 national weighted activity units (NWAU) require adjustment
- consider cost increases in non-acute streams such as increased demand and waiting times for emergency department and non-admitted services
- balance how activity and cost data is 'normalised' to approximate the volume of services that would have been delivered without the impact of COVID-19.

Stakeholders recommended IHACPA incorporate the following impacts resulting from the COVID-19 pandemic response in the development of NEP23:

- changes to in-scope activity, volume and casemix such as reductions in elective surgeries and changing patterns in emergency department presentations
- changes to models of care including increased use and demand for telehealth and hospital-in-the-home services, increased patient complexity due to delayed care
- workforce impacts including increased patient and treatment complexity, additional staff training, workforce shortages and increased staffing costs
- ongoing COVID-19 related costs for example, to comply with COVID-19 safety requirements or establishing new models of care, and changes in hospital throughput.

Stakeholders noted the following potential longer term impacts of COVID-19 on the development of future NEP Determinations:

- increased patient complexity due to delayed care
- changes to admission and discharge practices, models of care and resourcing required to deliver care
- mental health impacts or impacts resulting from increased use of alcohol or other drugs
- workforce and staffing impacts, including planning for future pandemic preparedness
- impact of providing care and managing patients with long COVID, particularly in regional and remote communities
- account for the potential cessation of the *National Partnership on COVID-19 Response* from 1 January 2023.

IHACPA's response

Stakeholders provided valuable feedback about IHACPA's proposed approach for analysing 2020–21 data, including that a standardised pricing approach may not adequately reflect the varying impact of COVID-19 across states and territories. Considerations included different patterns of activity, timing of impacted periods, variations in reporting, different models of care impacting length of stay and different public health policies, vaccination strategies and initiatives.

IHACPA notes that some of these models of care, such as telehealth and hospital-in-the-home, are already priced under the existing national pricing model. The increased demand and any additional costs associated with delivering these services will continue to be evaluated to ensure that they are captured and priced appropriately.

To support the development of NEP23, IHACPA worked with the states and territories to understand how the *National Partnership on COVID-19 Response* funding was allocated in the NHCDC and how changes in activity levels, service delivery and models of care have impacted NHCDC reporting.

To inform the development of NEP23, IHACPA undertook extensive analysis of 2020–21 activity and cost data in consultation with the jurisdictions to understand the impact of COVID-19. IHACPA's analysis indicates that for the admitted acute stream, at a national level in 2020–21, activity returned to a level that is not significantly different from pre-COVID-19 trends. At the jurisdictional level, activity in Victoria in the admitted acute stream is below trend, with substantially higher costs in 2020–21 in comparison to historical trends. IHACPA's analysis also indicated that activity for all other streams in 2020–21 is consistent with pre-COVID-19 trends.

Additionally, IHACPA's analysis indicated that the cost of treating COVID-19 patients is substantially higher when compared to non-COVID-19 patients in the same Australian Refined Diagnosis Related Group (AR-DRG).

IHACPA is working with jurisdictions to develop pricing model refinements to account for the impact of the COVID-19 pandemic response and inform the development of NEP23. IHACPA is exploring refinements to account for jurisdiction-specific changes in activity compared to historical trends, the legitimate and unavoidable cost variations associated with treating patients for COVID-19, and the implications from the *National Partnership on COVID-19 Response* and associated funding arrangements.

IHACPA will also review the need for ongoing pricing model refinements to account for the impact of COVID-19 for future NEP Determinations.

Stakeholders also provided feedback on the potential longer term impacts of COVID-19. IHACPA will review updated activity and cost data as it becomes available in consultation with jurisdictions to determine how to best account for these impacts in the development of future NEP Determinations.

3

The Pricing Guidelines

3. The Pricing Guidelines



The Independent Health and Aged Care Pricing Authority (IHACPA) did not ask any specific consultation questions on the Pricing Guidelines but received feedback from a small number of stakeholders.

Feedback received

New South Wales recommended broadening the 'System Design Guidelines' to support refinement of the activity based funding model to promote a sustainable and integrated model.

Victoria (Vic) noted that there may be opportunity for the 'Overarching Guidelines' in the Pricing Guidelines to be consolidated. Vic also noted concerns that the funding mechanism proposed by IHACPA to achieve private patient neutrality may overstate the adjustments and result in modelled rates that are lower than the actual amounts.

The Northern Territory recommended inclusion of an additional 'System Design Guideline' to improve access to health care with the aim of improving health outcomes for populations with different care needs.

IHACPA's response

IHACPA considers that the current Pricing Guidelines adequately advocate for equitable access to health care and integration with other tiers of the health system within IHACPA's remit of pricing public hospital services.

IHACPA considers that amendments to the Pricing Guidelines are not required at this time. IHACPA will continue to review the Pricing Guidelines in 2023.

IHACPA will consider the feedback provided by Vic regarding private patient neutrality in determining whether refinements to the private patient neutrality methodology are required for the National Efficient Price Determination 2024–25.

4

Scope of public hospital services

4. Scope of public hospital services

The Independent Health and Aged Care Pricing Authority (IHACPA) did not ask any specific consultation questions on the scope of public hospital services but received feedback from a small number of stakeholders.

Feedback received

New South Wales recommended updating the process for considering services for inclusion on the General List of In-Scope Public Hospital Services (the General List) under the *General List of In-Scope Public Hospital Services Eligibility Policy* (the General List Policy) to allow for the consideration of ongoing or quarterly submissions, to ensure the process is more responsive to changes in models of care and service delivery.

Victoria (Vic) recommended that IHACPA review the scope of public hospital services to account for changes in models of care in response to coronavirus disease 2019 (COVID-19), such as increased use of telehealth, hospital-in-the-home and other home and community-based services. Vic noted that these services are often funded in the same way as an in-hospital episode, irrespective of differences in cost structures.

The Victorian Healthcare Association noted that urgent care centres are not currently funded under the National Health Reform Agreement (NHRA) as they are not considered an emergency department or a substitute for an emergency department presentation and recommended that IHACPA consider extending the scope of public hospital services to include urgent care centres.

IHACPA's response

IHACPA will consider accepting ongoing or quarterly submissions as part of its 2023 review of the General List Policy, noting the assessment of services for inclusion on the General List will still need to align with the annual national efficient price development cycle.

IHACPA notes that some of the models of care arising from COVID-19 are already priced under the existing national pricing model. IHACPA will continue to review and account for changes to models of care and the increased demand, and any additional costs associated with delivering these services on the basis of available data to ensure they are captured and priced appropriately.

IHACPA notes that urgent care centres are funded through activity based funding, where an urgent care centre meets the definition for an emergency service, and as part of the National Efficient Cost Determination reporting is not adequately robust, including for small rural hospital modelling.

5

Classifications used to describe and price public hospital services

5. Classifications used to describe and price public hospital services

5.1 Admitted acute care

Consultation question

- Are there any barriers or additional considerations to using AR-DRG Version 11.0 to price admitted acute services for NEP23?
- Do you support IHACPA's proposal to refocus some resources on projects that prepare for ICD-11 implementation? Please provide suggestions for any specific 'readiness' projects you would like to see progressed.

Feedback received

AR-DRG Version 11.0

Stakeholders supported the refinements introduced for the Australian Refined Diagnosis Related Groups (AR-DRG) Version 11.0 and did not identify any barriers to using AR-DRG Version 11.0 to price admitted acute services for the National Efficient Price (NEP) Determination 2023–24 (NEP23).

The Northern Territory (NT) recommended that the Statement of Impact outline impacts at a jurisdictional level to enable anticipation and planning for potential funding impacts for 2023–24, given there will not be a shadow pricing period.

Stakeholders provided the following recommendations for refinements to the AR-DRGs:

- improve differentiation between end-classes of involuntary and voluntary consumers within Major Diagnosis Category 20 to reflect resourcing, length of stay and complexity

- review pricing for neonates admitted to specialist children's hospitals to better reflect the costs of providing sub-specialty care to newborns
- review Adjacent Diagnosis Related Group O66 Antenatal admissions based on diagnosis to provide greater consistency in reporting and subsequent pricing.

ICD-11 preparedness

Stakeholders supported refocusing resources to prepare for the implementation of the [11th Revision of the International Classification of Diseases \(ICD-11\)](#) and recommended the following projects:

- prioritise a gap analysis and developing mapping between ICD-11 and the International Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)
- a staged implementation approach including cost-benefit analysis, international examples of implementation and interactions with the Australian Classification of Health Interventions (ACHI)
- consider the impact on and opportunities for classification refinement for other patient service categories
- establish pilot sites to identify system capability and coding structure changes, including for maternity and paediatric sites
- investigate potential workforce shortfalls and develop education resources.

IHACPA's response

AR-DRG Version 11.0

The Independent Health and Aged Care Pricing Authority (IHACPA) notes the request from the NT for the provision of a Statement of Impact for introducing AR-DRG Version 11.0. A Statement of Impact has been provided to IHACPA's Technical Advisory Committee and Jurisdictional Advisory Committee for review prior to consultation with the Health Ministers' Meetings. Where requested, IHACPA has also provided states and territories with specific data to enable them to analyse and assess the impact of AR-DRG Version 11.0.

IHACPA notes that several proposed refinements to AR-DRGs are already captured with the update to Version 11.0.

IHACPA will assess the feasibility of incorporating other proposed refinements to future AR-DRG versions as part of its work program for the admitted care classifications development cycle.

ICD-11 preparedness

IHACPA notes broad stakeholder support to prepare for ICD-11 implementation. IHACPA will work with its advisory committees and classification working groups to identify gaps and assess potential impacts within the work program of projects to inform and support decisions on the implementation of ICD-11.

IHACPA notes it does not intend to introduce ICD-11 for NEP23.

5.2 Subacute and non-acute care

? Consultation question

- Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP23?

Feedback received

New South Wales (NSW), Victoria (Vic), Queensland and the NT recommended IHACPA undertake a two-year shadow period for the Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 5.0 in line with clause A42 of the Addendum to the National Health Reform Agreement 2020–25 (the Addendum), to assess the funding impacts and address any issues prior to implementation.

Vic, South Australia (SA), Western Australia (WA), Tasmania (Tas), the Australian Medical Association, the Royal Australasian College of Physicians (RACP), Services for Australian Rural and Remote Allied Health, the Victorian Healthcare Association and Women's and Children's Healthcare Australasia did not identify any barriers to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP23.

NSW, SA and Tas supported the introduction of a frailty measure for geriatric evaluation and management and non-acute episodes of care.

NSW requested the provision of a Statement of Impact to outline findings from the NEP Determination 2022–23 (NEP22) shadow pricing period and the impact of pricing AN-SNAP Version 5.0 for NEP23.

IHACPA's response

AN-SNAP Version 5.0 has been developed through statistical analysis and consultation with jurisdictions, clinicians and classification experts and represents a modest refinement of AN-SNAP.

The Addendum to the National Health Reform Agreement 2020–25 requires the completion of a two year shadow pricing period, unless agreed by the Commonwealth and a majority of states and territories.

A majority of jurisdictions requested that IHACPA undertake the full two-year shadow pricing period for the change.

IHACPA notes stakeholder feedback that additional time is required to assess the impact of coronavirus disease 2019 (COVID-19) on subacute activity and to assess potential variations in reporting of the updated classification across states and territories.

Following a review jurisdictional feedback, for NEP23, IHACPA will price admitted subacute and non-acute services using AN-SNAP Version 4.0 and will shadow price admitted subacute and non-acute services using AN-SNAP Version 5.0 for a second year.

5.3 Emergency care

IHACPA did not ask any specific consultation questions on emergency care but received feedback from a small number of stakeholders.

Feedback received

Australian Emergency Care Classification

NSW recommended IHACPA review the mappings between Systematized Nomenclature of Medicine Clinical Terms and ICD-10-AM codes. NSW supported in-principle the collection of new variables and noted the need for adequate jurisdictional engagement and lead time to commence collection of procedure codes.

WA noted work could be progressed on the Emergency Department Principal Diagnosis Short List, both in terms of the grouping of diagnoses into the short list and the potential to incorporate more than a single diagnosis.

The Australasian College of Emergency Medicine recommended that IHACPA consider tracking and mapping 'diagnostic modifiers' as drivers of investigation costs to more accurately reflect patient complexity within the Australian Emergency Care Classification (AECC).

Pricing emergency services

SA noted its support for the continuation of the Urgency Disposition Groups due to the need to transition some smaller rural hospitals to electronic medical records systems.

IHACPA's response

IHACPA is currently investigating emergency care interventions as a potential variable for future refinements of the AECC and will assess the feasibility of incorporating these proposed refinements based on impact analysis and in consultation with jurisdictions and health stakeholders.

IHACPA also continually refines the emergency department Principal Diagnosis Short List and associated mappings in consultation with stakeholders as part of the standard work program.

As part of this process, IHACPA will undertake thorough impact analysis and consultation with jurisdictions and health stakeholders.

5.4 Non-admitted care

IHACPA did not ask any specific consultation questions on non-admitted care but received feedback from a small number of stakeholders.

Feedback received

Tier 2 Non-Admitted Services Classification

Stakeholders provided feedback on the following proposed refinements to the Tier 2 Non-Admitted Services Classification:

- clarification of how long COVID-19 activity will be reflected
- the inclusion of a new class for genetic counselling consultations
- the inclusion of a new class for exercise physiology.

Stakeholders also provided the following recommendations for additional refinements to the Tier 2 Non-Admitted Services Classification:

- ensure cost drivers of virtual care are adequately reflected in the classification's clinics
- investigation of a code to identify Aboriginal Liaison Officer Health Workers
- refinement of the 40.39 Neurology and 40.48 Haematology and immunology clinics.

A new non-admitted care classification

Stakeholders supported IHACPA's recommencement of the non-admitted costing study, pending jurisdictional capacity, and recommended the following areas for consideration:

- increased expense and frequency of home visits
- accurate capture of costs of low volume, resource intensive services such as addiction medicine and alcohol and drug use intensive services
- inclusion of home delivered ventilation and genetic and genomic services
- potential issues with coding and mapping non-admitted services in electronic medical record systems and national variability in admitted settings.

IHACPA's response

Tier 2 Non-Admitted Services Classification

IHACPA notes support from stakeholders for the proposed refinements to the Tier 2 Non-Admitted Services Classification.

IHACPA intends to introduce four new classes for '20.58 Long COVID', '40.65 Violence, Abuse, and Neglect Services', '40.66 Genetic Counselling', and '40.67 Long COVID' to better account for the activity being reported against existing Tier 2 classes and to collect applicable activity and cost data to inform price weight refinement. The addition of these classes have been incorporated as part of the update to the Tier 2 Non-Admitted Services Classification Version 8.0.

For NEP23, IHACPA will use the Tier 2 Non-Admitted Services Classification Version 8.0 to price non-admitted services.

In its analysis of activity and cost data for future Determinations, IHACPA will consider whether the additional refinements recommended by stakeholders to the Tier 2 Non-Admitted Services Classification are required while a new non-admitted care classification is being developed.

A new non-admitted care classification

IHACPA is committed to developing a new non-admitted care classification and working with jurisdictions and its advisory committees and working groups on the program of work to recommence the non-admitted care costing study including assessing data limitations using electronic medical records systems, ethical and privacy considerations related to electronic medical records data and the impact of COVID-19 on service delivery and models of care.

5.5. Mental health care

? Consultation question

- Are there any barriers or additional considerations to using AMHCC Version 1.0 to price community mental health care for NEP23?

Feedback received

Community mental health care

Stakeholders recommended that community mental health care be shadow priced for NEP23 using the Australian Mental Health Care Classification (AMHCC) Version 1.0, noting the following concerns:

- additional time is required to address gaps in data collections, improve data quality and review model stability
- limitations of ABF in capturing community episodes, the potential to underfund services, and model limitations for episodes with de-identified clients, triage only or secondary support services
- lack of acknowledgement of the involvement of families, carers and supporters
- the need for education, change management and system changes or processes to support implementation.

A number of stakeholders supported using AMHCC Version 1.0 to price community mental health care for NEP23, noting it will provide a more accurate view of actual funding requirements, enable centres requiring higher funding levels to receive adequate funding and incentivise more direct consumer care activities through the new pricing model structure.

Refinements to the Australian Mental Health Care Classification

Stakeholders recommended the following refinements to the AMHCC:

- review the AMHCC grouper to remove age restrictions in Health of the Nation Outcome Scales (HoNOS) selection
- consider an AMHCC admitted class for electroconvulsive therapy noting the difference in cost drivers and resourcing required for this activity

- consider reviewing the indicator for patients treated on an involuntary basis to recognise resourcing requirements for consumers with persistent mental health disorders
- consider different types of community mental health care such as nurse-led models of care or the Mental Health Co-Response program
- inclusion of a new intervention code for consultation-liaison psychiatry within the updated ACHI.

IHACPA's response

Community mental health care

IHACPA acknowledges the concerns raised by states and territories regarding progression to pricing for community mental health care using the AMHCC Version 1.0, however notes that volume and coverage of community mental health data has improved substantially and stabilised since initial data collections.

IHACPA notes the Mental Health Phase of Care (MHPoC) facilitates engagement with consumers, families and carers. IHACPA has developed MHPoC education materials in consultation with jurisdictions, clinicians, consumer and carer representatives to guide consistent application of the MHPoC. These education materials will be released in late 2022.

IHACPA notes that volume and coverage of community mental health data has improved substantially since the introduction of the AMHCC. However, stakeholders provided feedback that additional time was required to improve the quality and quantity of activity and cost data for community mental health care, and to analyse the impact of the pricing model structure prior to progressing to pricing.

IHACPA's analysis of the available activity and cost data indicates that although data collections and model performance show improvements, an additional year of shadow pricing community mental health care using AMHCC Version 1.0 will enable better understanding of the impact of transitioning from block funding to ABF for community mental health care. The additional year of shadow pricing will also facilitate the further development of arrangements to support this transition and enable stable funding flow within the states and territories.

For 2023–24, IHACPA will continue to block-fund community mental health care under the NEC Determination 2023–24 (NEC23) while undertaking an additional year of shadow pricing using AMHCC Version 1.0.

IHACPA intends to progress to pricing community mental health services using AMHCC Version 1.0 for the NEP Determination 2024–25 (NEP24).

IHACPA notes that progression to pricing community mental health care using AMHCC Version 1.0 for NEP24 will continue to incentivise improvements in the volume and coverage of community mental health data and provide greater funding transparency.

Refinements to the Australian Mental Health Care Classification

As a result of improvements to the data, IHACPA plans to introduce refinements to both HoNOS and Life Skills Profile weights and thresholds as part of AMHCC Version 1.1, which will improve the performance of the classification without major structural change. Minor improvements to the grouper will also be considered as part of this refinement.

Following this, IHACPA will consider more substantial refinements to the classification, including the proposal for a class for electroconvulsive therapy, extending the AMHCC legal status to all age groups in the admitted setting and intervention codes. IHACPA will assess the feasibility of incorporating these proposed refinements as part of its classification development work program for the AMHCC.

IHACPA notes Mental Health Co-Response programs were included on the General List of In-Scope Public Hospital Services for NEP22. IHACPA also notes that consultation-liaison psychiatry was included in ACHI Twelfth Edition, released earlier in 2022.

5.6. Teaching and training

IHACPA did not ask any specific consultation questions on teaching and training but received feedback from several stakeholders.

Feedback received

Stakeholders supported the continued use of block funding for teaching, training and research (TTR).

NSW requested IHACPA provide an approximate timeline for progressing to pricing TTR using the Australian Teaching and Training Classification (ATTC) and clarification on collection of the 'research' component of the National Best Endeavours Data Set for 2023–24 and the nature of the work to be undertaken with stakeholders to improve data quality.

RACP noted the TTR activities in hospitals were disrupted due to COVID-19 and noted the shift in how TTR activities are conducted in the future such as online.

IHACPA's response

IHACPA notes that limited progress has been made towards pricing using the ATTC due to the small amount of data available. IHACPA will continue to investigate alternatives with jurisdictions until the ATTC can be implemented and priced.

For the NEC23, IHACPA will continue to determine block-funding amounts for TTR activity based on advice from states and territories.

IHACPA notes that the collection of the Hospital teaching, training and research activities NBEDS for 2023–24 is specified in the Three Year Data Plan 2022–23 to 2024–25. However, as defined in the Metadata Online Registry, the metadata item for the public hospital service research activities cluster is conditional, meaning that the data elements in this cluster are only required to be reported for establishments able to collect data on research activities.

6

Setting the national efficient price

6. Setting the national efficient price

6.1 Adjustments to the national efficient price

Consultation question

- Are there any adjustments IHACPA should prioritise investigating to inform the development of NEP23?

Feedback received

Patient transport costs

Stakeholders supported the Independent Health and Aged Care Pricing Authority's (IHACPA) proposed investigation of an adjustment for patient transport in rural and remote areas and provided the following considerations:

- the current patient residential and treatment remoteness area adjustments may not accurately reflect all costs associated with patient transport
- changes in demographics and increased demand for services resulting from internal migration to rural areas during the COVID-19 pandemic
- the impact of jurisdictional protocols on the number of patient transfers and transport requirements due to the coronavirus disease 2019 (COVID-19) pandemic
- costs of patient escorts and consideration of inclusion of non-admitted patients for allied health and dental care.

The Northern Territory (NT) requested prioritisation of the investigation into patient transport costs to support equity in health care access and service delivery, as it did not consider that patient transport costs are appropriately accounted for through the national pricing model.

Specified Intensive Care Unit eligibility criteria and adjustment

States and territories provided feedback that the current Specified Intensive Care Unit (ICU) eligibility criteria may preclude smaller facilities delivering ICU services from being adequately funded if they fall below the threshold. States and territories reported that this may hinder innovative models of care and constrain the ability of states and territories to respond flexibly to surges in presentation. States and territories also noted the eligibility criteria should take into account other high-cost treatments provided in the ICU.

States and territories recommended consideration of the following options:

- a tiered ICU adjustment to reflect cost differences between larger and smaller health services
- application of a loading to all hospitals delivering ICU services, reflective of the cost of service
- review or removal of the reliance on mechanical ventilation hours to update the criteria for recognising ICU status.

Criteria for assessing specialised children's hospitals

A number of stakeholders supported a review of the criteria for specialised children's hospitals, noting the adjustment could incorporate a sliding scale model dependent on patient age as opposed to the current model which is determined at the site level.

Women's and Children's Healthcare Australasia (WCHA) recommended IHACPA consider application of the paediatric adjustment to the specialised children's hospitals to emergency department patients, due to a significant reduction of national activity weighted units (NWAU) when emergency department activity was reported against the Australian Emergency Care Classification (AECC) compared to Urgency Disposition Groups. WCHA also recommended reviewing the application of the paediatric adjustment to admitted mental health care, as the current loading may not adequately reflect patient complexity.

Genetic services

A number of stakeholders expressed support for the investigation of an adjustment for genetic services, noting the need for improvements in data collection accuracy and consistency to capture variations in patient demand and types of genetic testing, including the use of expensive highly specialised pathology. Stakeholders also noted the significant time and resources required for genetic consultations, including pre-clinic and post-clinic work and the contribution of genetic counsellors, which is currently not adequately reflected in funding.

Socioeconomic status

Stakeholders supported investigation of an adjustment for socioeconomic status, noting the need to capture social determinants in health data and the potential influence of socioeconomic status on the costs of service delivery including inpatient lengths of stay.

The NT recommended investigation into the applicability of existing area-based measures to assess the influence of socioeconomic status on health care costs, separate to other cost factors.

Indigenous adjustment

Stakeholders noted that the Indigenous adjustment should account for geographical, socioeconomic and cultural barriers to accessing care, potentially longer consultation times and higher rates of premature discharge or patients leaving against medical advice.

Feedback indicated the following potential considerations for IHACPA's review of the Indigenous adjustment:

- investigation of incorporating an Indigenous population density factor
- investigation of an incentive-based adjustment to improve accessibility
- consideration of a loading to incentivise activity provided by Aboriginal Community Controlled Health Organisations and the use of Aboriginal Liaison Officers
- reviewing whether the pricing model adequately reflects the complexity and multidisciplinary needs and time for treating Indigenous patients.

Other proposed adjustments

Stakeholders proposed the following additional adjustments and areas for consideration:

- adjustment to account for patients with increased complexity and longer length of stay such as elderly patients, patients with comorbidities, National Disability Insurance Scheme (NDIS) patients or dementia patients
- pricing for virtual care and cost variations between virtual care and face-to-face care models
- increased costs associated with mental health Mother and Baby Units
- adjustment for facilities without adolescent mental health beds given the higher costs of treating an adolescent in these facilities
- adoption of a percentile-based approach to setting Diagnosis Related Group (DRG) length of stay inlier bounds.

The Society of Hospital Pharmacists of Australia recommended IHACPA consider the outcomes and impacts on drug pricing and hospital pharmacy input arising from several Commonwealth reviews and new clinical care standards.

IHACPA's response

Patient transport costs

IHACPA has reinvestigated the need for an additional adjustment for patient transport costs in rural and remote areas, including aeromedical ambulances and inter-hospital transfers.

IHACPA notes that although patient travel costs are highest for patients in rural and remote areas, the existing patient residential and treatment remoteness adjustments are intended to account for the legitimate and unavoidable cost variations in rural and remote areas.

Following a review of stakeholder feedback and the available data, IHACPA has determined that an additional adjustment for patient transport costs in rural and remote areas is not required. IHACPA also notes that its remit is limited to pricing public hospital services and does not extend to transport for allied health or dental care.

IHACPA has included updates to the Australian Hospital Patient Costing Standards (AHPCS) Version 4.2 to assist in improving data quality related to patient transport costs. AHPCS Version 4.2 is due to be released in mid-2023.

Refinement of existing adjustments and development of new adjustments

IHACPA notes stakeholder support for reviewing the specified ICU adjustment, investigating the need for new adjustments for genetic services and socioeconomic status, reviewing the Indigenous adjustment and exploring other proposed adjustments.

Instability was introduced into activity and cost data during 2019–20, 2020–21 and 2021–22 due to COVID-19. The development and review of adjustments to address specific areas in the national pricing model needs to be supported by stable data over multiple years to ensure the proposed area requiring an adjustment is sustained over time. Stable data is also required to inform the application of the adjustment, for example whether a single national adjustment is required or whether the adjustment should be applied to specific end-classes or target specific groups.

For NEP23, IHACPA has deferred further consideration of these adjustments to prioritise national pricing model refinements to account for COVID-19 impacts. IHACPA will further consider these adjustments for future NEP Determinations based on the availability of stable data.

IHACPA intends to work with its advisory committees to undertake a program of work to investigate and implement these proposed refinements, to inform future NEP Determinations.

Genetic services

IHACPA notes stakeholder support for an adjustment for genetic services and will work with jurisdictions and key stakeholders to undertake further investigation, noting the need for improved data reporting and capture as prices for genetics services are set using the cost and activity data submitted by the states and territories.

Socioeconomic status

IHACPA notes stakeholder support for an adjustment for socioeconomic status and acknowledges the potential difficulties of capturing socioeconomic status using area indicators as they may not adequately account for patient level disadvantages and impacts.

IHACPA will consider the feedback received from stakeholders and undertake further work to investigate whether an adjustment for socioeconomic status is feasible, or whether refinements are needed to the existing residential and treatment adjustments.

As part of this work, IHACPA will also consider undertaking longitudinal analysis of cost and hospital utilisation patterns for patients with chronic conditions to compare socioeconomically disadvantaged and non-disadvantaged patients.

Indigenous adjustment

IHACPA acknowledges the variance in health care access experienced by Aboriginal and Torres Strait Islander patients, which needs to be appropriately adjusted for to incentivise provision of best care and promote funding equity. IHACPA also notes that difficulties may arise from under-reporting of Indigenous status within health service patient level records and data sets.

IHACPA notes stakeholder support for review of the Indigenous adjustment and will work with jurisdictions and key stakeholders to further investigate this adjustment.

Other proposed adjustments

IHACPA notes that the potential introduction of a NDIS data item was previously discussed by the National Health Data and Information Standards Committee but not progressed as it was not supported by the majority of jurisdictions.

IHACPA considers the loadings applied in the paediatric adjustment sufficiently reflect variation in costs of delivering paediatric services and services in specialised children's hospitals for mental health patients. IHACPA may consider refinements to the adjustment for future NEP Determinations following a period of data stabilisation.

IHACPA will monitor the outcomes of the Commonwealth reviews along with any other changes to drug pricing or clinical standards and assess their impact on the national pricing model.

6.2. Cost pressures

Consultation question

- What cost input pressures that may have an impact on the national pricing model and are not included in the NHCDC should be considered in the development of NEP23?

Feedback received

Stakeholders noted the following cost pressures that are likely to impact the national pricing model and may not be included in the National Hospital Cost Data Collection (NHCDC):

- further increases in the superannuation guarantee, and indemnity and insurance premium
- workforce shortages, wage increases, award wages and retention incentives
- increased infrastructure, commodity and utility prices due to inflation and supply chain disruption
- increased responsibilities from legislative changes relating to work, health and safety and digital security.

New South Wales (NSW) recommended IHACPA consider undertaking analysis of the impact of the Strategic Agreement between the Commonwealth and the Generic and Biosimilar Medicines Association and Medicine Australia on pharmaceutical costs in public hospitals.

IHACPA's response

IHACPA notes the reported cost pressures associated with enterprise agreements, staffing, supply chain disruption and legislative changes.

IHACPA notes that ongoing costs associated with staffing are captured in the NHCDC and therefore reflected in the reference cost for NEP23. IHACPA also accounts for the superannuation guarantee and the effect of inflation through the indexation methodology and the incorporation of year-on-year cost growth amounts within the broader national pricing model methodology.

Costs associated with system management of public hospitals including planning, funding and delivering capital and managing industrial relations are the responsibility of states and territories and

not in-scope under the National Health Reform Agreement (NHRA).

In response to the feedback provided by NSW, IHACPA notes the Commonwealth Department of Health and Aged Care is leading a range of reviews relating to medicines pricing and pharmaceutical reform agreements, to be finalised in 2022. IHACPA will monitor the outcomes of these reviews along with any other changes to pharmaceutical pricing or clinical standards and assess their impact on the national pricing model.

IHACPA will work with jurisdictions to review the indexation methodology for future NEP Determinations.

6.3. Refinements to the national pricing model

Consultation question

- Which initiatives to refine the national pricing model should IHACPA prioritise investigating?
- What additional data sources are available to support refinement of the national pricing model in relation to adjustments, price harmonisation, unqualified newborns, private patients or organ donation?

Feedback received

Harmonising price weights across care settings

States, territories and broader stakeholders supported work to harmonise price weights across care settings as a priority and provided the following considerations:

- review of the impact of COVID-19 on activity and cost data, including the increased use of telehealth
- transitional arrangements and price stabilisation requirements
- price differences for disciplines which are remunerated at a higher price may incentivise prioritisation of those procedures over procedures with lower remuneration
- consideration of unintended consequences on future models of care.

Queensland (Qld) noted concerns around price harmonisation for haemodialysis and chemotherapy due to variations in patient pathways and resourcing between the admitted and non-admitted settings and recommended consideration of classification development or innovative funding models instead.

Victoria (Vic) recommended IHACPA consider other factors that explain variance in the price and cost structure between admitted and non-admitted activity, including different models and prioritisation of care, and utilisation of ancillary support services.

Unqualified newborns

States, territories and broader stakeholders supported IHACPA undertaking further investigation of funding arrangements for unqualified newborns, noting that the separation of newborns from mothers does not reflect contemporary best practice. Stakeholders noted that the current bundling of unqualified newborns within the maternal DRG does not adequately reflect the cost of care, which could drive adverse resource allocation. Stakeholders also noted the inclusion of stillbirths as unqualified newborns makes it difficult to quantify the number of stillbirth autopsies undertaken in public hospitals.

The following recommendations were provided to inform methodology changes:

- review the definition and criteria for newborn qualification including assessment for family based services
- record all newborns as admitted patients with a separate but linked record to the maternal record, with allocation of a separate adjustment per DRG
- clarify whether unqualified days are excluded from DRG development
- undertake a Mother Baby Unit costing study.

Stakeholders noted that activity and cost data for mothers and unqualified newborns was already collected separately or could be disaggregated in some health services.

Setting the national efficient price for private patients in public hospitals

Stakeholders provided the following feedback on the private patient neutrality methodology implemented by IHACPA:

- the current approach may incentivise the growth of public NWAU over private NWAU

- implementation of the adjustment may be more appropriately handled by the National Health Funding Body
- due to limitations and inconsistencies in data collections, the impact of back-casting and accounting methods, modelled estimates of funding reductions may be misaligned with the policy intent of the NHRA.

NSW and Tasmania did not support phasing out the private patient correction factor for NEP23 noting some episodes receive zero NWAU despite costs being incurred, which may disincentivise treatment of private patients.

Qld noted it had no concerns with phasing out the private patient correction factor.

Organ donation, retrieval and transplantation

States, territories and broader stakeholders supported the proposed investigation of costs associated with organ donation, retrieval and transplantation services, noting current cost data collections do not accurately reflect all costs incurred. Stakeholders noted that changes to the National minimum data set (NMDS) requirements may be necessary prior to undertaking a costing study.

Stakeholders noted additional data sources to inform refinements of the national pricing model, including transplant units within health services, jurisdictional health departments and DonateLife organisations, LifeBlood, and the Organ and Tissue Authority. Qld noted it already supplies activity data for organ donation episodes.

NSW recommended prioritisation of the non-admitted costing study over a costing study for organ donation, noting that transplantation services care could be incorporated in the non-admitted costing study.

Vic noted that a costing study and classification review for all aspects of organ donation, retrieval and transplantation should be prioritised and occur simultaneously with the transitioning of the Nationally Funded Centres to activity based funding.

Other proposed refinements

Stakeholders recommended IHACPA consider refinements to the national pricing model in the following areas:

- pricing and classification of virtual care to reflect resources utilisation
- the integration of disability services within health services
- the impact of bed block from bed shortages in residential aged care, NDIS assessment delays

and ambulance ramping on length of stay and costs

- reviewing the setting of DRG relativities to improve and incentivise efficiency in hospitals.

IHACPA's response

Harmonising price weights across care settings

IHACPA has deferred consideration of price harmonisation for NEP23 in order to prioritise national pricing model refinements to account for the impact of COVID-19.

IHACPA acknowledges the importance of progressing refinements to the national pricing model. IHACPA intends to work with its advisory committees to develop a proposed approach and timeframes for progressing price harmonisation, noting further consultation with states and territories is required to undertake analysis on the stability of the underlying data, the suitability of services for harmonisation and the potential unintended consequences of pursuing price harmonisation for future Determinations.

Unqualified newborns

IHACPA notes stakeholder support to investigate funding arrangements for unqualified newborns. IHACPA will work with its advisory committees to review the funding methodology of unqualified newborns for future NEP Determinations, noting available cost data is limited and changes may be required to jurisdictional costing practices to support refinements to the methodology.

IHACPA notes that the Consultation Paper stated that the criteria for determining qualification status which is set out in legislation would be considered out of scope for this review. IHACPA will consult further with the Commonwealth Department of Health and Aged Care regarding the feasibility of legislative changes related to the qualification status of newborns.

Setting the national efficient price for private patients in public hospitals

IHACPA will continue to implement the private patient neutrality methodology for NEP23 and future NEP Determinations. IHACPA will consider reviewing the methodology on the basis of alternative, evidence-based methodologies being proposed by the states and territories.

IHACPA will continue to work with the remaining states and territories to phase out the private patient correction factor for future NEP Determinations.

Organ donation, retrieval and transplantation

IHACPA notes stakeholder support to investigate costs associated with organ donation, retrieval and transplantation services and that changes to the Admitted patient care NMDS may be required.

IHACPA will review available activity and cost data and develop a project plan to investigate the feasibility of progressing this work in consultation with advisory committees, pending jurisdictional capacity. IHACPA will also work with its advisory committees, the Commonwealth and the Australian Institute of Health and Welfare to progress the development of the Posthumous organ procurement national best endeavours data set.

IHACPA notes improvement in data collection and reporting is essential to informing future refinements to classification systems and the national pricing model.

Other proposed refinements

IHACPA notes stakeholder support for additional areas of refinement to the national pricing model. IHACPA will consider this feedback and jurisdictional capacity in determining whether these proposed refinements will be investigated for future NEP Determinations.

7

Setting the national efficient cost

7. Setting the national efficient cost

7.1 Cost pressure for regional hospitals

? Consultation question

- What cost pressures for regional or remote hospitals should be considered in the development of NEC23?

Feedback received

Stakeholders noted the following cost pressures for regional or remote hospitals for consideration in the development of the National Efficient Cost (NEC) Determination 2023–24 (NEC23):

- rural-specific contracts and enterprise agreements
- costs associated with rural workforce shortages, including locum and contract staff, recruitment and retention costs, absences due to coronavirus disease 2019 (COVID-19), fly-in fly-out arrangements and accommodation
- regional and remote specific costs, including patient transport costs, cost of living and high cost of specialised services and medications due to limited access
- lack of access to primary care and higher incidence of chronic conditions, which may impact rates of adverse safety and quality events.

IHACPA's response

The Independent Health and Aged Care Pricing Authority (IHACPA) notes the cost pressures affecting regional and remote hospitals such as workforce shortages, high labour costs and high costs for transport and specialised services.

IHACPA has reviewed the available activity and cost data and considers the existing patient residential and patient treatment remoteness adjustments in the national efficient price (NEP) and the additional loading applied to the NEC for 'very remote' hospitals adequately account for additional cost pressures within IHACPA's remit of pricing public hospital services.

7.2 Standalone hospitals providing specialist mental health services

? Consultation question

- What should IHACPA consider when transitioning standalone hospitals providing specialist mental health services to ABF?

Feedback received

New South Wales (NSW), Victoria, Queensland (Qld), Western Australia (WA) and Tasmania did not support transitioning standalone hospitals providing specialist mental health services from block funding to activity based funding (ABF) for the NEP Determination 2023–24 (NEP23), noting there are significant differences in patient profiles, service models, length of stay and resource utilisation that are not adequately accounted for in the Australian Mental Health Care Classification (AMHCC).

Stakeholders noted that additional time may be required to assess the stability of the AMHCC model and improve data integrity. Stakeholders recommended consideration of the capacity of standalone hospitals to meet reporting requirements to ensure consistent and accurate data collection and mitigate potential unintended consequences. Stakeholders also noted the need to consider remoteness and population size of standalone hospitals, ongoing funding for long-term patients, and the role of families and carers.

IHACPA's response

IHACPA notes stakeholder concerns that the current AMHCC model may not adequately capture costs as some standalone hospitals report limited or incomplete activity and cost data.

IHACPA will continue to block fund standalone hospitals providing specialist mental health services for NEC23 and will work with jurisdictions to investigate the feasibility of transitioning block-funded standalone hospitals to ABF for future Determinations.

7.3 Quality assurance of public health expenditure data



Consultation question

- What specific areas of the Local Hospital Networks and Public hospital establishments national minimum data set would you recommend IHACPA focus on when developing its independent quality assurance process?

Feedback received

NSW and WA noted concerns around the appropriateness of IHACPA undertaking a quality assurance process for data which is submitted to and managed by other agencies and which has different collection and reporting requirements than data collections managed by IHACPA.

Qld recommended the inclusion of non-patient products in the National Hospital Cost Data Collection to enable a single collection to fulfill requirements for both the NEP and NEC Determinations.

The Australian College of Nursing and the Pharmaceutical Society of Australia recommended a focus on data to inform the demand for local services in rural and remote areas including cancer treatment, surgical procedures, imaging and mental health services and emergency department services, given the extensive wait times for emergency department visits in these areas.

The Royal Australasian College of Physicians recommended a focus on data related to patients with complex needs, such as disability, substance abuse and misuse, mental health diagnosis, intellectual disability and homelessness to assist in informing an appropriate funding model and improving the quality of care.

IHACPA's response

IHACPA notes stakeholder concerns regarding the appropriateness of undertaking a quality assurance review of data submitted to another Commonwealth agency.

Following consultation with the Australian Institute of Health and Welfare, IHACPA has developed a plan for undertaking additional quality assurance of the Local Hospital Networks and Public hospital establishments national minimum data set.

IHACPA will work with its advisory committees to refine and implement this quality assurance process to inform NEC23.

8

Future funding models

8. Future funding models

8.1 Trialling innovative models of care

? Consultation question

- How is virtual care delivery captured in information systems and data collections?
- IHACPA is proposing to investigate the inclusion of emergency department telehealth video consultations in the NAPEDC NMDS and Emergency service care national best endeavours data set for 2023–24. Are there any other examples of innovative models of care and services related to virtual care that IHACPA should also consider investigating?
- What changes, if any, to the national pricing model should IHACPA consider to account for innovative models of care and services related to virtual care?

Feedback received

Capture of virtual care delivery in information systems and data collections

New South Wales (NSW) noted the non-admitted data collection includes audio and audio-visual modalities and anticipated future capability to measure admitted and emergency department emergency department virtual activity.

Victoria (Vic) noted that virtual care delivery is captured through the following systems:

- Victorian Admitted Episode Dataset
- Victorian Emergency Minimum Dataset
- Victorian Integrated Non-Admitted Health minimum dataset.

Queensland (Qld), South Australia and Western Australia (WA) noted that virtual care is captured within existing admitted systems for admitted inpatient care and corresponding non-admitted systems for outpatient services.

Qld noted it is currently working to improve automation in data reporting processes.

WA noted that some metropolitan hospitals have developed the Hospital in a Virtual Environment “HIVE” model where care is provided by clinicians remotely from the bedside, which is included in national reporting. WA also noted that outpatient non-admitted service delivery is captured at both sides of the patient and service provider interaction.

The Northern Territory (NT) noted that virtual care delivery is currently captured by the NT in a limited manner in non-admitted patient records.

Stakeholders recommended that the Independent Health and Aged Care Authority (IHACPA) should investigate the most appropriate funding model for virtual care, noting the cost drivers and cost overheads may be significantly different to standard non-admitted services. Stakeholders noted the importance of minimising the burdens associated with data collection between settings and consideration of any limitations across systems and locations.

Stakeholders noted concerns that telehealth video consultations do not constitute an equivalent physical presentation to an emergency department. Stakeholders also noted concerns regarding the need for appropriate pricing of emergency department virtual care to support necessary resourcing and data collection systems.

Examples of innovative models of care and services related to virtual care

Stakeholders supported IHACPA’s proposal to investigate the inclusion of emergency department telehealth video consultations in the Non-admitted patient emergency department care national minimum data set (NAPEDC NMDS) and the Emergency service care national best endeavours data set (ESC NBEDS) for 2023–24.

Stakeholders provided a range examples of innovative models of care related to virtual care across different settings including:

- NSW: virtual ward rounds, clinical support for residential aged care residents
- Vic: Victorian Virtual Emergency Department, virtual specialist consultations in rural and remote areas

- Qld: virtual outpatient integration for chronic disease model of care, remote patient monitoring, Mental health co-responder program
- WA: Virtual Emergency Medicine, asynchronous health care, remote patient monitoring
- Tasmania: Tasmanian COVID@homeplus remote monitoring service
- NT: Medical Retrieval and Consultation Centre.

National pricing model changes for innovative models of care and services related to virtual care

Stakeholders provided the following considerations regarding changes to the national pricing model to account for innovative models of care and services related to virtual care:

- refine data collections to differentiate fixed and auxiliary costs to ensure pricing adequately reflects the resources required
- account for the impact on pricing for face-to-face consultations due to the potential shift in activity to virtual care and shift from provider-centric pricing to specialty specific pricing
- consider the potential use of pre-defined outcomes to incentivise providers.

General feedback

Stakeholders recommended that IHACPA's investigation of innovative funding models should include exploration of funding models beyond bundled and capitation payments and focus on state and territory nominated models of care and services, rather than specific models of care and services determined by IHACPA. Stakeholders also noted the importance of ensuring innovative models of care and services are evidence-based, adaptable across the health system and between states and territories and include timely evaluations.

Stakeholders recommended consideration of the following innovative models of care and services:

- home-based subcutaneous immunoglobulin therapy
- bundled payments for cancer care patients to minimise out-of-pocket costs
- virtual models of care that target social determinants of health
- initiatives to facilitate investment in high cost innovative technologies.

Stakeholders also requested that IHACPA consider a potential funding adjustment to incentivise the exploration of innovative funding models and to improve the efficiency of low value care and maintenance care.

IHACPA's response

Capture of virtual care delivery in information systems and data collections

IHACPA notes that the delivery of some virtual care services is currently being captured in the admitted and non-admitted data collections. IHACPA also notes the variation in the information systems and data collection processes utilised by the states and territories to capture data related to virtual care delivery.

IHACPA has commenced consultation with states and territories through its advisory committees to investigate the inclusion of emergency department telehealth video consultations in the NAPEDC NMDS and ESC NBEDS and consider the necessary changes to the national pricing model to account for innovative models of care and services related to virtual care. IHACPA proposes to undertake a staged implementation approach to minimise implementation burden and ensure sufficient time to develop an approach to capturing virtual care data across all care types in the future.

Examples of innovative models of care and services related to virtual care

IHACPA will undertake further investigation of other innovative models of care and services, including those related to virtual care. IHACPA notes that capture of virtual care within the national pricing model will rely on review of the activity and costs data and the Individual Healthcare Identifier data available in consultation with jurisdictions.

National pricing model changes for innovative models of care and services related to virtual care

IHACPA notes the considerations provided by stakeholders and will work with jurisdictions to consider the necessary changes to the national pricing model that are required to account for innovative models of care and services related to virtual care.

General feedback

IHACPA notes the considerations provided by stakeholders regarding the exploration and trial of innovative models of care, which align with IHACPA's proposed approach to incorporate patient reported measures, clinical involvement and flexibility in service delivery and setting.

IHACPA will engage with the National Health Reform Agreement Reform Implementation Group and the jurisdictions to facilitate the development of broader trial principles and guidelines for considering proposals of innovative funding models for trial under bilateral agreements with the Commonwealth.

9

Pricing and funding for safety and quality

9. Pricing and funding for safety and quality

The Independent Health and Aged Care Pricing Authority (IHACPA) did not ask any specific consultation questions on pricing and funding for safety and quality but received feedback from a small number of stakeholders.

Feedback received

New South Wales (NSW) noted concerns with the use of the condition onset flag (COF) to identify hospital acquired complications (HACs) due to mismatch between the Australian Coding Standards and the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM). NSW requested clarification to ensure that the COF accurately captures HACs.

Queensland recommended a review of the avoidable hospital readmissions adjustment to ensure the index episode is clinically related to the readmission episode and does not incorrectly penalise the index hospital.

The Australian Medical Association noted it did not support the application of funding penalties for reducing HACs and sentinel events as these events may arise from underfunding of primary and aged care services.

Stryker South Pacific recommended that IHACPA consider the following areas:

- funding incentivisation for hospitals to implement measures and health technologies that reduce HACs and avoidable hospital readmissions
- prioritisation of patient and staff outcomes to guide the evaluation of safety and quality reforms
- funding incentivisation for procedures and prostheses that reduce revision surgery rates, as a means of reducing avoidable and preventable hospitalisations.

IHACPA's response

IHACPA notes that HACs are identified using a combination of ICD-10-AM codes to identify the diagnosis, and the COF to indicate that the diagnosis occurred during the episode of admitted patient care. IHACPA will consider the feedback in consultation with the Australian Commission on Safety and Quality in Health Care (the Commission) to determine whether refinements are required to the use of COF.

IHACPA notes the list of avoidable hospital readmissions and associated condition-specific time intervals was developed in consultation with clinical experts and jurisdictions, and represents the subset of readmissions that are wholly preventable and can be attributed to the index admission. IHACPA notes the Commission has an ongoing work program to ensure the accuracy and currency of the list of avoidable hospital readmission conditions and ensure they are clinically related to the index admission.

IHACPA notes the funding adjustments applied as part of the safety and quality reforms not only act as a price signal, but also aim to identify areas to address for improving patient care.

IHACPA will consider the feedback provided by stakeholders alongside any feedback or directives received from health ministers regarding the options for further safety and quality-related reforms and ways that avoidable and preventable hospitalisations can be reduced through changes to the Addendum to the National Health Reform Agreement 2020–25.

Appendix A: List of stakeholders

The stakeholders that made submissions in response to *the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24* have been outlined below, except where respondents have been kept confidential due to commercial or other reasons.

Stakeholder	Abbreviation
States and territories	
New South Wales Ministry of Health	NSW
Victorian Department of Health and Human Services	Vic
Queensland Health	Qld
South Australian Department for Health and Wellbeing	SA
Western Australian Department of Health	WA
Tasmanian Department of Health	Tas
Northern Territory Department of Health	NT
Organisations	
AusPIPs Inc.	AusPIPs
Austin Health	Austin Health
Australasian College for Emergency Medicine	ACEM
Australian College of Nursing	ACN
Australian Genomics	Australian Genomics
Australian Healthcare and Hospitals Association	AHHA
Australian Medical Association	AMA
Blood Matters Program, National Bloody Authority	Blood Matters
Cancer Council Australia	CCA
Exercise and Sports Science Australia	ESSA
Pharmaceutical Society of Australia	PSA
Queensland Nurses and Midwives' Union	QNMU
Royal Australasian College of Physicians	RACP
Royal Australian and New Zealand College of Psychiatrists	RANZCP
Services for Australian Rural and Remote Allied Health	SARRAH
Society of Hospital Pharmacists of Australia	SHPA
Southern Adelaide Local Health Network	SALHN
Stryker South Pacific	Stryker
Tandem	Tandem
University of Melbourne	UoM
Victorian Healthcare Association	VHA
Women's and Children's Healthcare Australasia	WCHA



Independent Health and Aged Care Pricing Authority

Eora Nation, Level 12, 1 Oxford Street
Sydney NSW 2000

Phone: 02 8215 1100

Email: enquiries.ihacpa@ihacpa.gov.au

Twitter: @IHACPA

www.ihacpa.gov.au