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Professor Michael Pervan
Chief Executive Officer
Independent Health and Aged Care Pricing Authority
Via Email: submissions.ihacpa@ihacpa.gov.au

Dear Professor Pervan

RE: CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2024-25

Thank you for the opportunity to provide comment on the Independent Health and Aged Care Pricing Authority's (IHACPA) Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25.

The Northern Territory (NT) faces unique challenges in delivering hospital services as a result of significant geographical challenges and high rates of social disadvantage, chronic conditions, and premature death experienced by our Aboriginal and Torres Strait Islander population. To manage these challenges, it is essential that the national pricing model promotes equity of access to hospital services and ensures the financial stability of the public hospital system.

I wish to highlight the data included in our submission this year demonstrating the legitimate cost difference per NWAU from patients who require aeromedical transport, that is not accounted for within the remoteness pricing adjustments.

I welcome further discussion between IHACPA and NT Health on the content of our submission. If you require further information, please contact the NT's Jurisdictional Advisory Committee member, Stathi Tsangaris, Executive Director Funding and Performance, on 08 8999 2590 or at Stathi.Tsangaris@nt.gov.au.

Yours sincerely

Dr Marco Briceno
Chief Executive
NT Health
27 July 2023

Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25

Northern Territory Submission

NORTHERN TERRITORY GOVERNMENT

1. Foreword

This submission provides feedback on issues highlighted in the Independent Health and Aged Care Pricing Authority's (IHACPA) *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25*, particularly where there may be potential impacts to equity of access to hospital services or the financial stability of the Northern Territory public hospital system.

2. Pricing Guidelines

No comment.

3. Classifications used to describe and price public hospital services

3.1. Admitted acute care

No comment.

3.2. Subacute and non-acute care

No comment.

3.3. Emergency Care

Consultation question:

- Are there any other areas in the AECC that IHACPA should consider as part of the classification refinement work program?

Patients experiencing homelessness, including those in severely crowded dwellings, are likely to remain in the Emergency Department for longer and experience extended inpatient lengths of stay as a lack of housing and familial supports places these patients at additional risk of clinical deterioration post-discharge and outpatient care attendance is likely to be poor. NT would appreciate the opportunity to work with IHACPA on how the AECC could capture and classify this patient characteristic.

Consultation question:

- What clinical areas and/or structural features should IHACPA consider in the development of the EPD Short List Thirteenth Edition?

When developing the EPD Shortlist Thirteenth Edition, IHACPA should take into account different operating characteristics and service profiles of emergency departments in rural and remote locations. For example, if there are no other pathology services in the region, an IVF candidate may attend a remote ED to get follow-up blood taken for this purpose or as a GP service to get a medical clearance certificate for work. This activity is valid activity under COAG Section 19(2) exemption initiatives, for rural and remote sites to support the primary care sector, but these activities are not reflected in the EDP Short List.

In the EPD Short List Thirteenth Edition, NT Health recommends further breaking down the range of conditions encompassed in the ED short list codes, Z60.9 and Z04.9 and providing further guidance on circumstances in which clinicians should use these codes. For example, Z04.9 includes "examination and observation following alleged rape and seduction (includes application of rape kit). However, there is also an injury code, T74.2, for a sexual injury from the ED short list for sexual abuse.

3.4. Non-admitted care

Consultation question

- Are there any other proposed refinement areas for the Tier 2 Non-Admitted Services Classification for 2024–25?

The NT requests IHACPA prioritise work with jurisdictions to investigate refinements to Tier 2 to capture activity delivered through innovative models of care. In particular, models of care that involve clinician-to-clinician advice between specialised hospital services and remote services. The Tier 2 classification does not sufficiently account for services such as the NT's Medical Retrieval and Consultation Centre (MRaCC), currently captured as a general medicine clinic. One clinic will involve multiple phone calls, emergency telehealth and potentially the management of logistics to undertake an aeromedical retrieval. In instances that clinician-to-clinician advice is provided between hospitals, both hospitals may classify this event under the Tier 2 classification. However, MRaCC provides advice to remote primary health clinics managed by NT Health or Aboriginal Community Controlled Health Organisations who are not hospital services so are not eligible for activity based funding (ABF).

3.5. Mental Health Care

Consultation question

- Following three years of shadow pricing and the development of risk mitigation strategies to support the transition to ABF, are there any significant barriers to pricing community mental health care using AMHCC Version 1.0 for NEP24?
- Are there any other measures that will assist in transitioning community mental health care from block funding to ABF for NEP24?

NT Health welcomes IHACPA's recent provision of analysis of shadow-pricing data for community mental health using the Australian Mental Health Care Classification Version 1.0 (AMHCC). NT Health welcomes the incorporation of National Hospital Cost Data Collection (NHCDC) data into IHACPA's initial analysis of 2021-22 activity data to provide further depth of analysis on data issues associated with the transition to ABF.

NT would request IHACPA consider whether the transition to pricing is practicable for individual jurisdictions and local hospital networks. NT request a transitionary approach be determined in collaboration with the Administrator on the basis that jurisdictions need funding certainty for community mental health. NT requests that if a funding transition approach does not recognises the costs of delivering community mental health services, shadow pricing should continue for NEP24 in recognition that shortcomings in the data remain.

4. Setting the national efficient price

NT Health requests IHACPA investigate a mechanism to recognise that patients with a maintenance care-type remain admitted in public hospitals due to failures in the health interfaces of aged care and disability care. Such patients would not require extended hospital care if appropriate aged or disability care services were available in the community. NT consider this a form of cost shifting from the Commonwealth to other jurisdictions and suggest IHACPA investigate the equity of the Commonwealth paying 100% of the cost of increases in maintenance care days, as suggested by Professor Stephen Duckett submission to IHACPA's 2023-24 Pricing Framework consultation.

4.1. Impact of COVID-19

Consultation question

- How did the COVID-19 pandemic response impact activity and cost data in 2021–22, such as through significant events like lockdowns, and how should these impacts be accounted for in the NEP and National Efficient Cost Determinations for 2024–25?

The COVID-19 pandemic response continued to impact hospital costs in 2021-22, which was the first year there was also a significant negative impact on NT activity volumes. NT Health supports IHACPA's intent to take a similar approach to prior years to analyse the impact of COVID-19 on the available data and test assumptions adopted for previous NEP determinations.

As with all jurisdictions, the NT experienced a significant impact to service delivery costs associated with the COVID-19 response. This included reductions in hospital capacity to ensure safe distancing from potential COVID-19 patients and maintain readiness for a COVID-19 outbreak, diversion of staff to other duties and an increase in costs of consumables created by supply chain issues. This led to a general increase in average episode cost across all care-types and services.

The impacts of COVID-19 that are likely to remain in 2024-25 for the NT are:

- Increased costs associated with locum staff usage due to local workforce shortages
- Increased patient complexity due to delayed care
- Subdued activity levels due to continued workforce shortages, perpetuated due to demand for staff in other jurisdictions

Impacts on hospital activity volume from the NT's response to COVID-19 during 2021-22, as detailed in the Chief Health Officer's Report on the COVID-19 Public Health Emergency included:

- A proportion of hospital staff, particularly allied health and administrative staff, were unable to perform their regular roles as they were diverted to participate in the COVID-19 response including testing sites, contact tracing, COVID-19 hotline, vaccination clinics and rapid assessment teams deployed to communities with high transmission rates.
- Elective surgery was paused intermittently throughout the pandemic in line with outbreaks and peaks in cases and at other times prioritised to focus on the most urgent cases.
- Anaesthetists and surgeons were deployed to hospitals in regional centres to minimise the need for patients to travel to Darwin.

- Public hospital outpatient clinics across the NT shifted to a model of consultation via telephone or video calls by default, to minimise patient visits to hospital and travel into major population centres.

- From late 2021, a number of facilities were used for the isolation of COVID-19 positive persons from remote communities who were required to be in town for daytime medical outpatient appointments.

- While urgent elective surgeries and hospital treatment continued during this period, the diversion of resources away from non-urgent health services meant that people did not receive the same level of primary care monitoring of chronic disease, preventative health checks.

- Some people in the NT attended appointments with hospital specialists less frequently or chose not to travel for an appointment or surgery despite their need. Not all patients were comfortable with alternative telehealth services that were offered in lieu of face-to-face consultations.

- Movement and travel restrictions implemented at various times and locations including hard lockdown, lockdown, lockout, lock-in, border restrictions and biosecurity zones.

4.2. Adjustments to the national efficient price

The NT has undertaken a significant body of work in 2023 to review cost structures across the public hospital system. This work has utilised NHCDC data and has focused on assigning costs to one of three types. Costs that are:

- controllable by clinicians and hospital managers, and include cost drivers such as length of stay, pathology and radiology utilisation and staff rostering practices.
- a result of NT government policy decisions, such as wages policy and capital expenditure decisions.
- not controllable by either clinicians or the NT Government.

NT Heath acknowledges that there are improvements to be made across all three categories that will contribute to the ongoing improvement in technical efficiency in the NT Health system. A system wide project is overseeing improvements across all three categories to improve technical efficiency within the NT Health system.

4.2.1. Patient transport

Patient transport, including inter-hospital transfers and aeromedical evacuations, is fundamental to ensuring remote and very remote residents receive equitable access to healthcare.

Inter-hospital transfers

NT hospitals, especially those in remote areas but also those in regional areas, do not have the same level of specialist capability as hospitals in major cities. Given the NT's relatively small population, some specialist services are not clinically or financially feasible. This means that it is sometimes necessary to transfer patients from regional and remote hospitals to other facilities, including in other jurisdictions, to receive critical or specialist care services that are not available locally.

Aeromedical emergency evacuations

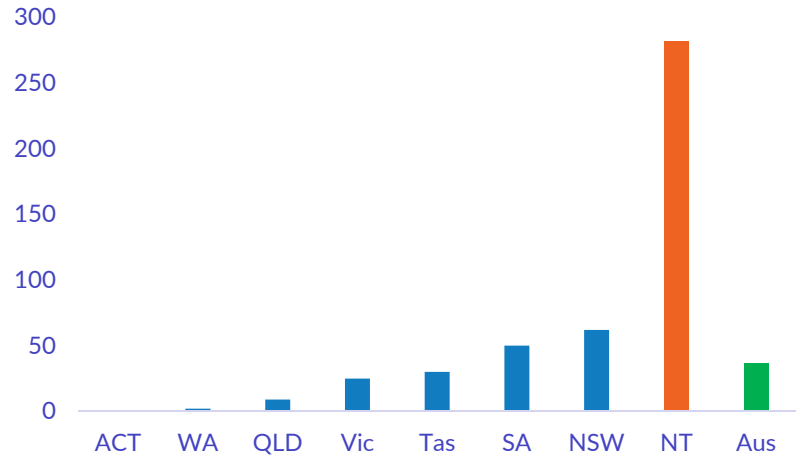
In addition to inter-hospital transfers, NT Health incurs substantial costs associated with medically evacuating patients by air from communities and points of incident (e.g. trauma) to the nearest appropriate hospital in order to receive critical care. Aeromedical emergency evacuation/retrievals are essential

services to facilitate equitable access to high quality health care for those living in regional and remote areas. These travel costs relate to patients assessed by a clinician as requiring emergency treatment at a tertiary hospital, and are not discretionary. The NT has rigorous protocols in place to ensure that only those patients requiring retrieval on medical grounds are transferred to hospital. Such costs are in-scope under the Addendum to the National Health Reform Agreement (NHRA). Clause 1 (g) of the NHRA reaffirms high-level service delivery principles provided by the National Healthcare Agreement (agreed by COAG in 2008 and amended in July 2012). Clause 24 (h) of the 2012 Agreement provides that "emergency responses", which includes "support for emergency air retrieval", are to be jointly funded by the Commonwealth and states/territories.

Patient transport costs

Patient transport costs are disproportionately high in the NT as demonstrated in table 1, due to the remoteness profile of NT residents and their proximity to health services. In 2020-21 patient transport costs reported through the NHCDC for aeromedical retrieval costs and inter-hospital transfers totalled approximately $48 million.

Table 1: Patient transport costs per NWAU20, NHCDC 2020-21



The NT does not agree that the magnitude of these costs for NT patients are reflected in the existing patient residential and treatment remoteness adjustments, as previously determined by IHACPA. Box 1 below provides the cost/NWAU profile of Royal Darwin Hospital Emergency Department (RDH ED) and national. The comparison shows significant variation in costs for inter-hospital transfers and medical evacuations across and within remoteness categories and illustrates that for the NT these costs cannot be homogeneously grouped using remoteness indicators.

NT Health notes that currently, only proxies are available to classify patient travel and additional data items would need to be developed. NT Health considers that patient travel is not technically feasible for ABF given patients cannot be classified into resource-homogenous groups that take into account travel status and distance travelled. NT Health recommends that travel costs be block funded while data development work is progressed. NT Health looks forward to working with IHACPA to develop a block funding approach to ensure that patient travel costs are appropriately funded.

Box 1: Cost per NWAU at the Royal Darwin Hospital Emergency Department

In 2020-21, RDH ED cost/NWAU was 35% higher than the national average. However, when patient travel costs relating to retrieval services are removed from the episode, RDH ED cost/NWAU is 5.3% lower than the national average, as shown in table B1.1 below.

Table B1.1: Hospital Emergency Department cost per NWAU (20), including/excluding travel, 2020-21.

	Cost per NWAU(20)		
	RDH ED $/NWAU(20)	National ED $/NWAU(20)	Variance %
Excluding travel costs	5,287	5,579	-5.2%
Total	**7,677**	**5,693**	**34.8%**

Expanding the comparison to account for patient remoteness (see table B1.2), shows that average cost for RDH ED remain significantly above national averages for most categories and more than double for very remote patients. However, when NT retrieval costs are removed, the IHACPA adjustments for patient remoteness significantly improve comparability.

Table B1.2: Hospital Emergency Department cost per NWAU (20), including/excluding travel, by remoteness, 2020-21.

	National ED	RDH ED		Variance	
	Total $/NWAU(20)	Total $/NWAU(20)	Exc travel $/NWAU(20)	Total %	Exc travel %
Major City*	5,718	7,717	5,062	35%	-11%
Inner Regional*	5,612	7,725	5,417	38%	-3%
Outer Regional	5,629	5,536	5,160	-2%	-8%
Remote	5,153	8,200	4,552	59%	-12%
Very Remote	7,073	15,192	4,735	115%	-33%
Total	**5,693**	**7,677**	**5,287**	**35%**	**-7%**

Table B1.2 demonstrates that the IHACPA adjustments for patient remoteness work well when retrieval costs are removed. It also demonstrates that the national model does not adequately capture the costs of patient retrievals that are unique to the Northern Territory. These patterns are similar in the admitted acute data for Royal Darwin Hospital (RDH), and NT Health would be please to discuss this in more detail with IHACPA.

* interstate patients requiring aeromedical retrieval to RDH

Commonwealth Grants Commission, Goods and Services Tax methodology

NT Health note that IHACPA, upon advice from the Commonwealth Grants Commission (CGC) in 2021, concluded that patient travel costs are already accounted for through the GST distribution model and therefore IHACPA are unable to undertake further work on a transport adjustment.

NT Health disagree with IHACPA and the CGC's conclusion that the GST methodology appropriately accounts for transport costs. The GST assessment is based on state expenditure reported through government finance statistics and then proportionately distributed on a per population basis with an adjustment for remoteness. There are a number of assumptions involved within the formulas and the

proportionate split of hospital and non-hospital transport services remains fixed for each five-year review period.

IHACPA's assessment that transport is already account for, albeit in a per capita model with a 5 year fixed data cycle, does not align with the overarching pricing guideline of fairness or the process guideline of evidence-based. Further, the guidelines state ABF should be used where practical and appropriate to ensure efficient cost and outcomes. In line with IHACPA's calculation of other hospital services and adjustments, which the CGC also assess in order to calculate the GST relativities, the NT request IHACPA investigate a more appropriate mechanism to fund patient transport. The NT reiterate that this assessment is within IHACPA's remit and should be prioritised in order for equitable access to healthcare to be upheld.

4.2.2. Specified intensive care unit eligibility criteria and adjustment

Consultation questions

To inform the review of the ICU adjustment:

- what available evidence demonstrates the underlying drivers of cost variation for complex ICUs?
- what additional or alternative measures, other than mechanical ventilation hours, should IHACPA consider for inclusion in the eligibility criteria for a specified ICU?

NT Health welcomes IHACPA undertaking a review of the ICU eligibility criteria. NT Health recommends that the role of mechanical ventilation in determining ICU eligibility should be reviewed. Contemporary clinical practice have likely changed the ICU service mix over time to better cater for patient experience, while still carrying high cost. For example, mechanical ventilation may have reduced over time in favour of non-invasive ventilation noting that this may lead to improved patient outcomes. The ICU eligibility criteria should take into account other high cost treatments provided in the ICU setting, such as non-invasive ventilation, increased medical and nursing staffing ratios and continuous renal replacement therapy.

4.3. NEP indexation methodology

Consultation question

- To inform the NEP indexation methodology review, what alternative indices or metrics are publicly available and applicable at a national level, that demonstrate an evidence-based correlation between price inflation and cost increases in the delivery of Australian public hospital services? Additionally, what are the underlying drivers of cost growth contributing to these cost increases?

IHACPA should consider the application of the national health producer price index (PPI) in the NEP indexation methodology review. Table 5 of the output of the services industries includes a number of services delivered in public hospitals including medical services, pathology and diagnostic imaging services and allied health services.

4.4. Harmonising price weights across care settings

Consultation questions

- What potential risks should IHACPA consider in progressing price harmonisation of chemotherapy and dialysis for future NEP Determinations?

- Are there any other public hospital services that are potential candidates for price weight harmonisation across settings?

NT Health reiterates the requirement for thorough investigation into clinical practices across jurisdictions to ensure it is appropriate to classify services across different settings into resource-homogenous groups. Price weight harmonisation should not mistakenly group patients where services differ.

NT Health also recommends applying transitional arrangements and price stabilisation in circumstances where price harmonisation is deemed appropriate.

4.5. Unqualified newborns

The NT supports IHACPA's proposal to review the pricing methodology for unqualified newborns in 2023-24 to reflect the costs of providing specialist medical and nursing care to unqualified newborns.

5. Setting the national efficient cost

No comment.

6. Data collection

6.1. Assurance of cost data

Consultation question

- What assurance approaches should IHACPA consider, to ensure NHCDC data is prepared in line with the AHPCS, and that would reduce duplication of data reporting for states and territories?

NT Health suggest that IHACPA provide targeted training to jurisdictions in applying the AHPCS and develop mechanism, such as community of practice forum, for staff involved in costing hospital services to seek guidance and receive expert advice on all aspects of AHPCS. Further, NT Health suggest that IHACPA use learnings through preparation of the NEP, including shortcomings in the NHCDC data, to independently investigate and remediate with jurisdictions in the subsequent NHCDC submissions.

6.2. Virtual models of care

Consultation question

- Given virtual care is a broad and evolving space, what specific areas and care streams where virtual care is being delivered should IHACPA prioritise for further investigation to inform future data collection, classification and pricing refinement?

NT Health currently captures virtual care data in a limited manner within non-admitted patient records. NT Health propose IHACPA investigate the most appropriate funding model for these services.

In particular, IHACPA should prioritise further investigating how virtual models of care that provide clinician-to-clinician connection are most appropriately classified and funded. The NT notes that Telestroke, a program that aims to connect emergency department doctors to stroke specialists via video consultation in NSW, will be funded through NEC23 as an innovative model of care under clause 97 of the Addendum.

Medical Retrieval and Consultation Centre (MRaCC) in Alice Springs provides expert emergency medical advice to remote locations where no alternative service exists, most often to primary health care providers, but in some instances directly to patients when there is no primary health care provider within range of the patient. MRaCC also provides a medical retrieval service for acute care cases, inter-hospital transfers and repatriation of patients. MRaCC provides a 24-hour, single-point-of-contact emergency consultation service for all clinicians and for sick patients.

MRaCC is currently funded through the non-admitted patient classification and is coded to general medicine. NT Health propose that IHACPA investigate this model of care alongside the delivery of virtual emergency care, as the two may align although this service offers more than just virtual emergency care. This model of care contributes to improved patient outcomes and there is likely savings potential in keeping some patients out of the Emergency Department and hospital settings.

Consultation question

- Do jurisdictions have the capacity to submit cost data for activity reported under the emergency care virtual care data specifications?

Emergency departments in NT public hospitals are not currently delivering virtual care and the NT will not be able to provide data through the emergency virtual care National Best Endeavours Data Set for 2023–24.

7. Treatment of other Commonwealth Programs

No comment.

8. Future funding models

8.1. Trialling of innovative models of care

NT Health recommends that IHACPA consider the following when exploring innovative models of care and funding approaches:

- **Jurisdictional variation and barriers:** Future funding models should account for the different clinical pathways and care cost drivers that exist across jurisdictions. In particular, funding models must be sufficiently flexible to adapt to varied access and cultural needs.

- **Funding stability:** IHACPA should compare alternate funding models to the existing ABF model to identify and address any potential risk of under-funding.

- **Primary interface:** Funding models should consider the critical role of primary care access in improving continuity of care and avoiding hospitalisation. In particular, any risk sharing/incentive implicit in funding models should appropriately reflect the Commonwealth's responsibility in ensuring access to an adequate level of primary care services.

- **Aged care and disability care:** innovative funding models should consider the availability of aged care and National Disability Insurance Scheme services, the interaction between funding mechanisms of hospital services and funding for residential aged care and disability care and how to avoid potentially unnecessary hospitalisations.

9. Pricing and funding for safety and quality

NT Health notes that the introduction of funding penalties for sentinel events, hospital acquired complications and avoidable hospital readmissions has increased the complexity of the national funding model. NT Health recommends that an evaluation of safety and quality penalties assess:

- Improved patient outcomes.
- Incentivised providing the right care, in the right place, at the right time.
- Decreased avoidable demand for public hospital services.
- Created signals in the health system for the need to reduce instances of preventable poor quality patient care, while supporting improvements in data quality and information available to inform clinicians' practice.

NT Health recommends that IHACPA's evaluation consider the impact of the following:

- Existing processes or programs implemented by state and territory health authorities to improve quality and safety, such as the NT's escalation system, "REACT" for patents and their families to raise concerns about hospital care.
- Clinician awareness and response to penalties. This will enable an assessment of a direct causal link between funding penalties and clinical performance.