

Pricing Framework for Australian Public Hospital Services 2015-16

25 July 2014

Introduction

The Victorian Healthcare Association (VHA) is the major peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health services, aged care facilities and Medicare Locals. Established in 1938, the VHA promotes the improvement of health outcomes for all Victorians, from the perspective of its members.

The Independent Hospital Pricing Authority (IHPA) has released a consultation paper to provide input to inform the *Pricing Framework for Australian Public Hospital Services 2015-16*. The VHA welcomes this opportunity to provide input to the pricing framework for Australian public hospital services.

The VHA agrees to the submission being treated as a public document, and the information being cited in the final report.

The VHA's Response

The VHA in its response is seeking to address funding inequities arising from the casemix of patients at some hospitals compared to those of its peers, assumptions in approaches to classifying and pricing of patients that don't always correctly translate to the resources used to treat a patient, and the use and provision of information to determine costing of episodes of care.

Issues observed by the VHA together with the VHA's recommendations for addressing the issue are listed below.

1. *The treatment of complexity in the AR-DRG classification system*

The experience of many Victorian hospitals is that the AR-DRG classification system is insufficiently detailed to reflect increased resource consumption in the care of more complex patients.

Two issues observed by the VHA are:

- a) *As a result of the Competitive Elective Surgery Initiative in Victoria, the casemix for some surgical procedures in Victorian public hospitals has become more complex:-* Implementation of the Competitive Elective Surgery Initiative in Victoria is seeing the less complex patients for some surgical procedures increasingly being treated within a private hospital. This leaves the public hospital with an increased proportion of more complex patients. While there may be an improved overall outcome for the state from this initiative, individual hospitals may be underfunded as a

result of the change in the patient mix. Hospitals experience factors such as age, obesity and social disadvantage as affecting the level of resources requiring additional resource consumption. When these hospitals have a higher proportion of these patients compared to other hospitals and the increased complexity is not acknowledged in the classification system, then these hospitals will be underfunded for the procedure.

- b) *Large disparity in costs for providing more complex maternity care:-* There can be an enormous range in the costs of providing care to patients in the AR-DRGs designated for complex episodes of care. The table below compares the average length of stay (ALOS) for two complex maternity related DRGs for two facilities in Mercy Health¹. The table shows the ALOS for an episode of care classified as AR-DRG O01A is twice as long at the Mercy Hospital for Women as at the Werribee Mercy Hospital. Similarly the ALOS for AR-DRG O60A is considerably longer at the specialist hospital. In these cases, an extended length of stay is not an indication of inefficiency, but reflects the increased complexity of cases at the Mercy Hospital for Women. More broadly this demonstrates the breadth of difference in these already complex AR-DRG classifications.

Table 1:- Comparison of ALOS for selected AR-DRG's within Mercy Health

DRG	Facility	ALOS (Days, rounded)
O60A Vaginal delivery with catastrophic or severe CC	Mercy Hospital for Women	4.1
	Werribee Mercy Hospital	2.9
O01A Caesarean delivery with catastrophic CC	Mercy Hospital for Women	10.8
	Werribee Mercy Hospital	5.1

Source: Mercy Health, 2014

Recommendations

- Prioritise the review of the Patient Clinical Complexity Level and the existing AR-DRG classification
- As a result of the review, AR-DRG classifications are refined so they are sufficiently detailed to include the impact to resource consumption arising from differences in patient age, obesity, lifestyle factors and social disadvantage.

2. Emergency care classification

Many Victorian hospitals find the current emergency care classification systems inadequately classify episodes of care according to the resources consumed. Issues identified include:

- a) *The use of the disposition variable in emergency care classification systems:-* The disposition variable of the current URG/UDG classification systems favours admission to a short stay unit (SSU) or a medical assessment and planning unit (MAPU), as opposed to providing all care in the Emergency Department (ED). In hospitals that don't have an SSU or MAPU, very unwell patients may be treated in the ED for long periods of time and will require extensive resources for their

¹ The Mercy Hospital for Women is a state-wide referral centre specialising in maternity, gynaecology and neonatal services in Victoria. Werribee Mercy Hospital is a public hospital serving the south western region of Melbourne. Amongst other services, it provides maternity and neonatal services to the population it serves.

care. However, as the patient's care took place in the ED, they are classified as non-admitted, and so they attract less funding.

- b) *The use of triage as an indicator of severity or complexity in the emergency classification systems:-* The use of triage is a poor indicator of severity and complexity in the URG and UDG classification systems. Discharge diagnosis has been identified as a potential classification driver that would provide a more specific and meaningful classification of emergency care. However, due to the nature of the work within the ED, there are concerns that this information is potentially open to subjectivity and error, and this may affect the suitability of diagnosis as an indicator of the level of resource consumed for an episode of emergency care.

Recommendations

- The VHA supports further development of the emergency care classification, but cautions the way that discharge diagnosis is used as the principal classification driver for identifying the level of resource consumption for the care of the patient in this setting.
- As part of the review and further development of emergency care classifications, review the use of the disposition variable in the emergency classification system and the relationship this has to resource consumption in different hospitals.

3. Private patient costing and pricing

While IHPA have improved the methodology for pricing private patients compared to previous years, Victorian health services continue to find that the private patient methodology employed by IHPA does not deliver consistent results across the AR-DRG framework. Health services need the ability to plan their public/private service provision with a consistent rule applied across the ABF landscape. The current methodology doesn't support this.

Relating to the costing of private patients, the VHA is supportive of the approach and efforts by IHPA to more accurately capture the cost of private patients in public hospitals. Arrangements for the billing of private practice in public hospitals are many and varied, and changes to this will require hospitals to undertake a significant body of work. Health services have limited costing resources to spread across an increasing ABF workload, and the time and effort required to improve private patient cost allocation by the health services cannot be supported with the existing ABF workload and the current level of resourcing.

Recommendations

- Review the private patient pricing methodology, particularly in regards to supporting health services to plan their public/private service provision.
- Provide support to health services to modify private patient cost allocation systems and processes to achieve IHPA's aims of more accurately capturing the cost of private patients in public hospitals.

4. *Rebasing*

The development of the 2013-14 NEP was based on 2010-11 activity data. Likewise 2014-15 NEP is derived from the reference cost of public hospital activity in 2011-12. While understanding the logistical difficulties of managing a national dataset, efforts need to be made to close the gap in order for the NEP and NEC to have true currency.

Recommendation

- Use more recent data for rebasing the NEP and NEC.

Further information

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