Attachment A

IHACPA response to request for information from the NSW Special Commission of Inquiry into Healthcare Funding

IHACPA provides responses to the questions received from the NSW Special Commission of Inquiry into Healthcare Funding in December 2024, as outlined below. For further information on any of the following information, please contact enquiries.ihacpa@ihacpa.gov.au.

1. **An identification of:**
    a. **the funding models encapsulated by the National Health Reform Agreement (NHRA);**
    b. **the role and function of the IHACPA;**
    c. **the role and function of the Administrator of the National Hospital Funding Pool;**
    d. **the manner and extent to which the New South Wales (NSW) government, including the NSW Ministry of Health, engages with these bodies.**

Funding models encapsulated by the NHRA

The NHRA and the Addendum to the NHRA 2020–25 (the Addendum) reflects IHACPA's functions as outlined in the *National Health Reform Act 2011* (the NHR Act). It also affirms IHACPA's independence and the expectation that IHACPA will carry out its functions to ultimately advance the objectives of the NHRA. The funding models encapsulated in the NHRA are the activity based funding (ABF) model implemented through the National Efficient Price (NEP) Determination and block funding model implemented through the National Efficient Cost (NEC) Determination.

Schedule C of the Addendum also includes specific provisions to explore funding and payment mechanisms that focus on paying for value and outcomes. Guided by a review of national and international literature and advice from clinical experts, IHACPA developed a methodology which identified different patient cohorts that may be amenable to ABF, bundled or capitation payments. IHACPA provided these findings as part of the joint advice on behalf of IHACPA, the Australian Commission on Safety and Quality in Health Care and the Administrator of the National Health Funding Pool to the Health Ministers' Meetings (HMM) for consideration in October 2021.

IHACPA did not receive response from HMM following the provision of this advice.

Further information regarding the current national funding model for public hospital services is available in IHACPA's October 2023 submission to the inquiry.

Role and function of IHACPA

The NHR Act provides the legislative foundation for IHACPA's role, purpose and determinative functions. Principally, section 129(2) of the NHR Act establishes IHACPA's role to "give independent and transparent advice in relation to funding for public hospitals." Section 130 of the NHR Act outlines the object of IHACPA to "promote improved efficiency in, and access to, public hospital services by

a. providing independent advice to governments in relation to the efficient costs of such services, and
b. developing and implementing robust systems to support activity based funding for such services."

Section 131 of the NHR Act provides the functions of IHACPA related to public hospitals and health care pricing and costing. These include the determining the NEP and the NEC, determining the scope of public hospital services that are to be funded by the Commonwealth, and developing and specifying classification and data collection systems

that are relevant to fulfilling these functions. The legislation also outlines the governance and consultation requirements IHACPA must adhere to in carrying out its functions.

In line with its legislative and policy foundations, IHACPA releases a range of publications each year that specify how it delivers on its functions, and these may be useful references for the Inquiry. The publications as required by legislation or under the Addendum include the:

- National Efficient Price Determination and National Efficient Cost Determination
- Pricing Framework for Australian Public Hospital Services
- Three Year Data Plan
- IHACPA Work Program and Corporate Plan
- Annual Report
- Data Request Specifications
- Australian Hospital Patient Costing Standards.

Role and function of the Administrator of the National Hospital Funding Pool

Section 238 of the NHR Act also provides the legislative foundation and functions of the Administrator and the National Health Funding Body (NHFB). Further information pertaining to the work of the Administrator and the NHFB is available on their website.

Engagement with the NSW Government

IHACPA has a long-standing commitment to consultation and transparency in the delivery of its functions, with a robust and consistent framework in place to achieve this.

The NHR Act specifies the following consultation and transparency requirements, to:

- call for and accept, on an annual basis, public submissions regarding its public hospital pricing functions (131(1)(l)) and work program (225(1))
- have regard to relevant expertise and best practice within Australia and internationally and submissions made at any time by the Commonwealth, a State or a Territory (131(3)(a-b)).

The NHR Act legislates 2 advisory committees related to public hospitals and health care pricing and costing, the Clinical Advisory Committee (CAC) and Jurisdictional Advisory Committee (JAC), with IHACPA required to have regard to the advice provided by these committees.

Exceeding the requirements of the NHR Act, IHACPA has also established an extensive set of advisory committees and working groups that support the CAC and JAC in providing advice to the Pricing Authority on a wide range of matters. This includes the IHACPA Technical Advisory Committee (TAC) and the National Hospital Cost Data Collection (NHCDC) Advisory Committee (NAC). TAC provides advice on all relevant technical matters that impact the classification systems, activity and cost data collection systems and the national pricing model. TAC and JAC committees convene on a monthly basis. NAC provides specialist input on all matters related to the cost data collection and quality assurance. NAC and CAC both convene on a quarterly basis.

IHACPA engages with the NSW Ministry of Health through their representation at IHACPA's JAC, TAC and NAC. Clinicians from NSW-based local health districts also form part of IHACPA's CAC. IHACPA also engages with NSW on a bilateral basis on a range of different issues as they arise. For example, IHACPA has engaged closely with NSW to support the proposed transition of community mental health care from block funding to ABF, and to support IHACPA's review of its intensive care unit (ICU) adjustment, incorporating the literature review undertaken by NSW Ministry of Health.

Furthermore, section 211(1) of the NHR Act requires IHACPA to provide the Commonwealth and state and territory health ministers with a comment period on reports of at least 45-days, prior to the report being published.

IHACPA fulfills these functions annually through its annual public consultation to develop its Pricing Framework for Australian Public Hospital Services and IHACPA Work Program and Corporate Plan. Furthermore, all draft reports are provided to all health ministers for comment periods of at least 45 days ahead of finalisation and publication. This includes the draft NEP and NEC Determinations. All jurisdictional and ministerial submissions are provided in their entirety to the Pricing Authority for their consideration, along with advice provided by IHACPA's advisory committees and working groups.

The NSW Ministry of Health is included in all these consultation mechanisms. Further information pertaining to IHACPA's consultation mechanisms is available in the IHACPA National Pricing Model Consultation Policy.

IHACPA responds to specific feedback provided by NSW through direct correspondence, IHACPA's advisory committees and working groups or the annually released Pricing Framework for Australian Public Hospital Services - Consultation Report.

2. **Please outline the annual process undertaken by IHACPA to set the National Efficient Price (NEP) and National Efficient Cost (NEC). Please provide examples of matters raised by NSW in its submission to IHACPA regarding draft NEC/NEP determinations during the last three years that has resulted in IHACPA amending either its draft NEP determination or draft NEC determination.**

The NEP and NEC Determinations are published each year for the upcoming financial year. The NEP provides a relevant price signal to states and territories, and local hospital networks (LHN), that will support improvements in patient access to services, public hospital efficiency and funding effectiveness.

In developing the determinations, IHACPA adopts a national, data-driven approach. The analysis, costing and pricing methodologies underpinning the national pricing model are exclusively based on activity and cost data from all jurisdictions and considered at a national level, supported by consultation with all jurisdictions. Each year, IHACPA releases a document, Understanding the NEP and NEC which provides a full overview of the NEP and NEC Determinations for a given financial year.

Prior to developing the determinations, IHACPA releases a Consultation Paper on the Pricing Framework of Australian Public Hospital Services in June each year. This provides an opportunity for public consultation on the development and refinement of the national ABF system. It includes proposed policy decisions, classification systems and data collection that will underpin the upcoming NEP and NEC Determinations. All submissions received from NSW to the annual Consultation Paper on the Pricing Framework of Australian Public Hospital Services are published on IHACPA's website. These submissions (2025–26, 2024–25 and 2023–24) outline the matters raised by NSW.

Following consideration of the feedback received, IHACPA develops a draft Pricing Framework of Australian Public Hospital Services (Pricing Framework) which is circulated to all health ministers for a 45-day comment period in September each year. Once all feedback is considered, IHACPA prepares the final Pricing Framework, published in December each year.

Simultaneously, the draft NEP and NEC Determinations are developed based on the decisions in the Pricing Framework, and the finalised costed activity dataset required for pricing. The draft NEP and NEC Determinations are provided to all health ministers for the 45-day comment period. Once feedback is received from jurisdictions, IHACPA considers the advice as part of the finalisation of the NEP and NEC Determinations. The final determinations are published in March each year, ahead of their implementation from 1 July that year.

3. **What is the relationship between actual cost of delivery of health services (which appear on the general list of in-scope public hospital services ("General List")) and the NEP/NEC?**

As required by the NHRA (as amended), IHACPA adopts a national, data-driven approach to fulfilling its determinative functions under the NHR Act, based on actual activity and costs. It is not the intent of the pricing and funding approach to incorporate changes to the national pricing model based on prospective estimates of cost such as state-based service agreements and or budgets. This is to ensure that the price signal is developed based on actual reported activity and cost data, rather than the projection of costs.

The NEP is based on the average cost of an admitted acute episode of care provided in public hospitals during a financial year. IHACPA collects patient-level cost data through the NHCDC, which reflects the cost and mix of resources used to deliver patient care. To account for the wide variation in complexity and resource use, each episode of patient care is measured using national weighted activity unit (NWAU), and each hospital episode of care is expressed as a common unit. The 'average' hospital episode of care is worth one NWAU. More complex and expensive episodes of care are worth multiple NWAUs, and simpler and less expensive episodes of care are worth fractions of an NWAU.

The price of each public hospital service is calculated by multiplying the NWAU allocated to that episode of care by the NEP. Each NEP Determination includes the NEP, the scope of public hospital services eligible for a Commonwealth funding contribution under the NHRA, as well as price weights for each classification end class and adjustments to the price to reflect legitimate and unavoidable cost variations in service delivery. Once made, the NHR Act does not allow the NEP and NEC Determinations to be amended.

The process of using actual reported activity and cost data results in a necessary lag between the year in which each NEP is applied and the data used to inform that price. For example, the development of the NEP Determination 2024–25 (NEP24) used activity and cost data from the 2021–22 financial year. To address the change in costs over the 3-year period, IHACPA applies an indexation rate to convert the average cost per separation in a given year to project a price in a future year. IHACPA uses the 5 most recent years of available patient costed admitted acute activity data to calculate an indexation rate.

A national data-driven approach relies on comprehensive and consistent reporting of activity and costs across all jurisdictions. Therefore, data reported by jurisdictions directly impacts the national price for public hospital services, which subsequently informs the Commonwealth funding contribution. Jurisdictions are responsible for ensuring the quality and accuracy of the data they report for pricing purposes, with support from IHACPA through the provision of nationally consistent data specifications and standards. IHACPA regularly consults with jurisdictions on the specifications of the data it collects and to ensure that the Australian Hospital Patient Costing Standards remain fit for purpose. However, if the activity and cost data is not accurately reported by jurisdictions, IHACPA is limited in its ability to develop both classification and pricing model refinements. Similarly, proposals of alternative data sources or items by one jurisdiction may not be reported nationally or consistently. As such, if the alternative data source or item is not reported on a national basis, it would not capture and reflect certain costs or activity in all jurisdictions and thus could not be implemented in the national pricing model.

In September 2018, IHACPA engaged Ernst & Young, KPMG and PricewaterhouseCoopers to independently perform a Fundamental Review of the National Efficient Price. The purpose of the review was to research, review and recommend new and/or improved methodologies to determine the NEP, to ensure they remain best practice. The national pricing model was found to be fit-for-purpose, with 14 key recommendations identified in the reports. The findings from the 3 reviews is available on IHACPA's website.

Additionally, in 2023, IHACPA undertook a review of the indexation methodology that highlighted that alternative indexation options do not have a clear advantage over the existing indexation methods in terms of predictive accuracy in forecasting inflation.

Further information regarding the calculation of the NEP and NEC is available in IHACPA's October 2023 submission to the inquiry.

4. **Please outline the process by which adjustment factors are determined and calculated for the purposes of ABF. Is there is an adjustment factor for patients with low health literacy, Culturally and Linguistically Diverse patients, or patients who require an interpreter, and if not, why is that the case?**

Clause 131(1)(d) of the NHR Act states that IHACPA's functions include determining adjustments to the NEP to reflect legitimate and unavoidable variations in the costs of delivering health care services.

IHACPA's Assessment of Adjustments to the National Pricing Model Policy outlines the considerations underpinning IHACPA's assessment of proposed adjustments to the national pricing model to address legitimate and unavoidable cost variations in the delivery of public hospital services. This includes the process IHACPA follows when assessing the materiality of proposed changes to the national pricing model, such as the introduction of new adjustments or alternative pricing approaches, or the review and potential removal of existing adjustments. This policy provides a high level guide of the issues that the Pricing Authority will consider in reaching a decision.

It is also important to note that with a national model, there are trade-offs IHACPA must consider, to ensure the model does not become overly complex. IHACPA considers a range of factors including the materiality of proposed adjustments when assessing potential refinements in response to changes in cost of care delivery; and only refinements that present material improvements to the national pricing model are pursued. The National Pricing Model Technical Specifications are released each year with the NEP and NEC Determinations, and outlines the process for calculating each adjustment.

IHACPA frequently reviews adjustments and stakeholder feedback identifying potential areas of legitimate and unavoidable cost variation in the delivery of public hospital services. In 2015, IHACPA undertook the Culturally and Linguistically Diverse Patient Costing Study to inform a policy decision for whether an adjustment is warranted to the NEP for culturally and linguistically diverse (CALD) patients. The study identified a lack of nationally consistent patient and service delivery indicators and accurate patient-level costing for interpreter services. This prevented the accurate differentiation of costs for CALD patients, and subsequently, the development of an adjustment.

It is important to note that the onus is on jurisdictions to ensure changes in care delivery, such as ICU services, are reflected in national data collections and costing practices, with support from IHACPA to maintain consistency in reporting. This is to ensure such changes can support and inform future refinements to the national pricing model. Variation in reporting of these changes across jurisdictions can constrain IHACPA's ability to respond to clinical changes and, at times, IHACPA may be required to undertake additional analysis and changes to data collections to establish that proposed refinements are data-driven. At a minimum, IHACPA requires a nationally agreed definition and method of measurement or indicator that can be collected and reported by health services across all states at territories for every patient episode, to be incorporated into the national pricing model. Achieving this can result in delays to the incorporation of service delivery changes in the national pricing model.

At present, there is no nationally agreed method of measurement or indicator for a patient's health literacy level that can be reported by all jurisdictions for each patient episode. Similar to the findings from the investigation into an adjustment for CALD patients, an adjustment for low health literacy would not be possible unless this patient characteristic was recorded by all jurisdictions. It would require substantial investment and commitment from all states and territories to establish a national definition and method of measurement before the feasibility of such an adjustment may be explored.

5. **Please outline the process for determining the threshold of activity for block funding health facilities, and whether this differs for acute admitted, subacute and community health services.**

Clauses A52–A55 of the 2020–25 addendum detail the process that the Pricing Authority is required to follow to determine the block-funding criteria and amounts for block-funded hospitals. States and territories provide advice to IHACPA on how their hospital services and functions meet the block-funding criteria on an annual basis. For small rural and small regional hospitals, this advice can be provided once every 6 years, or more frequently at the discretion of the state or territory. Hospitals are generally assessed using three years of activity data.

The Activity-based funding for Australian public hospitals: Towards a pricing framework consultation paper, prepared in December 2011, highlighted the limitations of the original methodology based on Commonwealth and state or territory bilateral agreements. This paper explored the policy options for block funding criteria, their implications and challenges including reviewing the eligibility criteria for block funding volume thresholds. It acknowledged that the IHACPA (formerly the Independent Hospital Pricing Authority) would need to develop a methodology for the 2013–14 Pricing Framework to assume its role in determining block funding payments.

IHACPA developed its initial block funding criteria for the NEC Determination 2013–14 (NEC13) following detailed analysis and consultation with stakeholders. IHACPA provided the following criteria to the COAG Health Council (now established at HMM):

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

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

As part of this, IHACPA established a 'low volume threshold' to determine whether a public hospital was eligible to receive block funding, which was applied for the first time in the NEC Determination 2013-14.

The low volume threshold included in the block funding criteria has been refined over time as follows:

- In the NEC Determination 2013-14, the first low volume thresholds were set based on inpatient NWAU only. Therefore, hospitals were eligible for block funding if they were:
    - in a metropolitan area (defined as 'major city' in the Australian Statistical Geography Standard (ASGS)) and they provided less than or equal to 1,800 acute inpatient NWAU; or
    - in a rural area (defined as all remaining areas, including 'inner regional', 'outer regional', 'remote' and 'very remote' in the ASGS) and they provided less than or equal to 3,500 acute inpatient NWAU.
- In the NEC Determination 2015–16, the low volume threshold for a rural area was changed to consider total NWAU per annum, rather than only total inpatient NWAU. This was due to the:
    - improved data quality and availability across other care streams; and
    - distortions that rural hospitals with relatively low admitted NWAU but high emergency department NWAU were introducing into the small rural hospitals pricing model.
- In the NEC Determination 2022–23, IHACPA changed the metro low volume threshold from being less than or equal to 1,800 admitted acute NWAU to less than or equal to 1,800 admitted NWAU, therefore including subacute and mental health NWAU in addition to acute NWAU.

In addition to the changes to the low volume threshold, IHACPA introduced the 'fixed-plus-variable' model in the NEC Determination 2020–21 (NEC20). Prior to NEC20, block-funded hospitals were clustered into volume groups based on set thresholds of activity. The efficient cost of a small rural hospital was determined based on these volume groups and other

factors including remoteness and whether the hospital provided surgical obstetric services. However, the block-funded model did not increase funding to a hospital commensurate to an increase in activity if it did not lead to a change in the volume grouping. This was occurring where services were relocated from metropolitan to regional and remote areas.

The fixed-plus-variable model is the total modelled cost of each hospital based on a fixed component as well as a variable ABF-style component. Under this approach, the fixed component decreases while the variable component increases, reflecting volume of activity.

Other than these major changes, the block funding criteria has been subject to other minor refinements over the years in consultation with IHACPA's advisory committees and all jurisdictions.

Each year IHACPA publishes the block funding criteria in its NEC Determination including any updates to the criteria and the low volume thresholds applied. The NEC Determination also includes the following:

- the NEC for small rural hospitals
- the efficient cost for other hospitals that may not be under the relevant low volume threshold but jurisdictions have supplied additional evidence that indicates block funding is warranted.
    - These hospitals are considered and approved by the Pricing Authority, based on factors such as a lack of diversity in casemix, high proportion of very long stay patients or extremely high fixed costs/unavoidable cost variations that aren't sufficiently addressed through adjustments.
- services in ABF hospitals that are eligible for block funding as the technical requirements for applying ABF are not able to be satisfied.
    - For NEP24, these include all residential and community mental health services.

The Pricing Framework for Australian Public Hospital Services 2025–26 outlines IHACPA's intention to transition community mental health care services from block funding to ABF for the NEC Determination 2025–26 (NEC25) using the Australian Mental Health Care Classification (AMHCC) Version 1.1, after 4 years of shadow pricing using the AMHCC Version 1.0. To support this change IHACPA determined that its existing block funding criteria was not considered appropriate to be applied to community mental health establishments, as the activity profile of community mental health establishments is sufficiently different to hospitals. As part of the planned transition of community mental health care services from block funding to ABF, IHACPA has worked with stakeholders to develop appropriate block funding criteria for these establishments for the NEC25. The 2 block funding arrangements for community mental health establishments for 2025–26 are intended to apply to:

- rural LHNs delivering a low volume of community mental health services
- standalone establishments delivering specialised forensic community mental health services.

The final block funding criteria will be published in the NEC25, and will be reviewed in the development of the NEC Determination 2026–27 following an anticipated uplift in data reported for community mental health care services following its transition to ABF.

6. Please outline the process IHACPA undertakes of "back-casting" activity under the NHRA when calculating the rate of growth, what "back-casting" is seeking to achieve and what impact this process may have on the Commonwealth contribution rate.

Back-casting is the process by which the effect of significant changes to the ABF classification systems or costing methodologies are reflected in the national pricing model the year prior to implementation, for the purpose of calculating Commonwealth growth

funding for each ABF service category. The Addendum states that if IHACPA makes significant changes to the ABF classification systems or costing methodologies, the effect of such changes must be back-cast to the year prior to their implementation for the purpose of calculating Commonwealth growth funding (clause A41).

Back-casting is important to ensure the calculation of Commonwealth growth funding is not adversely impacted by changes in the national pricing model or the calculation of the NEP and NEC over consecutive years. Commonwealth funding for hospital services is based on both the change in volume of weighted services and growth in the NEP and NEC, therefore it is imperative that the previous year's pricing model accurately reflects the relevant year's data.

IHACPA's Back-Casting Policy sets out the process IHACPA follows when back-casting the NEP or the NEC for the purpose of calculating Commonwealth growth funding. This policy is to be applied in conjunction with the IHACPA National Pricing Model Consultation Policy, which outlines the guiding principles and consultative processes associated with changes that materially impact the application of the national pricing model for the purpose of the NEP and NEC Determinations.

As per the Back-Casting Policy, the Administrator will calculate the Commonwealth's funding contribution for each ABF service category, as set out in clause A38 of the 2020–25 addendum. IHACPA will advise the Administrator of the back-cast effect of any changes that IHACPA has determined to be significant to the ABF classification systems or costing methodologies. The Administrator would be best placed to provide advice regarding the impact this process has on the Commonwealth contribution rate.

7. The reasons for shifting and escalating costs in public hospital services, how those changes are currently considered in the national pricing model, and whether there are other approaches to funding that may be available to respond to them.

IHACPA undertakes a robust, national data-driven approach to accounting for increased costs in the national pricing model. The range of drivers contributing to escalating costs are discussed in detail in IHACPA's submission to the inquiry in October 2023.

The NEP is designed to provide a price signal for the upcoming year. It is not intended to support prospective changes based on projected estimates, such as state-driven workforce recruitment initiatives. As noted previously, there is a time lag between data and pricing determination that has been a consistent feature of the national pricing model for over a decade. The length of this time lag, 3 years between the year of cost data used to develop the price and the year that the price is used for funding, is aligned to the minimum time all jurisdictions require to prepare and submit their cost data. This approach means that purported current higher cost growth will, over time, be captured in the cost data underlying future NEP determinations.

For example, if the cost of delivering a particular hospital activity rises in the period directly following the year of cost and activity data being used to develop the next NEP, then LHNs and jurisdictions bear the burden of that cost increase in the short-term and will therefore have an incentive to manage those cost increases.

As more recent cost and activity data is made available, it is used to inform NEP development. While certain costs may not be immediately reflected, such as incentive-based workforce initiatives to improve recruitment and retention of the workforce, these contributions will inform future NEP and NEC growth. Therefore, while states and territories may initially face lower price growth, this effect would be expected to reverse over time as higher historical cost growth potentially results in higher future prices and long-term growth. In this way, funding risk would be expected to balance over time between states and territories and the Commonwealth.

IHACPA accounts for the effect of inflationary and external cost pressures, and the incorporation of year-on-year cost growth amounts within the broader national pricing model

methodology. As part of the NEP development, IHACPA indexes costs from the latest available data to estimate those in the year of funding. IHACPA uses the 5 most recent years of available patient costed admitted acute activity data to calculate an indexation rate. The NHCDC is Australia's most comprehensive source of national public hospital cost and utilisation and is therefore used in calculating IHACPA's price indexes specific to Australian public hospitals. As costs of service delivery change, these changes are reflected in the cost data reported nationally in the NHCDC and other data sets and subsequently reflected in the NEP and NEC Determinations.

As mentioned in response to question 3, in 2023, IHACPA undertook a review of the indexation methodology. The review considered alternative metrics proposed by stakeholders as well as those identified through a literature review of existing methodologies. IHACPA tested a range of proposed options individually and in combination, and in both stable and volatile inflationary environments, to analyse the accuracy of their predictions and compared these to the existing indexation methodology. The review findings highlighted that alternative indexation options do not have a clear advantage over the existing indexation methods in terms of predictive accuracy in forecasting inflation.

Also in 2023, IHACPA committed substantial resources to engage and work with jurisdictions to evaluate its methodologies to ensure it accounts for in-scope costs reported by jurisdictions, and investigate alternative methods proposed by NSW and other jurisdictions. In December 2022, IHACPA was given notice by the former NSW Minister for Health requiring a report under section 208(1) of the NHR Act.

IHACPA undertook extensive analysis of the current indexation methodology and the alternative indexes proposed by NSW that sought to incorporate forecasted cost growth in forward years that is not reflected in historic cost data, including but not limited to increases in inflation and wages (as opposed to calculating indexation by only considering historic growth in public hospital costs and activity). Examples provided by NSW included the International Monetary Fund Australian inflation estimates, Deloitte Access Economics data, the Consumer Price Index and the Organisation for Economic Co-operation and Development Economic Outlook for Australia.

Findings from the investigations into alternative indexation methods for the NEP Determination 2022–23 (NEP22) proposed by NSW yielded a lower indexation rate of between 2.0% and 2.6% per year, compared to IHACPA's indexation rate of 2.8%. The resultant impact of using one of the proposed alternative methodologies would be a lower NEP and reduction in Commonwealth funding to the state, compared to IHACPA's existing methodology.

Additionally, many of the shifts in costs may be state-specific or time-specific and not appropriate to address through the national pricing model. In terms of alternative approaches to funding that could respond to shifting and escalating costs, jurisdictions as system managers may advise on the state-based options available to them to address these costs.

8. **The way in which the trialling and implementation of innovative models of care is currently funded, and whether there are alternative funding models to those currently available that may better support such initiatives. What is IHACPA's role in and experience of the process of funding innovative models of care, and the effectiveness of current funding approaches in supporting their development and implementation. To the extent available, the Inquiry would be interested to learn of some examples from NSW and other jurisdictions.**

Clauses A96 A101 and Schedule C of the Addendum outlines how innovative models of care and services may be funded under the NHRA. Clause A101 states that to support the trialling of innovative models of care, IHACPA will:

a. develop a funding methodology for HMM approval by April 2021 that does not penalise states or territories undertaking trials, or other parties to the Addendum.

Application of this methodology in individual instances would be agreed by the relevant state(s) or territory and the Commonwealth.

b. advise the Commonwealth and state(s) or territories on the application of the methodology at (a) above and on any issues it foresees with the proposed trial, with regard to the national funding model.
c. provide advice to HMM on any proposal to translate an innovative funding model to the national funding model. This advice would inform HMM consideration on the matter.

Based on these provisions, IHACPA incorporated a process to assess trials of innovative models of care and services for inclusion on the general list as part of the General List of In-Scope Public Hospital Services Eligibility Policy. However, despite IHACPA's significant expertise in this area, IHACPA's role in the development and assessment of innovative funding models and innovative models of care has been limited. Parties to the agreement are framed as the drivers of exploring innovative models but this has not resulted in any innovative funding models being trialled so far, with the exception of the bilateral agreement between the Commonwealth and NSW for a select number of innovative models of care.

IHACPA provided the 'Future Funding Models for Australia's Public Hospitals: A discussion paper on options for funding Australian public hospitals into the future' (Future Funding Models Discussion Paper) as part of the joint advice on behalf of IHACPA, the Australian Commission on Safety and Quality in Health Care and the Administrator of the National Health Funding Pool to HMM for consideration in October 2021. However, IHACPA did not receive any direction nor feedback from HMM in order to proceed.

In late-2021, IHACPA undertook analysis to help develop a chronic kidney disease capitation model aimed at providing health care services with greater funding flexibility to offer high quality care to patients who frequently utilise hospital services. This work was provided to IHACPA's JAC as an example to demonstrate the types of innovative funding models being considered by IHACPA, and potential project requirements and trial parameters. However, jurisdictional feedback has indicated that there is a preference for states and territories to nominate their own innovative funding models for consideration under the Addendum clauses, rather than models determined by IHACPA.

9. **Please outline the process that resulted in a bilateral agreement being entered into between the Commonwealth and NSW Minister for Health for the funding of Royal Prince Alfred Virtual, Telestroke, Pathways to Community Living (PCLI), Virtual Clinical Care Centres and Northern Sydney LHD Frail Aged Program as in scope for 2022–23, 2023–24 and 2024–25, including when the services incorporated within those programs may be considered for addition to the General List.**

Clause A97 of the 2020–25 addendum enables the Commonwealth and a state or territory to trial an innovative model of care for a fixed period of time through a bilateral agreement. Given the bilateral agreement for the aforementioned services was between the Commonwealth and the NSW Government, IHACPA was not privy to that process. IHACPA was advised of the outcome of the process and provided a copy of the bilateral agreement once signed, and thus these services were included in the NEC Determination 2024–25 onwards.

Should NSW wish to have these services added to the General List, they will be required to follow the process outlined in the General List of In-Scope Public Hospital Services Eligibility Policy.

10. **The range of approaches to funding public hospital services (whether currently in use in Australia and New South Wales, or not) - such as bundling or capitation payments etc. - including the advantages, disadvantages and practicalities or current impediments to introducing such models, whether as part of a national agreement, or within a particular state or territory.**

The Addendum provides opportunities for states and territories to trial new funding approaches and outlines IHACPA's role in supporting these reforms. As noted earlier, IHACPA is required to develop a methodology to support the trialling of innovative models of care and provide advice to HMM on continuing proposed trials for a further period or translation into a permanent model of care.

While ABF works well for funding predictable one-off episodes of care, it may not incentivise the provision of health services that are delivered across multiple settings of care or the delivery of more services in the community. For patients with conditions that lead to frequent use of hospitals (and other services) over an extended time period, capitation payments may work better than current ABF arrangements. That is, ABF may incentivise admitting patients to a hospital rather than aim to prevent hospitalisation. Preventing hospitalisations often requires alternative treatments and services which can lead to better health outcomes, reduced costs and an improved patient experience.

Bundling and capitation payment models provide better incentives for the management of patients with chronic health conditions beyond the hospital setting, thereby supporting approaches to reduce preventable hospital admissions for those chronic condition groups. Guided by review of national and international literature and advice from clinical experts, IHACPA developed a methodology which identified different patient cohorts that may be amenable to ABF, bundling or capitation payments.

As outlined in the Future Funding Models Discussion Paper, IHACPA's analysis found that:

- 70% of patients, accounting for around 50% of total hospital funding, would most likely be most suitable for funding under existing ABF arrangements
- around 20% of patients, accounting for around 20% of total funding could be amenable to bundled payment approaches
- approximately 10% of patients, who account for 30% of total hospital funding could potentially be covered by a capitation model.

However, the Future Funding Models Discussion Paper also identified a range of critical success factors that were essential to progressing with the development of alternate funding models. As outlined in response to questions 1 and 8, IHACPA provided these findings as part of the joint advice on behalf of IHACPA, the Australian Commission on Safety and Quality in Health Care and the Administrator of the National Health Funding Pool to HMM for consideration in October 2021. IHACPA did not receive response from HMM following this milestone.

11. The extent to which there are other approaches to funding public hospital services that may better promote allocative efficiency, value based care and better support the delivery of care to those with multiple chronic conditions.

Refer to response to question 10.

12. The extent to which there is need for increased data collection, linkage and/or sharing across the wider public health system (including across hospital and primary care settings) to support the development and implementation of alternative funding models, including by enabling an assessment of whether an initiative represents value-based care.

The advice provided to HMM through the Future Funding Models Discussion Paper highlights the critical success factors that need to be addressed to progress alternative funding models. One of these was data linkage and ICT requirements.

The Discussion Paper outlines that the success of introducing any alternate funding model relies on utilisation of the Individual Healthcare Identifier (IHI) in all national data sets. The IHI is a unique number used to identify an individual for health care purposes and would enable a patient to be tracked across the different classification system data sets more accurately. This will allow for the pathway of care to be classified and costs attributed

accordingly, as well as support the expansion of trials of innovative funding models beyond traditional hospital services. IHACPA commenced work on the IHI in 2019. To date, only 2 jurisdictions report the IHI – Queensland and South Australia and to varying degrees.

Currently, nationally reported activity and cost data is not sufficient to support the development of bundled payment and capitation models. There have been the persistent barriers to achieving such reforms and a strong need for the:

- development and reporting of nationally consistent outcome measures in national data collections, such as patient reported outcome or experience measures
- adoption of a unique identifier to map the entirety of the patient journey such as the IHI.

While there may be small-scale trials to work around this lack of data, scaling these nationally, which is the intent of the reforms, would be extremely difficult without this critical data. Jurisdictional feedback in 2019 and 2020 on the barriers to implementing the IHI primarily related to resourcing and capacity constraints of existing software systems. Additionally, a range of jurisdictions supported the national collection of patient reported outcome measures, however noted its collection could add extra burden to both clinicians and patients.

IHACPA has provided advice that there needs to be a commitment from all jurisdictions for the following if this to be achieved:

- investment in critical infrastructure to collect the IHI; and
- further work towards establishing national capability to capture patient outcome measures, to facilitate achievement of the reforms proposed.

13. The funding implications of the fragmentation between the primary care and public hospital sectors, including between the Medicare Benefits Schedule and state-based funding systems, as well as the influence of the aged care and disability sectors, and whether there are any funding models (for example, commissioning of services) that may be used to address the impact of that fragmentation.

It has become apparent that defining the services typically provided within a hospital has become more challenging. This is due to the delineation between primary and secondary care becoming increasingly blurred, as has been highlighted through IHACPA's work to transition community mental health care services from block funding to ABF. IHACPA understands that this issue of integrated care was highlighted in the Mid-Term Review of the Addendum to the NHRA 2020–25 and has been the subject of negotiations for the development of the Addendum to the NHRA 2025–30.

Certain funding models, for example bundled payments, may be more suitable for care provided across a full care pathway. However, as mentioned in response to question 12, it is impossible to achieve this without a robust data collection system that can identify care that spans different settings such as hospital and primary care. Additionally, the data collection systems for aged care are in their infancy and will require maturation prior to progressing with exploration of different funding models.

14. Any other issue that IHACPA wishes to raise with the Inquiry that relates to its Terms of Reference.

Nil.