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Independent Hospital Pricing Authority Consultation Submission – October 2016

The Independent Hospital Pricing Authority (IHPA) released a Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2016 -17. The following information is provided in response to the questions raised in the consultation paper regarding the incorporation of safety and quality into the pricing and funding of public hospital services.

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Alfred Health is a major metropolitan health service in Melbourne and is the main provider of public acute, sub-acute and rehabilitation, aged care, mental health and community health services for the communities of the inner south-eastern and bayside areas of Melbourne. The Alfred Hospital is a major tertiary referral hospital recognised as one of Australia's busiest emergency and trauma centres and with over 13 state-wide services including the Victorian Adult Burns Service, Victorian Melanoma Service and Heart and Lung Transplant Service. The Alfred is one of the two adult major trauma services for Victoria treating about two-thirds of all adult major trauma cases.

General Feedback

The paper raises the question as to whether taking funding away from a public health provider for performance that falls into the categories that are discussed and is considered sub optimal, actually changes behaviour and outcomes. The argument could be made that this will reduce a health services capability to change behaviour by reducing funding because the health service will (presumably) still aim to reach its targets. A health service that consistently does not reach its targets in safety and quality will already have its management under pressure through existing governance structures.

The paper appears to be based on a number of assumptions that require further validation;

1. Consistency in costing methodologies within a state and nationally.
   The existing Australian Hospital Patient Costing Standards are still reasonably broad and do not provide the level of guidance necessary to ensure consistency in costing. The major areas where costing is not consistent and needs work are in recognising complexity and acuity in patient level costing and in the costs allocation methodologies for organisational overheads. If costing is not consistent there will always be debate around the validity of the DRG weights.

2. Maturity and quality of DRG coding is consistent nationally.

There is a general consistency across most areas of patient level costing that the models do not recognise acuity and complexity enough in the risk adjusting of costing models. This is partly because of the costing itself but it is generally clear that as acuity increases health services tend to be underfunded for the increased requirements of that patient care.
If models are to be introduced to reduce funding for things like hospital acquired conditions and readmissions it is very important the large tertiary hospitals like The Alfred are properly risk adjusted and also any model takes into account the fact that complex patients are often transferred to hospitals like The Alfred.

3. Reporting of safety and quality targets and performance is transparent and timely.
The targets used to measure safety and quality performance needs to be transparent and timely and subsequent funding change has to be known in a timely fashion. Health service financial positions are not something that can be changed and reacted to quickly, the more complex the reporting of performance and subsequent funding changes the more difficult it will be for the health service to respond.

Comments to specific consultation questions

Section 4.4

- Agree that it is very important that the AN-SNAP system in sub-acute introduces comorbidities and a case complexity process. There is evidence to suggest that the current system does not recognise the cost of acuity and complexity sufficiently.

Section 6.1

- Application of activity based costing to all aspects of care types should be further considered especially to ambulatory care types and mental health.
- The measure of activity should;
  - be a fair measure of the cost of carrying out the service,
  - take into account that for many services there is a fixed cost or minimum cost required to set up the service and that activity increase or decrease does not necessarily have an enormous consequent cost effect.
  - be easily obtained and reported without large administrative burden from the administration and clinical staff.

Section 6.3

- Price Weights changes should not be restricted however it is recommended that the reason price weight movement should be investigated before changing the price weight at all. It could be that the model of treatment for that DRG has changed dramatically and that has led to a cost change, it could be that there was an error that is being fixed.

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Section 7.3

- Agree - In terms of the private patient adjustment and version 3.1 of the Australian Hospital Patient Costing Standards, assuming submitted data reflects accurate medical costs for private patients.

Section 11.4

- Risk adjustment model – very difficult to determine a suitable approach however the methodology needs to ensure health services with highly subspecialised case mix are properly risk adjusted especially those that have statewide or national services, such as burns, major trauma, and heart and lung transplantation

Section 11.5

- Agree overall and consideration should be given to adding events that should not occur such as wrong side/site surgery rather than complications of care such as infections.
- Agree overall however would see the Introduction of a sentinel event flag as problematic and difficult for health services to manage. Non-clinical coders will be making this decision without the required clinical input, especially for those where clinical judgement is required eg death due to medication error is often far from clear.

Section 11.6

Pricing and funding options for hospital acquired complications (HACs) raise a few issues:

- There needs to be confidence that the onset flag is applied consistently across the country and states where casemix funding has been in place for a long time.
    - Potentially disadvantages tertiary/quarternary hospitals who take the most complex patients.
    - How would interhospital transfers be treated – potentially this provides a perverse incentive to NOT accept complex transfers, if there is a concern that the health service will not be paid.
    - What methodology would be used to discount the payment and would this be uniformly applied eg. Blood stream infections may not be preventable in patients with neutropenia and will disadvantage hospitals with large haematology/ BMT services; Cardiac arrest in the case where the patient arrives in pre-arrest/ arrest eg ECMO CPR; major trauma.
- Option 2 – hospital level funding adjustment would be the preferred option out of the three options presented however none of the options presented address the concerns raised earlier regarding recognition of the impact patient complexity on pricing and HACs.

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- Consider a central funding pool created by the reduced funding of those health services that perform below the required level and those funds are used to reward the good performers. Consideration could be given to using the funds to assist the low performers to improve.
- The numbers quoted under HACs are high and would have significant impact on the health service which is why it needs to be proportionate, a mixture of reward and assistance to help underperformers.

Further information

For further information and follow up relating to this submission, please contact:

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