



Pricing Framework for Australian Public Hospital Services 2017-18

Independent Hospital Pricing Authority Consultation Paper

October 2016

Table of Contents

1	Overview	1
2	The National Efficient Price for Activity Based Funded Public Hospital Services	1
2.1	Stability of the National Pricing Model (Section 6.3).....	2
3	Setting the National Efficient Price for Private Patients in Public Hospitals	2
3.1	Pricing Private Patients (Section 7.3).....	2
4	Bundled Pricing for Maternity Care	3
4.1	Next Steps (Section 9.4).....	3
5	Pricing and Funding for Safety and Quality	3
5.1	Overview of Scope and Approaches to Pricing and Funding (Section 11.4).....	3
5.2	Sentinel Events (Section 11.5)	4
5.3	Hospital Acquired Complications (Section 11.6)	4
5.4	Avoidable Hospitals Readmissions (Section 11.7)	5
5.5	Implementing a Pricing and Funding Approach (Section 11.8)	6

1 Overview

The Australian Healthcare and Hospitals Association (AHHA) is pleased to provide this submission to the Independent Hospital Pricing Authority consultation paper on the *Pricing Framework for Australian Public Hospital Services 2017-18*.

The AHHA is Australia's national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high quality healthcare to benefit the whole community.

The AHHA in general supports moves towards improving safety and quality in public hospital services. It is vital that the health system is organised and incentivised to ensure that patients receive best practice care and operates as efficiently as possible. However, the use of a pricing and funding mechanism should be only one element in a more comprehensive system response to improving safety and quality in public hospitals. To the extent that pricing and funding impacts resulting from quality and safety outcomes are disconnected from clinical units, the usefulness of a modified pricing and funding framework will also be compromised.

It is also important that any changes associated with quality and safety in public hospitals provides an appropriate balance between incentives and penalties. As an example, it is not clear that rewarding existing "good performers" while financially penalising existing "poor performers" will necessarily achieve the policy objective of improved quality and safety in patient care. In some circumstances, it may be more appropriate to financially assist individual sites to enable a transition to be made to higher levels of safety and quality in patient care. The issue of risk adjustment also needs to recognise that some patients will have more complex needs and are at greater risk of adverse outcomes.

Finally, public hospitals should not be penalised for factors that are not within their control. Better coordination with the primary healthcare and aged care sectors is widely recognised as essential, but there are limits to what public hospitals can properly do across the multiple care systems and settings to optimise patient outcomes. There can also be instances where patient non-compliance, misadventure or delayed seeking of medical attention can lead to ostensibly sub-optimal care but for which a public hospital should not be penalised.

Pricing and funding of safety and quality should not just be a blunt instrument but should be implemented in a way that rewards safety and quality while enabling poorly performing public hospitals to achieve better results.

2 The National Efficient Price for Activity Based Funded Public Hospital Services

Section 6.2 raises the possibility of including all high cost outlier episodes in the calculation of the Patient Remoteness Area Adjustment. The AHHA supports the inclusion of these outliers to account for the type of issues raised by the Northern Territory.

Section 6.2 also states that IHPA is considering using the Statistical Area Level 2 of where a patient usually resides rather than their postcode as a more effective indicator of patient remoteness. The AHHA supports the examination of alternative geographic structures to more accurately assess the remoteness of a patient. However, it is also noted that there are other geographic classification

schemes that have been developed that specifically focus on remoteness that could be considered. Examples include the Australian Bureau of Statistics Remoteness Structure and the Modified Monash Model.

2.1 Stability of the National Pricing Model (Section 6.3)

Consultation questions:

- Should IHPA further restrict year-on-year changes in price weights?

IHPA recognises that large fluctuations in price weights between years can have a negative impact on the stability of funding for public hospital services. While further restrictions to year-on-year price weights may be less reflective of the actual cost of providing these services, AHHA supports the need for stable funding for public hospitals over reasonable periods such as two or three years. If the policy intention is for price signals to drive changes in service delivery, it is likely that hospitals will struggle with the cumulative effect of year-on-year changes to funding levels.

There are many drivers for service improvement, including requirements for accreditation, compliance with professional and care standards, and meeting contractual obligations. Each of these changes requires resources, time and effort to manage. A key issue with yearly changes to price weights is a likely lack of visibility at the frontline (ie will staff know of a change and be able to plan accordingly?) and the time it takes to enact change or innovation. The expectation that price changes can effect real change within a year across multiple services is unrealistic. The cumulative effect of years of price changes and the ability of hospital services to respond need to be understood before it is agreed.

There also needs to be a balance in changes to price weights. On the one hand, a change in price takes time to work through the system (with no guarantee state and territory governments will directly pass on the funding to hospitals). On the other hand, novel treatments coming online can cost more (or less) depending on the cost of the technology, medication, etc.

It would also be helpful in assessing the potential impact of a proposed further restriction of annual changes to price weights if Table 1 on page 18 of the Consultation Paper showed the proportion of hospital services and system funding affected by each of the percentage change bands.

3 Setting the National Efficient Price for Private Patients in Public Hospitals

3.1 Pricing Private Patients (Section 7.3)

Consultation question:

- Should IHPA phase out the private patient correction factor in 2018-19 if it feasible to do so?

The AHHA accepts the need to have a mechanism such as the private patient correction factor due to inconsistencies in the way private patient costs are reported, including the selective non-application of this correction factor to those public hospitals where private patient costs are fully included in the Hospital Cost Data Collection. If all states and territories are able to comply with the required reporting of private patient medical costs by 2018-19, the AHHA supports the removal of the private patient correction factor in 2018-19.

4 Bundled Pricing for Maternity Care

4.1 Next Steps (Section 9.4)

Consultation questions:

- Do you support IHPA's intention to introduce a bundled price for maternity care in future years?
- What stages of maternity care and patient groups should be included in the bundled price?
- Should IHPA include postnatal care provided to the newborn in the bundled price?
- What other issues should IHPA consider in developing the bundled price?

The AHHA does not support the introduction of bundled pricing for maternity care. While the Consultation Paper identifies a proportion of ostensibly uncomplicated deliveries, there are a range of clinical needs and alternative interventions that can arise over the course of the circa 36 week care period (from ten weeks gestation to six weeks postpartum) with associated resource implications. While the Consultation Paper motivates the introduction of bundled pricing for maternity care by observing that maternity care has a relatively predictable service utilisation and noting that there is the potential to incentivise the development of innovative models of care, this proposal does not provide evidence that the application of a uniform price across maternity care will lead to meaningful change in practice for the majority of cases and risks underfunding the remaining more complicated cases. If bundled pricing of maternity care does proceed, this should not impact on flexibility to meet the needs of individual patients and their care choices, and circumstances should be recognised where additional payments may be required for patients with more complex needs. Furthermore, if bundled pricing for maternity care is introduced, the bundled payment must include a component for necessary medical indemnity cover.

5 Pricing and Funding for Safety and Quality

5.1 Overview of Scope and Approaches to Pricing and Funding (Section 11.4)

Consultation questions:

- Is there support for pricing and funding models for safety and quality to be applied broadly across all types of public hospitals, all services, all patients and all care settings?
- What factors should be considered in risk adjustment for safety and quality in pricing and funding models for hospital care?

The AHHA broadly supports the use of pricing and funding models as one element of a broader system response to improving safety and quality across all settings. However, there must be an appropriate balance of incentives and penalties and an acceptance of factors beyond the control of a public hospital that can lead to adverse outcomes (eg complexity of individual patient healthcare needs, sub-optimal primary healthcare or patient non-compliance). It is also vital that any mechanism adopted is not an impediment to change in practices that will lead to an improvement in patient care. This may in particular have a disproportional impact on smaller public hospitals. The AHHA also notes the recognition by IHPA of the importance of developing strategies on multiple fronts to improve safety and quality in healthcare.

A further factor that should be considered in risk adjustment for safety and quality in pricing and funding hospital care is that current price models reflect the existing mix of safety and quality

outcomes. If higher levels of safety and quality are the policy objective, this will require a range of responses, not just removing or reducing the funding for adverse events.

The AHHA agrees that appropriate risk adjustments for safety and quality must recognise that some public hospitals will have more high-risk patients and that any adverse quality and safety outcomes may not be intrinsically related to the quality of care that is provided.

5.2 Sentinel Events (Section 11.5)

Consultation questions:

- Do you support the proposal to not fund episodes that include a sentinel event? If not, what are the alternatives and how could they be applied consistently?
- Do you support the proposal to include a sentinel events flag to improve the timeliness and consistency of data that is used for funding purposes?
- Do you agree with IHPA's assessment of this option (not funding episodes with a sentinel event)?

The AHHA supports the proposal to zero fund episodes of care that result in a sentinel event and to introduce a sentinel event flag to improve timeliness and consistency of reporting. However, it is also noted that two of the identified sentinel events, suicide of a patient in an inpatient unit and maternal death associated with pregnancy, may not be the result of poor quality of hospital care or be within the scope of manageable clinical risks.

5.3 Hospital Acquired Complications (Section 11.6)

Consultation questions:

- What are the advantages and disadvantages of Option 1 (remove the hospital acquired complication (HAC) so that it does not contribute to DRG assignment) which reduces funding for some acute admitted episodes with a HAC?
- Do you agree with IHPA's assessment of this option?
- What are the advantages and disadvantages of Option 2 (funding adjustments made on the basis of differences in HAC rates across hospitals) that adjusts funding to hospitals on the basis of differences in their HAC rates?
- Do you agree with IHPA's assessment of this option?
- What are the advantages and disadvantages of the approaches to risk adjustment?
- What are the advantages and disadvantages of Option 3 (a quality-adjusted NEP with funding incentives for hospitals with the lowest HAC rates) that combines funding incentives and penalties?
- Do you agree with IHPA's assessment of this option?
- Are there any other pricing or funding options that IHPA should consider in relation to HACs?
- How should IHPA treat hospitals with poor quality condition onset flag (COF) reporting?

AHHA notes the IHPA assessment of Option 1 relating to episode level of funding of preventable hospital acquired complications (HACs). However, given that 85 per cent of cases receive no extra funding for episodes that include a HAC, Option 1 would not meaningfully impact incentives related to the policy objective of improving quality and safety of patient care.

AHHA notes the IHPA characterisation of Option 2 relating to differences in preventable HAC rates across hospitals, including the assessment that if such an approach was implemented it should be applied at the hospital level and not the LHN level. There must be an appropriate risk-adjustment to

account for age and patient complexity and hospitals should only be compared within their peer group. However, the two thresholds identified by IHPA for reduced funding due to higher preventable HAC rates (the top quartile or above the national median) ensure that either 25 per cent or 50 per cent of all hospitals would be penalised with reduced funding each year due to their preventable HAC rates. A more targeted approach would be to first determine the historic preventable HAC rate for every public hospital, and for those that are found to be above the national average or other agreed benchmark within their peer group, to then be set an agreed period of time over which this preventable HAC rate is to be lowered towards the benchmark. This would provide an incentive for affected public hospitals to respond within a realistic timeframe to achieve the policy objective of reduced rates of preventable HACs without a simultaneous financial penalty to the public hospital during the transition period. It is also not clear that the policy objective of lowering rates of preventable HACs is best achieved by rewarding those hospitals already performing well in this regard. Finally, it is noted that any use of average HAC rates or benchmarks will always intrinsically include a distribution of actual rates around the mean. That is, there will always be public hospitals both above and below an empirical average regardless of the quality and safety performance of individual hospitals. This further supports adopting an approach that achieves quality and safety improvement against existing performance rather than an empirical average.

AHHA notes the IHPA characterisation of Option 3 relating to the development of a quality-adjusted National Efficient Price (NEP) with savings re-directed to invest in safety and quality initiatives. If such an approach was implemented, any savings from the use of a quality-adjusted NEP should be directed to state and territory governments given their responsibility as system managers for public hospitals and so that the funds can be deployed according to priorities within each jurisdiction's public hospitals system. However, the absence of targeted reduction in funding may not have as direct an effect on improving preventable rates of HAC within individual public hospitals.

Overall, a variant of Option 2 would likely best achieve the policy objective of reducing rates of preventable HACs. However, a balance must be struck between incentives and penalties. Public hospitals should be supported to achieve realistic and attainable rates of preventable HACs and not simply financially penalised even when an improvement in preventable HAC rates may be occurring. Individual public hospitals should instead be supported through a period of transition to attaining lower preventable HAC rates. The cost of identifying and reporting on HACs would also need to be considered.

5.4 Avoidable Hospitals Readmissions (Section 11.7)

Consultation questions:

- What approach is supported for setting timeframes within which avoidable hospital readmissions are measured?
- Is there Australian evidence (including guidelines or recommendations) that could be used to implement condition specific readmission timeframes?
- Is there support for pricing and funding models to be based on avoidable hospital readmissions within the same LHN?
- When should a pricing and funding approach for avoidable readmissions be implemented?

The AHHA in general supports the need to minimise avoidable hospital readmissions. However, evidence must first be identified to support any given readmission window. Identifying avoidable hospital readmissions will also require a chart audit which will require additional personnel and funding.

If this policy is implemented, readmission windows should also vary with specific conditions. The definition of avoidable hospital readmissions should ideally be as comprehensive as possible and be causally related to the initial admission. Avoidable hospital readmissions should be minimally considered within the same LHN. The AHHA would support the use of a de-identified unique identifier derived from a patient's Medicare number to enable patient identification across care settings. Any reduction in funding associated with avoidable hospital admissions should be applied at the episode level.

However, the policy objective of reducing avoidable readmissions not only relates to factors within the control of public hospitals but can also relate to factors outside of their control. Examples of the latter include sub-optimal primary healthcare and patient non-compliance. Furthermore, some patients with chronic and complex needs are inherently at greater risk of readmission regardless of the quality of care that has been provided. Any pricing and funding framework proposed for avoidable hospital readmissions should therefore be appropriately risk-adjusted and not penalise a public hospital for factors beyond their control.

5.5 Implementing a Pricing and Funding Approach (Section 11.8)

Consultation questions:

- What do you think are the most important considerations for implementation of pricing and funding approaches for safety and quality?
- Do you agree that IHPA would need to back-cast the impact of introducing new measures for safety and quality into the pricing and funding models?

The AHHA agrees that an effective safety and quality pricing and funding mechanism will rely on national, state and local health system managers working cooperatively. Furthermore, the use of a pricing and funding mechanism should be only one element in a more comprehensive system response to improving safety and quality in public hospitals. In the transition to any new pricing and funding arrangements, public hospitals should not be penalised for factors that are outside of their control, including an appropriate recognition of individual patient complexity of healthcare needs.



Australian Healthcare and Hospitals Association

Unit 8, 2 Phipps Close

Deakin ACT 2600

PO Box 78

Deakin West ACT 2600

P: 02 6162 0780

F: 02 6162 0779

E: admin@ahha.asn.au

W: ahha.asn.au



@AusHealthcare



facebook.com/AusHealthcare

ABN: 49 008 528 470
