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**AMA Submission on the
IHPA Consultation Paper on the Pricing Framework for
Australian Public Hospital Services 2017-18**

Key points

Achieving improved safety and quality for public hospital services requires a framework of positive incentives for the achievement of relevant targets, supported by the full range of quality and safety mechanisms in place and available to public hospital system operators, doctors, nurses and other hospital staff.

These include improvements in data quality and information available to inform clinicians' practice, whole-of-system efforts to deliver improved patient outcomes, and incentives that work to the level of the clinical department to focus efforts and effect change, with local implementation, monitoring and information sharing needed.

An essential pre-condition for all such improvements is adequate funding for public hospitals. Overall funding for public hospitals under the National Efficient Price (NEP) has been and continues to be inadequate.

The AMA has consistently advocated for the appropriate recognition of safety and quality in the framework of activity based funding and the NEP. However, any approach that sets out to improve safety and quality by financially penalising hospitals that are already under-resourced to achieve safety and quality standards is mis-conceived. The AMA's comments on the Framework's proposed options are made with this overriding caveat.

The HAC list and its use should be refined and tested over a longer period, for example, with the aim of implementing a fully developed approach from 2020, as part of the proposed longer term hospital funding agreement to operate from that date. At a minimum, the HAC list should be constantly assessed and evaluated against its purpose.

The technical merits of options 1 and 2 for HAC are primarily a matter for system operators, but overall there would seem to be some advantage in focusing funding adjustments to hospitals on the basis of differences in their HAC rates (option 2).

Option 3 would have the most extreme and exaggerated effect of reducing resources available to hospitals not meeting safety and quality targets, and locking such hospitals into a vicious circle of under-resourcing leading to under-performance etc.

General Comments

The AMA appreciates the opportunity to comment on the draft Pricing Framework for Australian Public Hospital Services 2017-18.

The AMA has a direct and significant interest in the Pricing Framework for public hospital services as a critical element in the overall functioning of our hospital system.

The major new element in the Pricing Framework relates to options for incorporating safety and quality into the pricing and funding of public hospital services.

The AMA acknowledges that the Pricing Framework is working to design and implement decisions taken in the April COAG Heads of Agreement on Public Hospital Funding and the subsequent Ministerial Direction to the Independent Hospital Pricing Authority (IHPA) (covering sentinel events, hospital acquired complications (HACs) and avoidable readmissions).

The AMA has consistently advocated for the appropriate recognition of safety and quality in the framework of activity based funding and the National Efficient Price (NEP). However, the AMA has significant concerns with how this longstanding gap in the framework is now to be addressed.

Any approach that sets out to address safety and quality by financially penalising hospitals that are already under-resourced to achieve safety and quality standards is misconceived.

Sustained improvements to safety and quality in hospital services will not be achieved by a financial approach involving penalties through pricing and funding. Penalties that impact on hospitals which are not meeting safety and quality targets do not assist the performance of those hospitals and their ability to meet such targets in future, they reduce it.

An initiative that is designed as a pricing and funding measure, that is defined and recognised in terms of its potential to reduce hospital funding, and that operates at the level of hospital administration (often at Local Hospital Network (LHN) level and above), will be regarded as a financial measure rather than a safety and quality measure, and will have no buy-in from those needed to make change.

Whilst this submission includes comments on the Framework's proposed options to address these areas, they are made with the overriding caveat that a primary focus on financial penalties through pricing and funding is unlikely to be a sensible or productive means of improving safety and quality in public hospital services.

Safety and quality reforms should not be made at the cost of funding public hospital services themselves.

Overall funding for public hospitals under the NEP has been and continues to be inadequate. This inadequate funding is demonstrated in key aspects of hospital performance against the targets set by governments, as documented over time in the *AMA Public Hospital Report Card*. The starting point for public hospital funding under the ABF and the NEP framework was the historic costs of an underperforming and underfunded system, since continued though the NEP methodology.

Inadequate funding levels are a key factor in poor safety and quality. Further reducing resources to hospitals will further compound existing problems. Reducing funding should not be confused with positive, supporting measures to encourage and deliver safe, high quality care.

There are many other and more productive approaches to improving safety and quality. As the Framework Consultation Paper itself identifies, these include improvements in data quality and information available to inform clinicians' practice, whole-of-system efforts to deliver improved patient outcomes, and incentives that work to the level of the clinical department to focus efforts and effect change, with local implementation, monitoring and information sharing needed. An essential pre-condition for all such improvements is adequate funding for public hospitals.

The risk of implementing options that involve reducing pricing and funding is that the focus of safety and quality improvements will be displaced to the avoidance of such funding reductions, at the expense of continuing (and increasing) the effort devoted to these more productive approaches.

There is little evidence to suggest at this point that pricing and funding for safety and quality will in fact fit seamlessly into a whole-of-system approach as asserted in the Framework, with

“...national, state, and local health systems working together to support implementation of the model and ensure that it is working to improve safety and quality across all services with clinicians and system managers working in partnership” (*Pricing Framework p54*).

There would also seem to be significant barriers that would need to be overcome in getting 'signals' from pricing and funding approaches to the required levels for improvements to safety and quality, including to individual hospitals and clinical departments.

Where hospitals and even LHNs effectively continue to operate on a block funding basis, the likelihood of pricing and funding approaches sending 'signals' to generate actions and improvements would appear to be minimal. Clear information on how well/how far the current ABF and NEP framework is currently operationalised into decision making at hospital and clinical department levels would appear to be an essential starting point to this or any other proposal for leveraging change at those levels through pricing and funding initiatives.

Detailed comments on relevant consultation questions

Bundled pricing for maternity care

The AMA acknowledges bundling of services can be sensible where there is a logical connection between the services which relates to a well-defined clinical need. Such services should be provided on a predictable, regular basis, with well-understood service and resource requirements. They should not include variations that would justify variable resource needs if they were funded individually.

Bundling of services is not likely to be appropriate or helpful where it substantially reduces transparency or comparability in terms of what is provided to patients, including for costing and management purposes. If information about bundled services would not enable an assessment about what is funded and how it compares across hospitals/LHNs, or support management decisions about costs or other resource allocation, the services should not be bundled.

In this context, maternity care would appear to be potentially suitable to bundled pricing, subject to resolution of the issues identified in the Framework. In relation to defining the patient cohort the AMA suggests that the starting point should be the patient cohort with the least significant variations, ie should not include women having complex vaginal births requiring operating room procedures. AMA agrees that shared care arrangements and women using public hospital services for only some of their care should not be included.

The final design of the bundled pricing approach must include provision for monitoring and evaluation, including to ensure there are no unintended consequences, such as artificially constraining maternal care services to ‘fit’ within the bundled price.

Pricing and funding for safety and quality

Application across all types of public hospitals services

Pricing and funding models for safety and quality that are based on reducing funding for hospitals that do not achieve relevant targets are misguided and counter-productive. A framework of positive incentives for the achievement of such targets, supported by the full range of quality and safety mechanisms referred to above, will achieve better results.

Subject to this overarching proviso, any such models should as far as possible be designed to apply broadly across all types of public hospitals, all services, all patients and all care settings. This should include consideration and any appropriate action to address the likelihood that reductions in pricing and funding may have different significance and impacts on different sizes of hospitals.

Risk adjustment for safety and quality

Risk adjustment should take account of timely data about relevant actual performance and patient characteristics, including any relevant specific needs of feeder populations, including Indigenous, and rural and remote population groups. Although there are many factors that affect risk and need to be considered, the final model for risk adjustment and its practical implications must be coherent and understandable at the level where changes and improvements can be made.

It should be reviewed at an early point to ensure it is closely aligned with the objective of improving safety and quality, provides broad equity across different hospitals, and takes account of any significant unintended consequences (such as possible tendencies to avoid risks that might impact on the achievement of safety and quality targets, for example, by minimizing interventions on high risk patients).

Assessment criteria to evaluate pricing and funding approaches

The proposed assessment criteria are broadly sensible and appropriate, although the criterion for ‘proportionality’ is not as immediately clear in its description and application as the other criteria. It appears to mean the degree to which any pricing or funding reductions correspond to the additional costs caused by the lapse, a version of the punishment fitting the crime?

Given this appears to be the only criterion against which the options perform differently it would be desirable to make it clearer and more intuitive.

It would also be desirable for the assessment criteria to include some means of taking into account what effects the options for pricing and funding reductions will have on hospital capacity to ‘make good’ on safety and quality shortfalls, and to provide services overall. It may also be useful to consider how the options integrate and fit with broader safety and quality measures.

Not funding of episodes that include a sentinel event

Given the number of sentinel events that occur this is not an unreasonable approach, even if it involves an element of ‘retrospectivity’ (ie if the costs of care provided up until the sentinel event occurred are not funded).

Pricing and funding options for hospital acquired complications (HAC)

Implementation of HAC model

The AMA notes the Direction to IHPA in respect of hospital acquired complications directs IHPA to have regard to the Parties intention to:

“... (b) implement a model for an agreed set of preventable hospital acquired conditions not before 1 July 2018, with a preceding shadow year.”

Fully consistent with this Direction, and given the AMA’s general concerns with the safety and quality measures, and both specific and potential problems of the HAC list in

relation to a pricing and funding purpose, the AMA argues strongly that more time is required to develop a robust approach to HACs, one that is properly integrated with the more productive safety and quality approaches referred to above.

The HAC list and its use should be refined and tested over a longer period, for example, with the aim of implementing a fully developed approach from 2020, as part of the proposed longer term hospital funding agreement to operate from that date. A HAC model should not be rushed to operate separately from and in advance of a longer term hospital funding agreement.

The HAC list

Regardless of the process to develop the current HAC list, there is no certainty of its appropriateness or correctness for the specific pricing and funding purpose for which it is now to be used.

At a minimum, the HAC list should be constantly assessed and evaluated against its purpose. It should be reviewed and updated, including careful assessment to ensure specific complications are included because they contribute usefully to its purpose and not because they happen to be comparatively easy to identify and report, or are high profile.

Complications that are poorly defined, of variable or ambiguous causation, or that may be pre-existing but are not recognised until after treatment has commenced (for example, delirium), should not be included.

Other than these issues, the technical merits of these two options are primarily a matter for system operators, but overall there would seem to be some advantage in focusing funding adjustments to hospitals on the basis of differences in their HAC rates (option 2). This option should work more directly to the hospital and through it to the level of the clinical department to provide feedback and focus efforts to effect change (although the challenge of achieving this is still significant as noted above).

For the general reasons listed above, the AMA believes that if this option is implemented the threshold for funding reductions should be set as low as practicable, and certainly lower than the examples quoted in the assessment.

Option 3 Quality adjusted NEP with funding incentives for hospitals with the lowest HAC rates

Option 3 would appear to have the most extreme and exaggerated effect of reducing resources available to hospitals not meeting safety and quality targets, and locking such hospitals into a vicious circle of under-resourcing leading to under-performance leading to under-resourcing etc. This option would also have a high risk of displacing and distorting focus on other aspects of hospital performance.

Avoidable hospital readmissions

The AMA considers the area of avoidable hospital readmissions is being addressed through the broader framework of safety and quality and through health reform more generally. Given the scale of potential funding reductions involved, this area should

continue to be investigated but as a lower priority, with a broad expectation of potential inclusion in a new long term funding agreement flagged to operate from 2020.

Qu. 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?

Back-casting is an issue for IHPA to decide in accordance with the relevant legislation. Although recent efforts have helped, there is still a need for the principle, practical application and consequences of back-casting to be more clearly explained.

Conclusion

The AMA's overarching concern is that pricing and funding models for safety and quality that involve funding penalties are misguided and counter-productive. A framework of positive incentives for the achievement of such targets, supported by the full range of quality and safety mechanisms referred to above, will achieve better results.

The AMA's comments on the options proposed in the Framework are subject to this overarching concern.

31 October 2016