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HCCA Submission to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2017-18

Submitted 31 October 2016

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Background

The **Health Care Consumers' Association (HCCA) is a health promotion charity that** provides a voice for consumers on local health issues and provides opportunities for health care consumers in the ACT to participate in all levels of health service planning, policy development and decision making.

HCCA involves consumers through:

- consumer representation
- consultations
- training in health rights and navigating the health system
- community forums
- information sessions about health services, and
- advocating for issues of concern to consumers

Most consumers have little understanding about the complexities of funding. It is invisible to us and for many consumers this is seen as a dark art. We have reviewed the document and offer a number of comments. We do not do this from a position of technical skill and knowledge in health financing but have come to this from the perspective of consumers who value safe, high quality care.

1. General comments on the Pricing Framework

We support the pricing process and system guidelines, in particular we strongly support the focus on improving patient outcomes and that ensure private public neutrality.

The guideline to focus the system on making adjustments to price, based on the patient rather than the provider needs, can be problematic. In principle we support this as it means that a fair price will be paid based on the complexity of the patient's

conditions at the same time we acknowledge there are cost issues at play for those health services and hospitals in regional and outer metropolitan areas.

In Canberra we often read about the increased cost of delivering care. The cost of health care in Canberra is well above the nationally efficient price. The reasons given for this have included economies of scale, higher payment of Visiting Medical Officers, higher pay levels of nursing staff, inadequate reimbursement from NSW for the delivery of care to NSW residents and legacy superannuation liabilities. ACT Health is currently looking with focussed attention at ways to improve efficiencies by removing waste and duplication and improving business processes in an attempt to reduce costs and improve access. We also believe that staffing costs require closer attention.

The reimbursement arrangements with NSW Government are insufficient and we have routinely been told that this situation can drive up costs for our local public inpatient and outpatient services. In essence, we understand that NSW reimburses the ACT at the NSW cost. As it costs more to provide services in the ACT the ACT Government is therefore subsidising care for NSW residents. This is a longstanding issue and needs to be resolved.

Jargon

There is no avoiding jargon in such a technical paper but we are firmly of the view that there needs to be a plain language companion document to explain to the community what this paper aims to achieve. Health financing is a fundamental aspect of our health system. As such there is a need for material to be available to build the understanding of consumer representatives, those members of our communities who put forward consumer perspectives and are committed to improving the quality and safety of our health systems. There is also value in improving the understanding of the broader community around the complexity of funding arrangements. This may go some way to reducing the deeply concerning politicisation of our health systems.

Patient Centred Care

Despite the rhetoric around improving access and care, there is only one reference to patient centred care in this document, which is an indirect comment relating to the inadequacy of the existing classifications for non-admitted patients. We do not consider this to be sufficient. In recent years there has been a reasonable level of activity into looking at how to integrate quality and safety into hospital pricing systems. We are disappointed that this is not progressing at a faster pace.
We also note that there has been much discussion about shifting the focus from the cost of services to value for money. We support this move in-principle as there is then

greater potential to linking funding to quality and safety. We would like to see the development of a range of performance indicators for improved patient care. One of our members commented:

> *"In general the model being proposed favours tertiary and other larger metropolitan and regional hospitals, small rural hospitals should continue to be block funded due to the reduced range of services they generally provide".*

2. Comments on Specific Issues

Section 4.4: Additional areas to be considered

- There is support to include paediatric and rehabilitation services, noting that while the report states there is insufficient evidence to support inclusion of paediatric palliative care, it seems there is anecdotal evidence that these services are scant and the need is there. Would block funding be more appropriate for this group?
- We have support in our membership for the use of the Mini Mental as the endorsed universal tool to assess cognitive impairment in the aged care sector. This method is currently used in the community setting as a first step in assessing impairment but should not be considered the only diagnostic tool.

Section 6.3: Price weights

We would support a move to make allowance for jurisdictions to apply for additional funding based on 'legitimate and unavoidable cost variations' as highlighted under 6.2.1

Section 9: Maternity Care

- We also support bundled price for maternity care and see that this will enable the delivery of a range of maternity services such as midwifery led care and home birthing programs. Services should be supported following existing guidelines and Medicare funding arrangements: eg, number of ante natal visits etc
- We support the use of data from Australian Institute of Health and Welfare (AIHW) to define the inclusions for bundled services, and would relate generally to ante, intra and post partum care. We would include elective caesarean sections where the caesarean is being considered due to maternal factors and would otherwise be a normal delivery (pre supposing a non eventful antenatal period, gestation in line with current guidelines and uneventful post natal period, and not including unexpected events).

- We support the inclusion of post natal care
- National Minimum Data Sets (NMDS) should be examined to report on the range of birthing options provided in each maternity facility including numbers of elective caesarean sections due to maternal physical incapacity.
- Elective Caesareans for cosmetic reasons should not be included in bundled funding.

Section 11: Quality and Safety

In general we are supportive of the move to have a major focus on quality and safety. One of our members expressed concern that action needs to be taken to ensure small hospitals are not disadvantaged and suggested further consideration of bundled funding for small rural hospitals.

Section 11.4.1: Support for Safety and Quality Models to be Applied

Once again we support this but would like to see arrangements to minimise any disadvantages for rural services. This section should have a major focus on consumer outcomes, including consumer input to the design, delivery and measurement of the quality and safety services, and the performance indicators are in place to measure this. There needs also to be strong indicators in place to ensure accurate reporting of sentinel events to ensure funding is administered equitably.

Section 11.4.3: Factors in Risk Adjustment

Any risk adjustments need to take into account current known data in relation to sentinel events and what steps are currently taken to respond to risk events (eg: review of current reporting data against national standards). One member suggested that sliding scale funding based on size, location, inpatient services, consumer engagement and past HAC should be considered. Performance indicators need to allow for type of hospital, eg: tertiary, teaching, regional, rural.

Section 11.5.4: Pricing and Funding Sentinel Events (3 questions)

We have mixed feelings about this, I suggest that there be consideration of funding reduction with frequent and recurrent sentinel events that in ordinary circumstances could have been avoided and have resulted in poor patient outcome/s.

The inclusion of a sentinel events flag is essential and would enable more accurate outcomes indicators. We are not convinced by the value of blanket non-funding of

sentinel events, and remain concerned that this could potentially lead to under reporting and does not appear to be for much financial gain ($5m).

Section 11.6.4:

Option 2

This option is favoured as it may act as a measure of quality and safety, especially for major hospitals, and should capture any ongoing issues in a particular facility and/or service. It could also act as an indicator for improvement in service delivery, training for staff and reporting without necessarily causing data to be manipulated.

Option 3

This is a carrot and stick option that impacts, possibly unfairly on funding and therefore on services which could then lead to service deficits. It is the least client centred of all three options and suggests 'in and out' medicine. On the plus side, incentive payment is useful and can improve services.

Could there be a model where Option 2 is modified so that hospitals that have few (range to be set) HACs are given incentive payments while those who have a history of higher than average HACs are given no growth funding along with a KPI around proven reduction in HACs?

Section 11.7.4: Re within same LHN

We suggest there needs to be consideration about transfers out of the Local Hospital Network (LHN) – such as from the NSW South Coast to the ACT. This would be the same with small rural hospitals in jurisdictions where there are no LHNs with tertiary hospitals.

Section 11.8.2: Important considerations

Consumer engagement is essential in any quality and safety model and this must be meaningful and reportable. Consumer feedback (eg: patient feedback) needs to be actively encouraged with evidence provided that the result of meaningful consumer engagement is reflected in reporting to funders.

- While the words and principles outlined in this document suggest that the definitions and pricing options are designed to improve patient outcomes there is a real sense that the whole exercise is much more about reducing costs for

the Commonwealth and even shifting costs to the jurisdictions and/or hospitals themselves.
- In noting that there obviously need to be systems and processes to manage the finite health dollar resources the overarching first principle should be to ensure that health services are consumer centred and that the pricing structure in place is truly reflective of the real cost of providing safe quality care.
- There seems to be a strong focus on the "stick" approach to reducing sentinel events, hospital acquired complications, avoidable admissions/readmissions, etc. There is almost no discussion of using more positive "carrot" types of approaches that might provide incentives to help address these quality and safety issues and that may still result in enhanced efficiencies and outcomes in terms of improving patient outcomes and reducing costs.

We remain wary of perverse incentives that may concentrate efforts on low cost interventions that provide bonus payments, and away from high cost efforts.

Private patients in public hospitals

We support the proposal that IHPA deducts payments made by insurers and the Medicare Benefits Schedule for services delivered to private patients. We understand that this is appropriate.

We are also of the view that there are opportunities to increase the rates at which people with private health insurance activate this on admission to public hospitals. We have anecdotal evidence to support that the administrative staff in public hospitals do not encourages this and indeed actively discourage patients from using private health insurance because of the paperwork involved. This needs to be addressed. There is a reluctance from consumers to use their private health insurance as they are concerned about out of pocket costs. Some jurisdictions have developed workable solutions and assure patients that there will be no gap. We see this as something worth supporting all public hospitals to do and there may be value in looking at ways to incentivise this change in practice. We do not want private patients to be prioritised over people without private health insurance but there may be consideration of bonuses for encouraging consumers to activate their private health insurance. Any work in this area would need to be done in partnership with consumer organisations.

Efficiencies

Choosing Wisely

There has been considerable work with the Medical Colleges and other professional groups on the development of recommendations for Choosing Wisely Australia. At what stage can we expect to see these recommendations linking to the financing of our health system?

Teaching, training and research activities

Teaching, training and research are important aspects of our public health system and require adequate funding to occur.

Please do not hesitate to contact us if you wish to discuss our submission further. We would be happy to clarify any aspect of our response.