Peninsula Health

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Independent Hospital Pricing Authority
Level 6, 1 Oxford Street
Sydney NSW 2000
submissions.ihpa@ihpa.gov.au.

Dear CEO,

Response to Pricing Framework for Australian Public Hospital Services 2017-18

I am responding to the call for submissions from the Independent Hospital Pricing Authority regarding pricing for safety and Quality under the National Health Reform Agreement.

I understand that the options being considered include:

i. Sentinel events – where a hospital will receive zero funding for a sentinel event;
ii. Hospital acquired conditions where either
    a. All hospital acquired codes, leading to greater complexity and associated funding will be removed as part of the DRG assignment;
    b. Funding adjustments will be made on the basis of hospital acquired conditions across hospitals with the lowest 25% losing funding associated with complications; or
    c. Price incentives for hospitals with the lowest hospital acquired conditions.
iii. Options for pricing that recognize avoidable hospital admissions.

A key concern is that any new scheme does not have unintended consequences. Prices are intended to convey a message to suppliers, in this case workers or the individual hospitals, and modify or reinforce their behaviour. It should also be noted that both workers and hospitals have a number of non-price signals regarding quality and safety. It is important that these are consistent and it is important to recognise that the evidence seems to suggest that non price signals are more effective.

Under the current system where there is no explicit price or revenue impact for quality, hospitals in most cases lose financially for poor quality and safety practices by incurring higher costs. The costs for poor quality are incurred through a longer length of stay, readmission to theatre, unnecessary admission to ICU etc. This may suggest that a mechanism of further reducing net funding to a hospital to improve quality and safety may not be that effective and better returns would be received from stronger non price mechanisms. This is supported by the literature review undertaken by the Australian Commission on Safety and Quality in Health Care indicates a generally poor response to broad quality price measures in other countries but better responses to more targeted and local initiatives.

In Victoria following the publication of the Duckett review and the establishment of the new Quality and Safety body, additional reporting requirements, focus on clinical networks and board composition and skills are key recommendations. It is important to recognise that these non-pricing measures are

designed to lead the change to improved quality and that the pricing incentives should support those directions. It is important not to provide mixed messages or for pricing to give priority to particular areas (potentially because they are currently easier to measure) which are considered a lower priority by the quality bodies.

Similarly, any future mechanism needs to recognise that hospitals have different physical facilities affecting quality measures. For example, Peninsula Health has issues with Clostridium difficile rates despite having hand hygiene rates well above Victoria's average and an excellent antimicrobial stewardship program in place. This is due to Frankston Hospital having a large number of four bed rooms and patients that are older than other health services. These are only two examples of risk adjustment that are required.

The design of any system also needs to recognise the potential for future "gaming" of the system to avoid losses of income. It is important that there should be no avoidance of reporting, rather that reporting of incidents should be encouraged to improve greater transparency of issues to enable them to be rectified. At present coding data is of variable quality and different hospitals have different levels of thoroughness in coding for Hospital Acquired conditions. It is important that this level of variability is recognised and that complete reporting of data is encouraged. It would be expected that compliance auditing would encourage only a minimum standard of compliance.

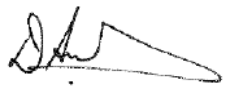
With regard to the identified options, it is considered that non funding of sentinel event would be a good initial start. It would not affect quality reporting, would not result in unintended consequences, and follows a well-established classification.

Removing hospital admission conditions codes (HAC) would be liable to changes in reporting practice and would need to be risk adjusted to be a viable solution. It also runs the risk that the WIES or NWAU measure would lose its integrity as an activity measure. If HAC codes are excluded, this may affect the DRG and therefore the activity measure. Thus actual activity would not be recorded due to some elements of it being excluded.

Funding on the basis of HAC rates would be viable if there is full reporting of HAC's across hospitals, and there is adequate risk adjustment. Incentives to hospitals with the lowest HAC rates would also enable "league table" reporting and further discussion to improve funding mechanisms.

I support the efforts to improved quality but it needs to learn the lessons of previous implementations and be sure that unintended consequences are avoided.

Yours Sincerely,



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