Hon Jill Hennessy MP

Minister for Health
Minister for Ambulance Services

GPO Box 4057
Melbourne Victoria 3001
Telephone: +61 3 9096 8561
www.dhhs.vic.gov.au
DX: 210081

e4351186

Mr Shane Solomon
Chair
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Dear Mr Solomon

Thank you for the opportunity to comment on the Independent Hospital Pricing Authority's Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2017-18. Victoria is supportive of the direction of the national pricing framework development including the exploration of a bundled price for maternity services and the proposed pricing for quality and safety.

Victoria supports the proposal by the Independent Hospital Pricing Authority to introduce payment reforms that support the improvement of safety and quality in healthcare. In supporting the proposal Victoria acknowledges the role funding and pricing can play in supporting the delivery of better care as well as avoiding unnecessary costs. Victoria is acutely aware that to be effective these payment reforms must complement a broad range of quality improvement initiatives within and across health care organisations and are committed to maintaining our efforts in these areas.

Victoria supports the proposed approach for sentinel events which will result in funding being reduced to zero. These events are infrequent but significant and occur in health services as a result of systems and process deficiencies. Victoria also supports the Independent Hospital Pricing Authority's proposal that the definition of what constitutes an avoidable readmission requires further work, thus no option can be developed until this work is progressed.

Whilst there are merits for each of the Independent Hospital Pricing Authority's options in relation to hospital acquired conditions, Victoria's preferred option at this stage in the development is Option 1. However, Victoria urges the Independent Hospital Pricing Authority to consider the following refinements to option one:

- The adoption of a risk adjusted approach.
- Consider state specific approaches to ensure hospitals continue to provide quality hospital–coded data.
- Consider year-on-year improvements, as opposed to a pure penalty approach.
- Complement local and system manager approaches to improvement of quality and safety

VICTORIA State Government

The Independent Hospital Pricing must recognise that all states have a different level of maturity related to the adoption of the casemix funding model. As such, there must be recognition of the impact that this maturity, and existing system incentives, has on the provision of complete and accurate hospital–coded quality data. The strength of the Victorian model has been that it has encouraged the recording of hospital acquired conditions and as a result Victoria's reported rates may appear higher relative to other states. This variable starting position for each state emphasises the importance of any national safety and quality approach being tailored to state specific circumstances.

The introduction of the proposed new model constitutes a significant change and it will be important to ensure there is investment in improvement activities alongside these reforms.

Victoria also anticipates that the Independent Hospital Pricing Authority approach to implementation will be consistent with the National Health Reform Agreement, specifically Clause A40.

I look forward to receiving the Independent Hospital Pricing Authority's advice to Council of Australian Governments' Health Council and the draft Pricing Framework and National Efficient Price and Cost Determinations on 30 November 2016.

If you have any queries about Victoria's response, please contact Terry Symonds, Deputy Secretary Health Service Performance & Programs on 03 9096 8038.

Yours sincerely

Hon Jill Hennessy MP
Minister for Health
Minister for Ambulance Services

1 / 11 / 2016

Encl.

Victorian Department of Health and Human Services' response to the
Consultation paper on the pricing framework for Australian public hospital services 2017-18.

Consultation paper on the pricing framework for Australian public hospital services 2017-18

Victorian Department of Health and Human Services response

October 2016

VICTORIA State Government | Health and Human Services

Contents

1. Introduction

Victoria welcomes the opportunity to comment on the Independent Hospital Pricing Authority's *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2017-18*. The Pricing Framework 2017-18 forms part of Independent Hospital Pricing Authority's sixth annual process for establishing a national activity based system for the pricing of public hospital services in Australia, in support of the efficiency and transparency goals of the National Health Reform Agreement.

The *Pricing Framework 2017-18* is an opportunity to further refine and improve the pricing models introduced in 2012-13 and revised in subsequent years. Victoria is supportive of the direction of the national pricing framework development including the exploration of a bundled price for maternity services and the proposed pricing for quality and safety. Victoria continues to reiterate a number of concerns related to the need to further mature aspects of the national pricing model.

Victoria supports the proposal by the Independent Hospital Pricing Authority to introduce payment reforms to support the improvement of safety and quality in healthcare. Victoria is supportive of payment reforms that support quality improvement initiatives underway at all levels of the health care system – federal, state, regional, local, and within health care organisations. Underpinning the payment reforms, it will be critical to ensuring that quality measures are consistently implemented across jurisdictions, there is appropriate data dissemination and benchmarking, and continual measurement and comparisons of outcomes with those of the best performers, as these strategies will assist in evaluating organisational performance and help drive the change that is being sought.

The Independent Hospital Pricing Authority should recognise the differential maturity of the State's with respect to their implementation and experience with the casemix funding model and its built-in incentive for hospitals to provide quality hospital–coded data as it relates directly to funding. While this is a strength of the Victorian model, it does mean the rates of hospital acquired conditions reported in Victoria relative to other states is much higher. This variable starting positon emphasises the importance of any national safety and quality approach being tailored to state specific circumstances, as it must reflect different levels of maturity.

Victoria recognises the Independent Hospital Pricing Authority's challenge in developing a funding and pricing model that addresses as many of these issues as possible. The use of disincentives by withholding or reducing payment for safety and quality is complex due to the difficulty in attributing causality. Conversely, while incentive payments can promote improvements in poorer performing health services, noting that the size of the incentives and the targets matter in determining the level of effectiveness, they too are complex to administer.

To refine the proposed approach, Victoria recommends that the pricing and funding for safety and quality approach should also recognise:

- year-on-year changes in the level of the quality of services provided within hospitals
- the overall rate of incidence (recognising that this should continually reduce)
- a penalty for poor performance below a given threshold
- recognition for improvement above a given threshold.

Victoria's recommended pricing and funding approach would consist of:

a. a national framework with state specific parameters to recognise different levels of maturity across jurisdictions with respect to activity based funding

b. a state specific quality and safety pool to enable funding to be quarantined by the respective state

c. a penalty if the health service falls outside the expected range of incidence and the relative level of improvement is not sufficient

d. a possible adjustment if the health service's incidence of hospital acquired conditions is below the expected range

e. provide appropriate disincentives and incentives to drive behaviour change and better patient outcomes.

Concurrent with the introduction of the safety and quality funding reforms, Victoria recommends that the Independent Hospital Pricing Authority work with states and territories to address the challenges associated with consistent capture of quality and cost information.

As the introduction of this model constitutes a significant change, Victoria anticipates that the Independent Hospital Pricing Authority will act in accordance with the National Health Reform Agreement, specifically Clause A40.

Victoria recognises the Consultation Paper on the Pricing Framework is continuing towards improving the national Pricing Framework.

2. Pricing guidelines

The Pricing Framework includes important pricing guidelines that direct how the Independent Hospital Pricing Authority should undertake its work. In assessing how the Independent Hospital Pricing Authority has implemented Activity Based Funding to date, there should be greater regard for applying these guidelines in a more consistent, balanced and comprehensive manner.

Victoria acknowledges that Activity Based Funding implementation may require a compromise between different and competing policy objectives. However, adhering to one particular guideline should not mean disregarding or creating conflict between other guidelines but instead strike a balance that is consistent with (or at least not undermining) other guidelines.

3. Scope of public hospital services

Victoria would encourage the Independent Hospital Pricing Authority to exercise flexibility when determining whether a service is ruled in-scope as a public hospital service, and therefore eligible for Commonwealth funding under the National Health Reform Agreement. Challenges faced by states and territories by the Independent Hospital Pricing Authority making determinations can include limiting opportunities for innovative clinical and funding models, whereby the Independent Hospital Pricing Authority requires services to be operational before considering these to be in-scope.

4. Classifications used by IHPA to describe public hospital services

Victoria welcomes the ongoing development of classification systems for hospital services. These should be evidence-based and clinically relevant to the medical professions. The Independent Hospital Pricing Authority should allow sufficient time to collect key elements of a classification system.

Classification systems used for funding models need to be based on robust data with evidence supporting decision making. The Independent Hospital Pricing Authority should remain mindful of the potential variance in new models as data is submitted and may wish to consider collecting additional information which supports the model.

Australian national subacute and non-acute patient classification

Consultation question

- What additional areas should IHPA consider in developing Version 5 of the Australian National Subacute and Non-Acute Patient classification?

Victoria supports the Independent Hospital Pricing Authority's implementation of the Australian National Sub-Acute and Non-Acute Patient Classification Version 4 system for pricing admitted subacute and non-acute services in National Efficient Price 2017.

Victoria is also supportive of continued development of Australian National Sub-Acute and Non-Acute Patient Classification Version 5 in consultation with jurisdictions. At this time Victoria has no suggested additional areas the Independent Hospital Pricing Authority should consider for Australian National Sub-Acute and Non-Acute Patient Classification Version 5.

Tier 2 Non-admitted services classification

Victoria supports Independent Hospital Pricing Authority's current work in developing a new patient-centred Australian Non-Admitted Care Classification.

Emergency care classification

Victoria supports the Independent Hospital Pricing Authority's current work in developing a new classification system for emergency care with a stronger emphasis on patient factors, such as diagnosis. Victoria is also supportive of the Independent Hospital Pricing Authority undertaking the development of an Emergency Department Principal Diagnosis Short List to help improve consistency of diagnosis reported across jurisdictions.

Teaching, Training and Research classification

Victoria is supportive of the Independent Hospital Pricing Authority's work developing a new teaching and training classification system.

Australian Mental Health Care Classification

Victoria supports the work that the Independent Hospital Pricing Authority is currently undertaking in the development the Australian Mental Health Care classification system.

5. Data collection

Victoria supports the ongoing development of the National Hospital Data Collection as a key dataset used to analyse costs. Victoria welcomes the expected release of Version 4 of the Standards in 2017 for future rounds of the National Hospital Cost Data Collection and will continue to work with the Independent Hospital Pricing Authority to develop these standards going forward. In particular, Version 4 should include developments from the classification work currently underway such as incorporating guidance for identifying cost drivers and/or homogenous resources which will enable consistency and comparability.

6. The National Efficient Price for activity based funded public hospital services

Technical improvements

Pricing non-admitted services

Victoria is supportive of the transition to using the National Hospital Cost Data Collection to derive price weights which is a better reflection of costs for non-admitted services.

Pricing mental health services

Victoria is supportive of the Independent Hospital Pricing Authority attempting to identify a suitable proxy for 'mental health phase of care' for the National Efficient Price Determination 2017-18. However, using a proxy approach to develop a funding model requires the proxy to fully support the model with sound evidence demonstrating that the proxy is valid.

It is also important that the number of changes in a short period of time are minimised to meet the Independent Hospital Pricing Authority's pricing stability principles. There is a risk that moving from use of Diagnostic Related Groups to a proxy approach, and then an approach supported by the reporting of activity and cost data that is based on the Australian Mental Health Care Classification, will introduce unnecessary instability in pricing.

Victoria would be supportive of a proxy being used if it is verified by evidence - otherwise it is suggested that the Independent Hospital Pricing Authority wait for sufficient robust evidence to be available.

Stability of the national pricing model

Consultation question

- Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2017-18?
- Should IHPA further restrict year-on-year changes in price weights?
- What are the priority areas for IHPA to consider when evaluating adjustments to NEP17?
- What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.

Victoria is supportive of the Independent Hospital Pricing Authority's work to improve and refine the National Efficient Price model.

Restrictions to year-on-year changes in price weights should be considered in the event that the variation unfairly impacts on one jurisdiction or a small group of hospitals, or if it affects a Diagnosis Related Group containing a high volume of cases or a number of very expensive cases.

In contrast to this there may be scenarios where a significant variance (for example 20 per cent or greater) is justifiable, in which case, it should be accompanied by explanatory notes for increased clarity.

7. Setting the National Efficient Price for private patients in public hospitals

Consultation question

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

Victoria supports the phasing out of the private patient correction factor provided that the complexities associated with Standard 3A.002 can be updated in early 2017 to enable sufficient time for public hospitals to implement and test that costs reflect the guidance and ensure compliance. Should an update

be delayed, the Independent Hospital Pricing Authority may consider deferring the phasing out of the private patient correction factor until 2019-20.

Victoria also supports the Independent Hospital Pricing Authority continuing to develop Version 4 of the Australian Hospital Patient Costing Standards due to be completed in 2017.

While Version 3.1 provides guidance on how to allocate costs to private patients, the purpose of the cost standard (3A.002) remains unclear. Victoria suggests that the Independent Hospital Pricing Authority undertake further work and consultation to clarify whether the standard reflects an assurance that all expenses recognised on the general ledger relating to the treatment of private patients in a public hospital are allocated regardless of any private practice arrangements (actual cost), or whether these expenses are offset by any private practice arrangements (what funding uses as a cost base). It should also be consistent and with existing standards.

8. Treatment of other Commonwealth programs

Victoria continues to give support to the Independent Hospital Pricing Authority's exploratory work regarding how blood costs can be more accurately reported in future years. Any adjustment for blood products should be based on evidence.

9. Bundled pricing for maternity care

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?

Victoria supports the exploration of a bundled price for maternity services.

The pricing model needs to be clinically relevant and support the delivery of the most appropriate care in the right setting. Development of a pricing or funding model should not create perverse incentives or cause unintended consequences especially in relation to the patient's choice to elect a mix of public and private services. The model should also provide fair payment for partial episodes that include out-of-hospital care. Further, the model needs to be flexible to recognise the variation in delivery of services within jurisdictions and across Australia, for both complicated and non-complicated births.

Victoria recommends that antenatal care is excluded from the bundled price given the complexity associated with models of care and funding. This will also help to exclude atypical patients such as pregnancies that terminate before birth and patients who present late is pregnancy for antenatal care. Victoria suggests that the Independent Hospital Pricing Authority consider including lower-risk vaginal and caesarean section births into the bundled price. This will minimise unwanted clinical variation which could include unnecessary caesarean sections and instrumental births.

In Victoria, unqualified newborns are bundled into the price for the mother. Therefore, Victoria would be supportive of the Independent Hospital Pricing Authority including postnatal care in the bundled price if this was only for unqualified newborns.

10. Setting the National Efficient Cost

Victoria supports the Independent Hospital Pricing Authority's approach to better identify in-scope expenditure, by using reported expenditure data. To ensure stability of the National Efficient Cost model, it is suggested that the Independent Hospital Pricing Authority works with jurisdictions to improve data quality to minimise any reported variations.

11. Pricing and Funding for Safety and Quality

Victoria supports the proposal by the Independent Hospital Pricing Authority to introduce payment reforms that aim to support the improvement of safety and quality in healthcare. The introduction of any new pricing mechanism must sit alongside existing regulatory and information approaches focussed on quality improvements if they are to have the intended impact. Victoria recognises that achieving the aim of incentivising better care without compromising the quality of data or unduly penalising good performing services is complex.

Victoria is supportive of the efforts being made to consider a range of approaches. While there is no clear single approach to addressing all aspect of the issues, Victoria does consider that it will be important in the application of any of the funding for quality and safety changes that the Independent Hospital Pricing Authority consistently apply the fundamental features of the health funding model as it is required under the National Health Reform Agreement. This includes, but is not limited to, the application of back-casting (Clause A40 of the Agreement) to the National Efficient Price and National Weighted Activity Unit for changes in classification as well as the pricing for safety and quality reforms to enable accurate calculation of price and activity growth.

When further developing options for funding and pricing for quality and safety, the Independent Hospital Pricing Authority should consider funding levels being a function of the rate of change within hospitals year-on-year. The Independent Hospital Pricing Authority will need to account for sources of variation other than actual quality and safety issues and continue to encourage full and accurate reporting of hospital acquired conditions.

This approach would reward in-hospital efforts to maintain the high level of clinical documentation evident in Victoria, improve quality and safety, account for unique patient cohorts that exist for each hospital, and avoid issues with reporting consistency between hospitals. In addition, it would provide the right incentives for poor performers to continually improve quality and safety. The alternative of being compared to other hospitals only, that would also be improving, risks introducing perverse incentives as well as removing incentives for improvement if there is little chance of reward.

Over time as all hospitals improve and quality and safety indicators converge, then the funding models could move towards a more competitive framework with comparisons between hospitals for funding adjustments.

Consultation question

- 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?

Victoria notes that the Directive from the Commonwealth Minister for Health and Aged Care was limited to public hospitals. Victoria supports longer-term changes to funding for quality and safety to improve patient outcomes, and supports longer-term reforms that would apply changes more broadly across all types of public hospitals, all services, all patients and all care settings, including private hospital settings.

However, to extend quality clinical coding beyond the admitted acute setting requires every state and territory to:

- increase the skilled workforce of clinical coders across all states and territories
- invest in expanding the health data systems and standards to capture this information
- attach funding to the reporting of codes across the other care settings as this will drive reporting
- establish regular auditing of coded data to ensure that coding is accurate, complete and appropriate.

This is not practical in the short to medium term as different states and territories have different levels of activity based funding implementation and maturity across service streams and organisation type.

In many instances, significant investment would be required as data collections beyond the admitted setting are not fit for the pricing and funding purposes that the Independent Hospital Pricing Authority are outlining. It is recommended that the pricing and funding approach should not apply where the maturity and suitability of these systems is assessed as inadequate.

Victoria recommends that the Independent Hospital Pricing Authority work to implement the pricing and funding models for safety and quality for acute admitted services, and seek to refine it before expanding the scope of the work.

Consultation question

- What factors should be considered in risk adjustment for safety and quality in pricing and funding models for hospital care?

Victoria supports the Independent Hospital Pricing Authority's view that the design of a risk adjustment model must balance the casemix of the hospitals (specifically those that take on more high-risk patients) with the needs of the patients requiring high quality care.

It should also balance the need of the health system (patients, hospitals and government at all levels) to accurately and fully measure quality and safety (that is, the need of the system to know what's going on and to support the states as system managers to manage their quality and safety programs).

If risk adjustment is simply about reducing funding to hospitals (states) this may lead to changes in reporting behaviour to minimise financial risk. Risk adjustment should not be about reducing the total amount of funding available to the health system; rather, it should focus on redistributing funds to promote improvements in quality and safety at the organisational and system level (that is, any discounting due to hospital acquired conditions and sentinel events should be returned back to the Local Health Networks).

Broadly, the risk adjustment model would need to reflect peer grouping of hospitals and the locality of the hospital.

- Peer grouping of hospitals: Figure three in the Independent Hospital Pricing Authority's consultation paper demonstrates that hospital acquired condition rates can vary between different peer groups of hospitals. This difference arises due to the large metropolitan hospitals and specialist hospitals taking on more complex patients (due to their expertise). Smaller or more remote hospitals deal substantially with less complex patients and often refer complex patients to specialist services.

  Any risk adjustment model would need to reflect this difference in hospital acquired condition rates between peer groups to minimise the possibility of creating perverse incentives (or disincentives) at the hospital level when planning or reporting on service delivery.

- Locality: catchment areas of hospitals may also display different demographics such as age, obesity, etc. A risk adjustment model would need to reflect the patient mix within the catchment area for a hospital (or Local Hospital Network) to avoid penalising a hospital merely for its location.

Victoria notes that there are a number of other considerations to be taken into account when developing a risk adjustment for safety and quality in funding and pricing models, and include:

- Variations in the different hospital acquired condition rates across the list of hospital acquired conditions. Consideration should be given to different risk adjustment thresholds for each type of hospital acquired condition.
- Not all hospital acquired conditions are suitable for pricing and funding adjustments.
- Not all risk should be risk adjusted and consideration should be given to the impact of the hospital acquired condition on patient outcomes when making the necessary risk adjustments (for example pressure sores should never occur and should not be risk adjusted despite there being an increased prevalence amoung the older population).

Consultation question

- Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing and funding for safety and quality? Are there other criteria that should be considered?

Victoria supports the proposed assessment criteria and proposes the additional two criteria of **budget certainty** and **supporting hospitals to accurately, consistently and completely report patient-level quality and safety data** be considered.

Budget certainty

This is consistent with the Directive, which states at 2(iii)b(iii):

> *'the design and implementation of pricing and funding models should not compromise state system financial sustainability and quality and should therefore be focused on system level performance improvement'.*

Budget certainty allows states and health services to plan service delivery in advance, and to confidently allocate resources with minimal (or predictable) risks of funding adjustments during – or after – the period of service delivery.

The assessment criteria should be applied from the point of view of the system managers (that is, states and territories), and less from the point of view of national bodies or the Commonwealth as the primary funder, noting the Commonwealth contribution is capped at 6.5 per cent from 2017-18 to 2019-20.

Supporting hospitals to accurately, consistently and completely report patient-level quality and safety data

The current funding model provides a financial incentive for health services to accurately and completely code events occurring in the patient's care. Victoria strongly advocates that the Independent Hospital Pricing Authority considers this criterion for any changes that it may apply.

Hospitals must be continuously supported to accurately, consistently and completely report patient-level quality and safety data under any proposal. Risk adjustment models must take account of the differential maturity of systems and establish mechanisms that support a culture of complete and accurate data reporting. In turn, this would support states and territories (as system managers) in delivering quality and safety programs, and the efforts of the Independent Hospital Pricing Authority to price quality and safety.

Consultation question

- 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?

Victoria acknowledges that the Independent Hospital Pricing Authority has limited approaches to support a funding and pricing approach and supports the proposal to not fund episodes that include a sentinel event, subject to the development of a consistent definition for each event.

Whilst sentinel events are events that should ultimately not ever occur, there are some sentinel events such as suicide which is one of the two largest groups of sentinel events which a hospital can reasonably be expected to prevent, by it is also impossible to eliminate.

Victoria's position is that non-financial mechanisms have a far greater potential to reduce risk and prevent patient harm in the future. A culture where there is careful investigation and analysis of the events (events not primarily related to the natural course of the patient's illness or underlying condition), as well as evaluation of corrective actions is embedded in routine practice, is essential to further reduce risk and prevent patient harm in the future.

Complementing the corrective action, a culture of further reporting these events to enable the "lessons learned" from the event to contribute to the general knowledge about sentinel events, and to reduce the risk for such events in many other hospitals, should be promoted.

A pure financial penalty approach may discourage reporting in borderline cases and discourage a culture of continuous improvement.

If the Independent Hospital Pricing Authority decides to introduce this approach, it should review at a later stage whether this approach has impacted the incidence of these events.

Consultation question

- 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?

Victoria supports a sentinel events flag through the supply of a new data file as opposed to introducing another field in the National Minimum Dataset, in the longer term.

The timeliness of data submission will be critical due to changes outlined in the Council of Australian Governments' Heads of Agreement. The submission of data related to sentinel events will need to be developed in a way that avoids unnecessary delay in data submission.

As there is a lead time in implementing data changes at a state and Local Health Network level, it is recommended that the Independent Hospital Pricing Authority consider implementing a sentinel events flag in the national minimum datasets in 2018-19 to avoid duplicating processes and having to submit multiple data-sets to the Independent Hospital Pricing Authority.

In the short term, the Independent Hospital Pricing Authority should accept a manual offline submission containing all episodes with a sentinel event which will allow states and territories sufficient time to improve internal systems and processes to ensure accurate and robust data can be provided.

Consultation question

- Do you agree with IHPA's assessment of this option (not funding episodes with a sentinel event)?

Victoria agrees with the Independent Hospital Pricing Authority's assessment of this option. Victoria agrees that the implementation of this process will be simple subject to a nationally consistent definition of sentinel events being developed.

Consultation questions

- What are the advantages and disadvantages of option one which reduces funding for some acute admitted episodes with a HAC?
- Do you agree with IHPA's assessment of this option?

Victoria agrees with the underlying principle of option one which is to pay a differential rate for episodes with hospital acquired conditions.

The advantage for option one is largely its simplicity, transparency, and ease of implementation; although some minor system changes would be required. The approach would also allow health services and states and territories to monitor the potential pricing and funding impact of hospital acquired conditions throughout the year, but it fails to recognise improvements that hospitals may be making to quality and safety.

Victoria does not agree with the assessment that there is an equitable risk adjustment. The option is an 'ideal world' approach, whereby any hospital acquired condition is penalised, and there is no risk adjustment or comparison of hospitals within a peer group. Each hospital has differing levels of complexity in its patient mix, and so applying the change at the patient level will apply a greater penalty to hospitals that take on high-risk patients.

Victoria has concerns that the Independent Hospital Pricing Authority does not propose to regroup the cost data supplied by hospitals prior to calculating the National Efficient Price and the relevant cost weights. Victoria's position is that the cost data should be regrouped (quality adjusted diagnosis related group) prior to the development of the annual model. This will result in the cost weight for the most

complex patients accurately reflecting their costs without being influenced by hospital acquired conditions costs. It will still encourage hospitals to avoid hospital acquired conditions in the less complex adjacent diagnosis related groups.

The Independent Hospital Pricing Authority may also choose to phase the transition from the non-quality adjusted cost weight to the quality adjusted diagnosis related groups cost weights.

By applying this approach, the Independent Hospital Pricing Authority will preserve the incentive for health services to accurately and completely code events occurring in the patient's care which will continue to support local initiatives for quality and safety.

Consultation questions

- What are the advantages and disadvantages of option two 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?

On the surface, option two would support the theory that health services will drive towards greater quality and safety, due to its mechanism of creating a competitive 'league table' between hospitals. This assumes that the financial pressures imposed on poor performing hospitals will result in improved clinical practices. However, this option has a high risk of simply changing coding behaviour as a means of minimising any negative financial implications.

The possible public release of league tables may also result in the diversion of resources away from true quality and safety initiatives to approaches that are required to address the potential reputational risk / media risk of the approach.

Option two as currently designed also has budget predictability issues, depending on the stratification approach employed. For example, if the approach compared hospitals with other hospitals in other states and territories, it is not possible for each jurisdiction to know the relative performance of their hospital (and any associated penalty) until after finalisation of data. This has significant impact for a jurisdiction's budget certainty.

Further to this budget predictability issue, it is noted that adjustments under option two would occur after final reconciliation of activity data in the following financial year. Cashflows in the following financial year would be impacted around January to March, but it will not be possible to know by how much cashflow will change when setting service levels for the year ahead (the Victorian budget is set in May of the preceding year).

Option two is a *relative* risk adjustment approach. That is, performance of each hospital is relative to performance of other hospitals. This raises the following issues:

- Hospital A may be improving quality and safety, and should be rewarded (or not penalised) for these efforts. However if other hospitals are outperforming Hospital A, Hospital A will ultimately be penalised.
- The funding adjustments are applied to a certain percentage of poor performers - for example, hospitals with risk adjusted rates in the top quartile – so even if improvements are made system-wide, there will always be hospitals in the top quartile to be penalised regardless of efforts to improve quality and safety.

It should be noted that one of the limitations with comparing hospitals on 'raw' hospital acquired condition rates is that the risk adjustment does not account for factors beyond the control of the hospital, and therefore does not compare 'real' hospital acquired condition differences.

A key limitation of option two is the differential reporting and coding behaviours across jurisdictions. The Independent Hospital Pricing Authority should recognise the differential maturity of the State's with respect to their implementation and experience with the casemix funding model and its built-in incentive for hospitals to provide quality hospital–coded data as it relates directly to funding. While this is a strength of the Victorian model, it does mean the rates of hospital acquired conditions reported in Victoria relative to other states is much higher. This variable starting positon emphasises the importance of any national safety and quality approach being tailored to state specific circumstances, as it must reflect different levels of maturity.

This option as presently designed significantly disadvantages Victoria not because of necessarily poorer quality and safety, but for its long history with activity based funding where accurate and complete coding of patient events are rewarded. If this option was implemented, it would:

- reward hospitals for not reporting hospital acquired conditions and thereby reducing the hospital acquired condition rate
- reward hospitals for poor coding practices such as recording a hospital acquired condition as present on admission rather than hospital acquired (that is, double reward, once by higher payment through the Diagnostic Related Group hierarchy and again by reducing the hospital acquired condition rate)
- potentially result in hospitals expending resources to prove that certain conditions were pre-existing (for example, more pathology).

The Independent Hospital Pricing model should also account for changes in the risk adjustment, but it should be noted that the incidence of hospital acquired conditions will also change significantly from year to year because of:

- changes in coding standards that occur from time to time (for example, in 2012-13, the Victorian coding standard for reporting of sepsis at birth for neonates changed - hospitals where required to change the prefix of sepsis at birth from a P to a C prefix; that is, volume of sepsis codes remained fairly stable but the mix of C & P prefixes changed significantly from P to C)
- changes that reflect improvements in the accuracy, completeness and consistency of coding within and between states, and these changes should be supported, not penalised.

If this option was pursued, Victoria recommends setting either a state specific threshold or a higher threshold in the first year to allow a phased approach to the new scheme, with the threshold becoming lower over time (eventually bringing it down to close to zero).

In addition, it would be beneficial to have regular reporting throughout the year of how hospitals compare against the threshold, to reduce surprises at year-end. However, due to the data lag, this is impossible to mitigate.

If option two is pursued, Victoria would recommend a state based approach in conjunction with rewards to further improve budget certainty for Local Hospital Networks. This would send clearer signals to the health sector that better performance is encouraged, not just that poor performance is penalised.

Consultation questions

- What are the advantages and disadvantages of option three 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?

Victoria has several concerns in relation to option three including those raised in option two.. Victoria does not agree with the Independent Hospital Pricing Authority's assessment of option three as it assumes all hospital acquired conditions are avoidable, and does not reflect any adjustment for preventability.

As the lower National Efficient Price is applied across the system, option three is effectively an 'efficiency dividend', and unreasonably pushes inefficient hospitals (who could be inefficient for a range of reasons unrelated to quality and safety) to not only reduce costs to meet current National Efficient Price as intended through the National Health Reform Agreement, but to go further to meet the reduced National Efficient Price.

A reduced National Efficient Price may simply lead to decisions by health service management to reduce costs in other ways, rather than reducing costs by improving safety and quality, or to seek alternative revenue sources (car parking revenues, laundry services etcetera).

It is not clear why the Independent Hospital Pricing Authority's impact assessment proposes to only redistribute 50 per cent of the funding reduction back into the pool of funds, and not 100 per cent. The Independent Hospital Pricing Authority has not explained what will happen to the balance of funds. Victoria points to the Council of Australian Governments' Heads of Agreement which specifically states that funding reductions for sentinel events, hospital acquired conditions or avoidable hospital readmissions should not be deducted from the available pool of funding under the overall cap of 6.5 per cent.

In addition, if this option was pursued, Victoria also assumes that any change to the National Efficient Price would be backcast in accordance with the Independent Hospital Pricing Authority's obligations under the National Health Reform Agreement.

Consultation question

- How should IHPA treat hospitals with poor quality COF reporting?

As pricing and funding for hospital acquired conditions will commence from no earlier than 1 July 2018, Victoria believes there is sufficient time for Local Hospital Networks to change processes and systems to ensure better reporting of hospital acquired conditions.

Victoria proposes two approaches in response to poor quality condition onset flag reporting:

1. Apply a penalty for not reporting hospital acquired condition events to improve data quality. For example, this could consist of withholding a percentage of the monthly payment to Local Hospital Networks for poor reporting until rectified, or an amount deducted from eligible payments. Victoria acknowledges that this approach would be the responsibility of the Administrator of the National Health Funding Pool, and not the Independent Hospital Pricing Authority.

2. Apply a standard hospital acquired condition rate based on the worst performing peer hospitals if hospital acquired condition events are not disclosed.

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?

Consultation question

- Is there support for pricing and funding models to be based on avoidable hospital readmissions within the same LHN?

Victoria supports limiting readmissions to the same Local Hospital Network, rather than including readmissions at any hospital across the state. However, states and territories do not have a consistent number of Local Hospital Networks. A process of identifying readmissions within the same Local Hospital Network may inadvertently benefit states like Victoria that have a high number of Local Hospital Networks.

There is also the added complexity of hospitals covering an area bordering two states. For example, the Administrator of the National Health Funding Pool treats the Albury campus and the Wodonga campus of Albury Wodonga Health as two separate Local Hospital Networks, after creating a notional Services Local Hospital Network in New South Wales for the Albury hospital activity. A patient may be readmitted to one of these two campuses, but will not be identified in the data matching within a Local Hospital Network. Victoria believes that this risk may be immaterial, but has not conducted any analysis to measure the risk.

Considerations for the development of avoidable hospital readmissions funding options

When developing options related to avoidable hospital readmissions, the Independent Hospital Pricing Authority needs to take into account the quality of the primary care services in the area. Readmission rates can be partially explained by the adequacy of the local primary care sector and hospitals may not be able to exercise full control over readmissions. It would be unfair to influence hospital funding for events that are beyond the control of the hospital, and counter to the Directive which specifies that the model must reflect ‘an agreed set of conditions and the *circumstances* in which they occur’ [emphasis added].

Readmission rate risk adjustments should also reflect a casemix adjustment, and not just peer hospital adjustments. There will be different baseline readmission rates for different broad cohorts of patients such as rehabilitation, mental health, surgical, medical, etcetera.

Readmission rate risk adjustments also need to adjust for patient demographic factors. Patients of low socio-economic areas are more likely to have readmissions. It would not be equitable for hospitals with a cohort of patients that are less likely to be readmitted, and undertake less risky treatment, to benefit on the readmission funding adjustment.

Consultation question

- When should a pricing and funding approach for avoidable readmissions be implemented?

Victoria believes that a pricing and funding approach for avoidable readmissions should be implemented no earlier than 1 July 2019, to allow sufficient time to ensure:

- the development of consistent standard definitions
- reliable and robust systems are implemented across jurisdictions
- the reliability of data collated and provided to the Independent Hospital Pricing Authority by jurisdictions
- the implementation year is preceded by a shadow year to provide an opportunity to refine any processes as necessary.

Victoria proposes that there should be a national approach to pricing and funding of avoidable readmissions, but any adjustments for avoidable readmissions be calculated and applied at the individual state levels, making necessary adjustments for the type of hospitals and the different patient mix treated.

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?

Important Considerations

Victoria proposes the following considerations when developing options:

- states and territories will continue to be the **system managers** of health services within their jurisdiction
- **budget certainty** is important for states and territories to plan service delivery in advance
- **predictability**, specifically in relation to minimising reconciliation adjustment impacts on current year's funding, and consideration of the flow on impacts this can have on service delivery
- **correct signalling** to the health sector to improve safety and quality in healthcare, whilst minimising any perverse incentives.

Backcasting

At the Council of Australian Governments' meeting of 1 April 2016, all First Ministers signed a Heads of Agreement on Public Hospital Funding that committed all the Parties, in conjunction with the Independent Hospital Pricing Authority and the Australian Commission on Safety and Quality in Health Care to develop "a comprehensive, risk adjusted model to integrate quality and safety into hospital pricing and funding".

This represents a significant change which Victoria expects that the Independent Hospital Pricing Authority will act in accordance with the National Health Reform Agreement, specifically Clause A40:

> *"If the IHPA makes any significant changes to the ABF classification systems or costing methodologies, the effect of such changes must be back-cast to the year prior to their implementation for the purpose of the calculations set out in clauses A34, A35 and A38. The IHPA will consider transitional arrangements when developing new ABF classification systems or costing methodologies".*

The Independent Hospital Pricing Authority's advice to the Administrator of the National Health Funding Pool should support the requirements of Clause A40 to allow the Administrator to accurate calculate the correct entitlement in in accordance with Clause A34 and A35 of the National Health Reform Agreement.