Government of **Western Australia**
Department of **Health**
Office of the Director General

Contact: Andrew Joseph (08 9222 2259)

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Dear Mr ~~Downie~~ James

CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR PUBLIC HOSPITAL SERVICES 2018-19

Thank you for the opportunity to provide a submission to the *Consultation Paper on the Pricing Framework for Public Hospital Services* released on 17 July 2017.

Detailed feedback to the consultation questions is provided in the attached document. WA Health supports the IHPA's current work program on classification system refinement and development, funding model enhancements and innovations, and pricing for safety and quality.

As a general comment, WA Health notes that we are now in the fifth iteration of the Pricing Framework and it is therefore appropriate that a review of IHPA's ABF model be undertaken with a focus on ensuring the ongoing applicability, flexibility and completeness of the ABF model so that it can equitably meet all jurisdictional needs. In this regard, as you would be aware, WA Health continues to be disadvantaged due to the prevalence of unique factors, which have previously been presented and discussed in WA Health submissions to the IHPA. These issues include location based rural and remote cost disabilities, diseconomies of scale and scope that arise from providing a comprehensive health service to a smaller and more heavily dispersed population and the ongoing Federal under-funding of primary and aged care services in this State.

To redress these inequities, not only must WA Health apply specific adjustments to the National ABF model arising from the failure to recognise these unavoidable costs, but the State is also required to contribute additional resources to mitigate funding shortfalls that result from a strict application of the ABF model. WA Health believes that a comprehensive national funding model that is cognisant of these issues should be developed to ensure fair and equitable funding to all jurisdictions.

Accordingly, WA recommends that a strategic independent review of the national ABF model be undertaken with consideration also given to the roles and responsibilities of the relevant bodies involved in the implementation and operation of the model.

Please note WA Health will provide further comments during the statutory 45-day Ministerial consultation period when the Draft Pricing Framework 2018-19 is released.

Should you require any further information, please contact Andrew Joseph, Group Director Resources on (08) 9222 2256 or via Andrew.Joseph@health.wa.gov.au.

Yours sincerely

Dr D J Russell-Weisz
DIRECTOR GENERAL

20 August 2017

Attachment 1 – WA Health Submission to the IHPA Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2017-18

Government of **Western Australia**
Department of **Health**

ATTACHMENT

WA HEALTH SUBMISSION TO THE CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2018-19

1. INTRODUCTION

The Western Australian Department of Health (WA Health) welcomes the opportunity to provide feedback to the Independent Hospital Pricing Authority (IHPA) on the Consultation Paper for the Pricing Framework for Australian Public Hospital Services 2018-19.

As a general comment WA Health notes that given that it has been five years since the implementation of the Pricing Framework, it is timely and appropriate that a review of IHPA's ABF model be undertaken with a focus on ensuring the ongoing applicability, flexibility and completeness of the ABF model so that it can equitably meet all jurisdictional needs. In this regard, WA Health continues to be disadvantaged due to the prevalence of unique factors, which have previously been presented and discussed in WA Health submissions to the IHPA. These issues include location based rural and remote cost disabilities, diseconomies of scale and scope that arise from providing a comprehensive health service to a smaller and more heavily dispersed population and the ongoing Federal under-funding of primary and aged care services in this State.

To redress these inequities, not only does WA Health apply specific adjustments to the National ABF model arising from the failure of the model to adequately recognise the unique and unavoidable cost issues prevalent in WA, but the State is also required to contribute additional resources to mitigate funding shortfalls that result from a strict application of the ABF model. WA Health believes that a comprehensive national funding model that is cognisant of these issues should be developed to ensure fair and equitable funding to all jurisdictions.

Accordingly WA recommends that a strategic independent review of the national ABF model be undertaken with consideration also being given to the roles and responsibilities of the relevant bodies involved in the implementation and operation of the model.

2. PRICING GUIDELINES

WA Health is generally supportive of the Pricing Guidelines outlined in the Consultation Paper and notes that no changes have been proposed for the *Pricing Framework 2018-19.*

While it is acknowledged that the IHPA's fundamental principles for ABF adjustments are focussed on 'patient-centric' characteristics, WA Health maintains that many remote and very remote cost pressures are not sufficiently recognised within the

Pricing Framework, as they pertain to the structural costs associated with staffing hospitals in remote and very remote locations.

WA Health will continue to work with the IHPA to further explore these types of cost variations via its submission to the Legitimate and Unavoidable Cost Variations Framework provided to IHPA on 30 May 2017.

3. SCOPE OF PUBLIC HOSPITAL SERVICES

WA Health acknowledges that IHPA is not proposing any changes to the scope of public hospital services for 2018-19.

4. CLASSIFICATIONS USED BY IHPA TO DESCRIBE PUBLIC HOSPITAL SERVICES

WA Health supports the ongoing classification refinement and development for activity based funding purposes and will continue to participate in this work through its representation on the IHPA working groups and advisory committees. The IHPA should ensure that jurisdictions are provided with adequate time to implement any new classifications before introducing pricing based on that new classification.

Australian-Refined Diagnosis Related Groups (AR-DRG)

Consultation Question - What additional areas should IHPA consider in developing Version 10 of the Australian Refined Diagnosis Related groups classification system?

WA Health acknowledges that IHPA will use AR-DRG Version 9 in NEP18 to price admitted acute services. WA Heath is supportive of the continuing development of AR-DRG Version 10, however there are issues that need consideration as follows:

- Variations in jurisdictional admission policies particularly for ADRGs R61 (chemotherapy), L61 (dialysis) and Z64 (other factors influencing health status) are reducing the meaningfulness of these DRGs, both clinically and as a funding tool. A national admission policy is essential for a system based on national averages and national benchmarking.
- AR-DRG version 9 made a significant change to the terms used in describing procedures; eschewing the term 'procedures' for 'interventions'. At DRG level, the use of the term 'procedure' persists. Consistency of terminology should be considered.
- IHPA plans to undertake the development of AR-DRG 10 'in-house'. The mechanism for any planned consultative process specifically for that revision should be described and in particular the ongoing process for making submissions. Will this part of the process continue via the Australian Consortium for Classification Development?
- Due to the significant volume of personality disorders within designated mental health wards, it is suggested that a further breakdown of personality disorders within U67A and U67B may be useful to better understand the clinical needs of the consumer. This needs to be balanced with the implementation of the Australian Mental Health Care Classification which will replace the DRG model for mental health services.
- Further development and review of the Episode Clinical Complexity Model.
- Review into using gestational age rather than birth weight for neo-nates.
- Continued development and refinement of DRG type Z's. These are DRGs that comprise all the reasons for contact with health services which do not fit neatly into one Medical Diagnostic Category either because they don't affect a specific body system (signs and symptoms in general), or they go across body systems or they fall into a category of check-up/screening/follow up.
- Review oral DRGs in the light of the National Oral Health Plan 2015-2024 which states that the DRGs and funding models for dental services require review and refinement to better reflect the relative costs of providing care to different population groups in different settings and to better support the

provision of effective and evidence-based dental care. As an example, DRG D40Z (dental extractions and restorations) lacks clinical distinctiveness. A single DRG is not reflective of the resource utilisation and costs associated with the scope of services.

Consultation Question - Do you support the phasing out of older versions of the Australian Refined Diagnosis Related Groups classification system?

Yes, in principle as an incentive for private funds to update to newer versions to be more in line with the versions used by public providers. However, WA Health strongly suggests having four older versions available to enable cross mapping. Locally there is still a strong demand for earlier versions to inform local processes like mapping of activity to Extended Service Related Groups (ESRGs).

Consultation Question - What time frame would be sufficient for the health care sector to transition to the more recent versions of the classification?

Between three and five years should provide sufficient time for systems to be upgraded and the associated education/training to be undertaken.

Australian National Subacute and Non-Acute Patient (AN-SNAP)

WA Health acknowledges that for NEP18 IHPA will continue to use AN-SNAP Version 4 to price subacute services and DRGs for episodes that are not classified to AN-SNAP. Further it is noted that the IHPA is considering whether there is sufficient and reliable data to price subacute paediatric services using AN-SNAP.

Tier 2 Non-Admitted Patient Services

Consultation Question - Do you support the proposal to shadow price non-admitted multidisciplinary case conferences (MDCC) where the patient is not present for NEP18?

Yes, MDCCs are valuable services for determining the best management of individual patients and add value to the audit of clinical outcomes and contribute to research. They assist in driving safety and quality locally and across health care systems. Rules for counting this activity must be well defined to ensure comparability across States/Sites and minimise administrative burden on health services.

Infact WA Health supports counting of any activity that incurs a genuine cost and provides benefits to patients.

Consideration should also be given as to how this can be captured for non-admitted mental health services which are currently block funded or how it can fit into the Australian Mental Health Care Classification.

Consultation Question - Do you support investigation of the creation of multiple classes in the classification for home ventilation?

WA supports multiple classes if current splits are not cost homogenous, and the investigated to be supported by robust and consistent data. For example, there will be cost differences between paediatric and adult populations.

Emergency Care

WA Health acknowledges the use of URG/UDG systems to price ED presentations until development of the new classification is completed in early 2018 and will be used for pricing from NEP19.

WA Health notes that the implementation of the Emergency Department Principal Diagnosis Short List in the national data collection has been deferred to 2018-19.

Teaching, Training and Research

WA Health acknowledges that IHPA will continue to block fund teaching, training and research activity in NEC18 and until suitable classifications are adequately tested for pricing purposes.

Australian Mental Health Care

Consultation Question - What other issues should be considered in the development of Version 2 of the Australian Mental Health Care Classification?

The continuing development of the Australian Mental Health Care Classification (AMHCC) is supported and WA is keen to participate in any development work.

Issues for consideration in Version 2:

- review of the split of settings to accommodate the classification of outreach, day program, and hospital-diversion based services;
- development of case studies to guide clinicians in decision making around mental health phase of care;
- further division of the 0-17 age group;
- development of additional complexity variables;
- review of weighted HoNOS score thresholds for complexity;
- consideration of effort and cost involved in intervening to improve caregiving environment and other social ecology factors;
- consideration of effort and cost involved associated with treating patients of Cultural and Linguistic Diversity, or with speech/hearing difficulties;
- division of 'therapeutic interventions' into subcategories to reflect the various types of therapies provided by mental health clinicians; and
- involvement of both community and hospital-based child and adolescent mental health services in the next stage of development of the AMHCC.

5. DATA COLLECTION

WA Health acknowledges that IHPA will be releasing version 4 of the Australian Hospital Patient Costing Standards in 2018 for use in future rounds of the National Hospital Cost Data Collection (NHCDC).

6. THE NATIONAL EFFICIENT PRICE FOR ACTIVITY BASED FUNDED PUBLIC HOSPITAL SERVICES

Consultation Question - Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2018-19?

As noted in our previous years' Pricing Framework submissions, WA Health would be strongly opposed to any change in the calculation of the NEP that has the potential to reduce the Commonwealth contribution to jurisdictions under ABF going forward. Furthermore, WA Health does not support a move away from the current process of setting a NEP based on the weighted mean cost of admitted services. This is particularly important issue as it would result in more funding being subject to funding guarantee considerations.

WA Health maintains that many rural and remote cost pressures are not sufficiently recognised within the Pricing Framework, and would like to continue to work with IHPA to ensure that WA is not disadvantaged in national pricing. Consideration should be given to a hospital–based remoteness adjustment applied in the same manner as paediatric hospitals and based on distance from a regional centre.

Consultation Question - What are the priority areas for IHPA to consider when evaluating adjustments to NEP18?

WA Health appreciates IHPA's plan to further investigate the Remoteness and Indigenous adjustments following WA's submission via the Legitimate and Unavoidable Cost Variations Framework. WA Health believes the current loadings do not adequately provide for the delivery of services in rural and remote areas. The submission provided supporting evidence that there are legitimate and unavoidable input costs associated with attracting and retaining hospital workers, the requirement to pay accommodation subsidies, and other factors such as higher utility costs, which all affect the ability of the WA Country Health Service (WACHS) to operate at the NEP. WA Health recommended that the IHPA consider the following:

1. Investigate and provide evidence around whether the current remoteness measure and associated categorisation of remoteness classes is fair and providing the necessary provider equity, especially for areas that are extremely remote relative to a major health service or population centre such as those in the far north of Western Australia.

2. Model alternative measures of remoteness, specifically ones that recognise the extreme isolation and distance that impacts on some service providers significantly more than others and does not seem to be captured under the existing variable.

3. Undertake modelling and provide supporting evidence around whether the current patient focused, location based adjustment is both adequate and fully compensates for all instances of higher costs incurred in providing services in a remote location or that may exist due to differences in a patients region of residence.

4. Investigate and provide evidence that the current patient focussed location based adjustment provides greater explanatory value in the model than a provider side measure and additionally that both measures together are not relevant and could work within a model. As it is WA's view that at least in theory these two types of measures are likely to be fitting for different costing effects.

5. Investigate whether a special class of hospitals exist that have much higher costs due to exceptional circumstances, for example mining towns where the higher input costs are both demonstrable in their payment and unavoidable and whether a further loading is necessary in these circumstances.

It is noted that many hospitals in remote areas of North-West WA have sufficient volume to be considered suitable for Activity Based Funding (ABF), but have severe and limiting fixed cost structures (including internal and external factors) that make ABF an inequitable funding source in practical terms.

WA Health would consider WA hospitals to be disadvantaged from their place at end of a cost spectrum that is funded at the average, and adjusts primarily to meet patient-based bed factors limiting the recognition of the severe location-based structural issues at play in the North West of WA. Further work is required to address inequity in the ABF Framework when it impacts individual hospitals severely, and that a secondary assessment made to establish an alternative funding mechanism for those hospitals.

Consultation Question - *What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.*

In consideration of WA's submission via the Legitimate and Unavoidable Cost Variations Framework that is currently under review by IHPA, a funding framework that provides adjustment based on patient-based factors does not adequately address the cost issues that arise from providing health services in rural and remote locations, particularly when a proportion of treated patients have metropolitan-based postcodes and attract no adjustment to the NEP.

Across Pilbara-based NEP funded public hospitals, this can comprise between 10% and 30% of patients treated in a given year, without any adjustment to NEP in recognition of rural/remote cost disabilities.

For the Kimberley, where there are only 5 postcodes for over 423,000 square kilometres of land, it is difficult to capture the extreme remoteness and distance experienced in treating patients from very remote communities.

WA Health considers that remoteness is no different to the adjustment made for specialist paediatric services, which is not addressed at a patient level but a site level.

Adjustments due to Homelessness and Methamphetamine/drug issues may be considered in future iterations of the ABF pricing model, informed by robust data.

7. SETTING THE NATIONAL EFFICIENT PRICE FOR PRIVATE PATIENTS IN PUBLIC HOSPITALS

WA Health supports the current process of IHPA estimating and adding back additional costs incurred by private patients that are not currently included in NHCDC submissions by the States, as well as the continued adjustment to the price weights to recognise this external funding source.

Given the current significant jurisdictional differences in private patients percentages in public hospitals, without appropriate adjustments to the price weights it would further compromise the capacity: (1) to have a single national efficient price and (2) to provide an equitable funding distribution or make assertions around the relative efficiency of one hospital compared to another.

If the private patient adjustment is inadequate, States with higher private patient utilisation will be advantaged.

8. TREATMENT OF OTHER COMMONWEALTH PROGRAMS

WA Health acknowledges that IHPA is not proposing any changes to the treatment of Commonwealth funded programs for NEP18. WA Health welcomes the opportunity to work with IHPA to investigate how blood costs can be more accurately captured in the NHCDC.

9. SETTING THE NATIONAL EFFICIENT COST

Consultation Question - Should IHPA ensure that there is no financial penalty due to the transfer of public hospital services from ABF hospitals to block funded hospitals? If so, how should this be carried out?

Yes, penalties for transfers out of ABF funded services should not influence patient care. Maximisation of the benefits of step down services within a network is a core tenet of efficient public hospital service delivery and financial penalties may create perverse incentives.

Focus should be placed on understanding the lack of economies of scale in smaller rural sites and the ability to 'flex' service capacity. Seasonal fluctuations to local populations in rural and remote regions can have significant impacts on service demand. Furthermore, attracting and maintaining a highly skilled clinical workforce in rural sites can be challenging, especially if funding is less predictable for the health service manager.

The NSW approach of addressing fixed and variable costs, as mentioned in the Consultation Paper, is a good start, coupled with a marginal rate for additional activity.

Consultation Question - Do you support IHPA's proposal to continue to block fund residential mental health care in future years?

Yes, until consistent and robust data to support an ABF model is available. Additionally, as these services often have small patient volumes with very long lengths of stay, a per diem rate per occupied bedday could be considered. Block funding may need to continue for some sites to maintain a safe, high quality patient centred service.

10. BUNDLED PRICING FOR MATERNITY CARE

Consultation Question - Do you support the proposed bundled pricing model for maternity care? Do you agree with IHPA's assessment of the preconditions to bundled pricing?

WA Health considers there is still substantial work required on the development of a bundled pricing approach for maternity services before it can be implemented for pricing and funding. The quality and consistency of data across jurisdictions will need to be at a level that would support the implementation of the bundling approach.

WA Health agrees that the preconditions identified in the consultation paper be used as initial test prior to develop bundled pricing models. Having a single patient identifier as a precondition presents challenges for patients with a mix of public and private care where patient identifiers are unique for both sectors. As part of assessing the benefits to both patient and the health care system, it would be beneficial to consider an option of retention of the status quo in order to achieve greater acceptance of the proposed change.

WA Health will continue to provide input in this area via its representation in the Bundled Pricing Advisory Group.

Consultation Question - Do you support investigation of whether the Individual Healthcare Identifier or another unique patient identifier could be included in IHPA's national data sets?

Yes, including safeguards around privacy/confidentiality to ensure data is only used for bundling purposes.

WACHS has recently undergone significant reform in the area of unique patient identification through the implementation of a Statewide Patient Administration System built upon a Statewide Patient Master Index. Prior to the implementation of webPAS, the HCARe system (operating across WACHS sites) did not have the capability of maintaining a unique patient identifier. So, multiple activity for a patient receiving services across multiple sites could not be identified and would be missed if service bundling was applied. Therefore for WACHS sites, the risk is evident if historical data (prior to webPAS implementation) is used. The same risk applies to patients moving between jurisdictions.

Consultation Question - *What issues should IHPA consider when examining innovative funding model proposals from jurisdictions?*

Consideration needs to be given to the amount of change which has occurred in relation to the service or services impacted, as change fatigue can have a significant impact on service delivery and overall credibility of the Activity Based Funding model. Patient outcomes, effective data capture, professional expertise and user training, and implementation time/costs should also be considered to ensure sustainability.

The IHPA also needs to take into account the lead times for innovative funding model proposals, to ensure sufficient time for these proposals to be included in funding calculations.

The Consultation Paper suggests block funding maybe applied for patients enrolled in innovative funding programs. This approach is moving away from the principles of a patient-based pricing and funding model. Justification that guaranteed funding is efficient is required. How would variable activity be considered in developing pricing and funding mechanisms?

Consultation Question - Should IHPA consider new models of value-based care, and what foundations are needed to facilitate this?

Value-based care models that improve patient care should be considered particularly if they have the potential to minimise hospital acquired complications, improve quality outcomes and reduce length of stay. While there is a general understanding that an ageing population will drive health care costs upward, a value-based health care system should be the goal. A flexible, evidence based, patient focused model of value-based care will assist in achieving a more efficient and effective health care system that is properly and appropriately funded. It would be necessary to support this with a systemic measurement of health care outcomes, and a focus on distinct population segments. Consideration would also need to be given as to how new models of care would be treated on a national scale. For example, are new models of care only relevant to the jurisdiction who suggests it and who determines 'value'? There is also a need to recognise the proper and appropriate methods of funding the cost of implementation, change management, communications and education with respect to any new models of care.

The focus should be on both hospital and community based care as the overall cost is determined by both components of patient care. Foundation steps should include robust and consistent hospital and community care data and the ability to link these two datasets, which would lead to having improved Patient and Clinician Reported Outcome Measures. A robust dataset would better inform where the value is achieved and what services or processes jurisdictions do that don't add value. It will also inform cost drivers which further inform any discussion on where the value or waste in healthcare came from and inform service funding accordingly.

The IHPA and the jurisdictions need to continue to identify areas for development that we can be practically achieved in any given year and safeguard spreading scarce health resources thinly.

12. PRICING AND FUNDING FOR SAFETY AND QUALITY

Consultation Question - Do you support the proposed risk adjustment model for HACs? Are there other factors that IHPA should assess for inclusion in the model?

Yes, provided data collection is consistent across all States/Territories. Without risk adjustments, the model lacks credibility and it will be a 'hard sell' to clinicians and health services around funding equity. The inclusion of Aboriginal and Torres Strait Islander status in the model is proposed, as this population is subject to a greater degree of co-morbidity. Types of drugs administered should also be considered.

Consultation Question - Do you agree that HACs third and fourth degree perineal lacerations during delivery and neonatal birth trauma be excluded from any funding adjustment?

Yes, these cases should be excluded from funding adjustments especially when obstetricians themselves cannot reliably distinguish between third and fourth degree lacerations. However, there may be value in quantifying the scope and value of the exclusions in each of the jurisdictions.

The HAC list in Table 1, page 38 of the Consultation Paper would have been more informative if it included the relevant ICD-10 codes to ensure standardised identification of cases. WA Health is interested how the incremental cost of HAC is derived (Table 2, page 39). It seems counterintuitive that a perineal tear has a higher cost burden than a cardiac complication; in the same manner as venous thromboembolism and pressure injuries have greater cost burden than unplanned returns to theatre which is usually for complications and may be associated with detour through ICU.

Risk adjustment for hospital readmissions and HAC should ideally include comorbidities like obesity and diabetes.

Consultation Question - What pricing and funding models should be considered by IHPA for avoidable hospital readmissions?

WA Health has identified a number of concerns/issues with the approach taken for a number of aspects on the methodology for defining and identifying "avoidable readmissions":

- The Australian Commission on Safety and Quality in Healthcare (the Commission) is using a "fast track approach" for the literature review. This may enable the project to meet the timeframes but there is a very high risk this will negatively impact the quality and comprehensiveness of the outcomes. It is implied that the avoidable hospital readmission project results will contribute to a funding/pricing model to drive improvement in patient outcomes. This highlights the importance of allowing sufficient time to ensure quality project outcomes. The Commission's Project timeframes appear to have analysis and technical advice occurring before the literature review has been completed. There is a high risk in doing so as important information relevant to the technical aspects and analysis may be missed.

- Adopting a definition for the purpose of the project without stakeholder consensus undermines project outcomes.

- A key point to the *Definitions* is that readmission must be potentially avoidable through better clinical management. Need to define clearly what determines "better" clinical management. Potentially avoidable would be highly subjective and should be strengthened to wholly avoidable.

- There may also be some subjective interpretation of the terms used within the current proposed criteria, for example "clearly related". Need to provide more detailed information and examples of what constitutes a condition being "clearly related" to the original admission.

- *Preliminary analysis* is unclear and suggests that restrictions are placed around the identification of index admissions that may limit/reduce the inclusion of cases which are genuine avoidable hospital readmissions. This limits the extent to which the approach can be supported.

A model that considers both individual patient complexity and quality of care would be supported, where re-admission is deemed 'avoidable' or 'preventable' for reasons relating to the health care service. Exclusion criteria would require consideration whereby re-admission may not be deemed preventable in terms of healthcare provision e.g. patient non-compliance. Deductions of full costs of re-admission presentations are not supported. There is no funding provided for cases deemed avoidable after a clinical review of the case, and therefore this should not be purely a data based decision.

Any model that applies financial penalty for the episode of re-admission should only be applied to cases of avoidable re-admission to the same hospital/service. Any pricing model applied to cases of re-admission to a different hospital/service would need to apply any financial implication to the primary admitting facility and episode of care, under the assumption that it was a deficiency in care at this stage that led to the re-admission.

A proposed model could be that a proportion of the costs of the return episode are deducted on the basis of risk adjusted likelihood of re-admission of the individual patient on the basis of the principal diagnosis/DRG being considered at the initial hospital separation. Another model worthy of consideration is a modest financial penalty applied at a facility level for hospitals that exceed the risk adjusted national mean rate of re-admissions (provided that this mean rate is condition specific).

Alternatively there is potential that a positive funding incentive could be applied at a facility level for top performing services with the lowest avoidable re-admission rates for specified conditions. Percentage reductions in accordance with weighted complexity scores would be necessary in any model to counteract effects on re-admission rates of chronic disease and complex co-morbidities

Consultation Question - Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing and funding adjustments for avoidable hospital readmissions? Are there any other criteria that should be considered?

The assessment criteria are appropriate to facilitate a review of the merits of the various models, though it is acknowledged that a considerable amount of work is still required including capture of accurate and consistent data across jurisdictions.

WA Health looks forward to the finalised definitions for sentinel events. It would be prudent to get consistency of definitions between the various Commonwealth agencies. For example, for transfusion the Commission excludes near miss but National Blood Authority includes it in the national Haemovigilance data set.

IHPA should ensure they assess each aspect of the proposed methodology up to the five assessment criteria outlined in the consultation paper, and this work should not be fast tracked as this will put the safely and quality outcomes at risk.