Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2019-20

Submission from the Department of Health

The Department of Health (the Department) welcomes the opportunity to provide comment on the *Consultation Paper on the Price Framework for Australian Public Hospital Services 2019-20* (the Consultation Paper).

The Department notes that the Independent Hospital Pricing Authority (IHPA) has sought comment on eight areas within the Consultation Paper:

- Scope of public hospital services;
- Classifications used by IHPA to describe public hospital services;
- Data collection;
- Setting the National Efficient Price for activity based funded public hospitals;
- Setting the National Efficient Price for private patients in public hospitals;
- Setting the National Efficient Cost;
- Innovative funding models; and
- Pricing and funding for safety and quality.

This submission addresses the questions posed by the IHPA throughout the Consultation Paper.

Scope of public hospital services

What changes, if any, should be made to the criteria and interpretive guidelines in the Annual Review of the General List of In-Scope Public Hospital Services policy?

The Department supports the IHPA in identifying any changes that should be made to the criteria and interpretive guidelines in the Annual Review of the General List of In-Scope Public Hospital Services, to ensure it remains fit for purpose and reflects up-to-date public hospital services.

Classifications used by the IHPA to describe public hospital services

How could 'Australian Coding Standard 0002 Additional Diagnoses' be amended to better clarify what is deemed a significant condition for code assignment?

The Department supports the IHPA's decision to revise 'ACS 0002 Additional diagnoses' for the Eleventh Edition to ensure the standard clearly identifies what deems a condition to be significant for code assignment in an admitted acute episode of care.

Do you support the proposed timeframe to phase out support for AR-DRG classification versions prior to AR-DRG Version 6.X from 1 July 2019?

The Department supports the proposed timeframe for the phasing out of older versions of the AR-DRG classification system, provided the change does not affect the data quality and accuracy of relevant national data collections.

The Department suggests that the IHPA investigate how any in-scope public hospital services that are delivered in private hospitals can be coded with the same AR-DRG version that is used in public hospitals, in circumstances where different versions may be used. This will support greater data comparability.

The Department also encourages the IHPA to adopt a standard, published approach to the continued maintenance of older versions of the AR-DRG classification systems, so that all areas of the Australian health sector that use those older versions will be aware when they will become unsupported.

Do you support the current biennial AR-DRG development cycle. If not, what is a more appropriate development cycle?

The Department notes the IHPA's assessment of the potential consequences of increasing the length of the development cycle. However, the Department is concerned that if the period for development of each new version of the AR-DRG system is too short, this causes unnecessary burden on front-end staff and coders, due to the re-education and re-learning required.

Furthermore, the Department considers that the introduction of classification changes without an appropriate shadow period may result in an unexpected impact on Commonwealth funding for public hospital services.

The Department is of the view that revisions to specific classifications within each new version of the AR-DRG should only occur if there is robust evidence to indicate that clinical practices have changed.

What areas should be considered in developing Version 5 of the Australian National Subacute and Non-Acute Patient classification?

The Department supports the IHPA identifying any additional areas for consideration in developing Version 5 of the AN-SNAP classification system through its Clinical Advisory Committee and relevant working groups, to ensure it remains fit-for-purpose and reflects up-to-date clinical approaches.

Data collection

Should access to the public hospital data held by IHPA be widened? If so, who should have access?

The Department supports the IHPA's commitment to transparency and open access to information, whilst respecting and maintaining confidentiality, commercially valuable and personal information.

The Department supports new data sharing and release arrangements which will benefit Australians. New arrangements should provide trusted access to datasets that have substantial and community-wide benefits for research, innovation and policy.

Setting the National Efficient Price for activity based funded public hospitals

What are the advantages and disadvantages of changing the geographical classification system used by IHPA?

The Department supports the IHPA in identifying any changes that should be made to the geographical classification system used, to ensure it remains fit for purpose and reflects the cost incurred for public hospital services due to geographic remoteness.

What areas of the National Pricing Model should be considered as a priority in undertaking the fundamental review?

The Department supports IHPA's decision to review alternative approaches to calculating the National Pricing Model. Options explored should attempt to strengthen the price signal provided by the National Efficient Price.

Should IHPA consider any further technical improvements to the pricing model used to determine the NEP for 2019-20?

The Department considers that the existing NEP model is adequate and fit for purpose for determining 2019-20 pricing. Any further technical improvements should only be considered if it can be demonstrated that they would:

- Materially affect the distribution of hospital funding, and that the benefits of the improved distribution would outweigh the costs involved in implementation; and/or
- Improve the consistency, quality and/or timeliness of the provision of hospital activity and cost data.

For future years, the Department encourages the IHPA to examine the current basis of the NEP model (using an average of the three most recent years of available hospital cost data) and consider transitioning to a more efficient pricing model.

What are the priority areas for IHPA to consider when evaluating adjustments to NEP19?

The Department is of the view that the priority the IHPA should consider when evaluating adjustments to NEP19 is the value of the adjustments to improving outcomes in the health care system.

Do you support price harmonisation for the potentially similar same-day services which are discussed above?

The Department supports price harmonisation for the potentially similar same-day services, such as non-admitted and admitted chemotherapy services, which can potentially be provided in either care setting. The Department supports a system of harmonising price weights across care settings, with the price weights based on clinical evidence of best practice site of care. The Department recommends that the IHPA reassess the harmonised prices regularly.

When should IHPA implement a shadow period for ABF classification systems and the National Pricing Model?

The Department is of the view that shadow pricing ABF classification systems should apply to all changes, in order to ensure consistency and stability across financial years. The Department notes that shadowing changes can assist in minimising the risk of unintended consequences.

Innovative funding models

What countries have healthcare purchasing systems which can offer value in the Australian context and should be considered as part of the global horizon scan?

The Department supports the IHPA's decision to undertake a global horizon scan this year to identify potential innovations in the international setting to incorporate into Australia's healthcare purchasing systems.

Pricing and funding for quality and safety

Do you agree with the proposal that pricing and funding models for avoidable hospital readmissions should be based on readmissions within the same Local Hospital Network (either to the same hospital or to another hospital within the same Local Hospital Network)?

The Department supports IHPA's suggestion that, as a starting point, pricing and funding models for avoidable hospital readmissions should be based on readmissions within the same Local Hospital Network. The Department is of the view that funding adjustments should aim to target the initial treating hospital in which the index admission occurred. Once implemented IHPA should revisit the proposal and attempt to maximise LHNs' incentives to avoid readmissions.

Do you support the proposal to limit the measurement of readmissions to those occurring within the same financial year?

The Department agrees with the IHPA's approach of limiting measurement of readmissions to those occurring in the same financial year as the index admission. The Department notes that to measure readmissions across two financial years would introduce complexity and potentially delay Commonwealth reconciliation funding for public hospital services.

Do you agree with IHPA's assessment of this option [Option 1]?

The Department considers that Option 1 would involve the greatest ease of implementation due to the simplicity of funding model adjustments with this approach.

Do you agree with IHPA's assessment of this option [Option 2]?

The Department notes that this option implicitly assumes that the initial treating hospital would have incurred additional costs if they had taken effective action to avoid a readmission. The Department agrees with IHPA's assessment of Option 2.

What are the advantages and disadvantages of Option 3?

The Department notes that one of the advantages of Option 3 is that it allows for peer review, which may encourage individual LHNs to modify their policies or behaviours on the basis of the number of avoidable hospital readmissions.

Should benchmarks for avoidable hospital readmissions be measured and calculated at the level of individual hospitals or at the level of Local Hospital Networks?

The Department notes that historically benchmarking has occurred at the level of individual hospitals. The Department supports a continuation of this method to allow for easy stratification of hospitals using the Australian Institute of Welfare's hospital peer groups.

How should the threshold be set for –'acceptable' rates of avoidable hospital readmissions?

The Department supports the benchmarks being set at the top quartile or top 10% of hospitals with the highest readmissions rates. This would allow improvements against individual performances, but would unfortunately reduce transparency and cause increased complexity.

How should the funding adjustments be determined for 'excess' rates of avoidable hospital readmissions?

The Department supports the approach of not funding the entire cost of the selected readmissions services. This approach results in increased transparency of funding arrangements, whilst introducing less complexity than other options available.

Do you support an incremental approach to introducing funding adjustments for avoidable hospital readmissions based on one or two clinical conditions from the list of conditions considered to be avoidable hospital readmissions?

The Department supports IHPA's exploration of an incremental approach to the introduction of funding adjustments for avoidable hospital readmissions. Given the complexities of identifying avoidable hospital readmissions compared to hospital acquired complications, the incremental approach will provide a more pragmatic approach to implementation.