AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

AMA Submission on the proposals set out in the Independent Hospital Pricing Authority – Pricing Framework for Australian Public Hospital Services 2019-20

Introduction

The AMA welcomes the opportunity to comment on the ideas proposed in the 2019-20 Pricing Framework. By and large our feedback is pitched at a policy level, although we also have some comments on specific consultation questions.

Scope of public hospital services (chapter 3 consultation paper)

The AMA appreciates the clear explanation of eligibility criteria for public hospital non-admitted services - in particular, Tier 2 Class 40 services. The AMA supports the policy decision that eligibility for in-scope services is independent of service setting. This creates flexibility to deliver best practice treatment at a site best suited to the patient's clinical and socio/social needs. It is also positive in-scope non-admitted services will be funded under Tier 2, Class 40, if there is evidence the service is directly related to public hospital efforts to reduce avoidable re-admissions.

However, it still seems State Governments are liable to use State own revenue to fund innovative care trials, in order to collect the empirical evidence to show a strong relationship between a new service and hospital avoidance - before the service becomes eligible for Commonwealth contributions. While evidence is important, evaluated trials to establish which non-admitted services have the strongest causal effect on reduced hospital presentations will be expensive. It is unlikely the effectiveness of a particular service type, in a particular innovative care trial, will be totally transferable to a different patient cohort in a different innovative care trial in another setting. A Commonwealth contribution to defray the trial cost could be achieved if non-admitted services were temporarily deemed eligible for Commonwealth Tier 2 funding for an agreed trial period. Services with a strong causal relationship to reduced hospital presentations could be considered for on-going Commonwealth funding eligibility thereafter.

Non-admitted services that already have an evidence base to show they prevent hospital admissions should be listed as eligible services without delay. For example, Pulmonary rehabilitation is very effective at preventing chronic obstructive pulmonary disease (COPD) admissions. One of the frustrations is that despite the evidence to show patients benefit from non-admitted pulmonary rehabilitation programmes – limited access means public patients may need to wait up to 4-6 months. Adequate funding to address these access barriers should be a priority under activity-based funding.

Classifications used by IHPA to describe public hospital services (chapter 4 consultation paper)

Caesarean classification differentiation

The AMA requests more information about the proposal to create separate classifications for caesareans section deliveries according to whether they are performed prior to the commencement of labour or following the commencement of labour. We would not accept classification differentiations that result in reduced funding for pre-labour caesarean sections when this treatment decision is patient choice or based on the clinical judgement of the treating doctor. There are many valid clinical reasons to arrange a caesarean section prior the onset of labour. These include:

a. Placenta Praevia
b. Previous Uterine surgery for congenital anomalies, septa, fibroids, adenomyosis
c. Previous uterine rupture
d. Previous cervical malignancy treated with trachelectomy
e. Women with gynaecological malignancies that require exenterative surgery that can be done at the same time as the baby becomes viable and is electively delivered by section
f. Previous recurrent miscarriage due to cervical incompetence treated with non-absorbable cervical cerclage
g. Breech presentation especially if preterm or weighing less than 800g or more than and 2500g
h. Breech presentation when the woman is not happy to accept the increased risks of vaginal delivery to the baby
i. Preterm Labour
j. Need for preterm delivery because of foetal or maternal reasons when induction of labour neither possible or practical
k. Significant growth restriction etc where in the opinion of the consultant obstetrician, the baby would not easily tolerate labour and the resultant emergency C section if the woman were forced to labour
l. Multiple pregnancy if the presenting twin is non-cephalic
m. Multiple pregnancy of higher orders than twins
n. Maternal Diabetes (Type I, II, Gestational or MODI etc) with poor control
o. Maternal medical conditions like vertebral and disc issues
p. Maternal issues like hernias, where labour and active pushing may worsen existing conditions
q. Maternal issues like fractured coccyx, or pelvis from congenital or trauma related issues
r. Maternal issues like fixed flexion deformities where the woman can't open her legs enough to deliver a baby vaginally
s. Maternal intracranial pathology where increased intracranial pressure associated with labour and pushing contraindicated
t. Maternal issues like previous urological (bladder) repairs where in the expert opinions of either an Obstetrician or urologist, delivery is best effected by section rather than vaginal delivery
u. Maternal issues where there has been a previous third or fourth degree tear or obstetric fistula or female genital mutilation that has resulted in significant anatomical variation

v. Maternal issues where ICU and tertiary specialised services may be needed at a predictable time during 'public service' hours to afford women appropriate care and avoid the vagaries and unpredictability of labouring after induction of labour and its attendant risks of requiring emergency caesarean section in worse condition to these units.

w. Maternal HIV infection or other infectious diseases where vertical transmission during labour provides an unacceptable risk to the family and which can be eliminated by employing a planned elective operative delivery without a vaginal delivery.

x. Patient choice to elect C Section where women identify as survivors of sexual abuse. Australian Bureau of Statistics show around twenty percent of this group choose C section due to this prior trauma.

Recording additional diagnoses

As noted in the consultation paper, determining the additional diagnoses that are significant to the patient's episode of care is a clinical judgement. The AMA understands hospital coders do currently discuss patients individually with clinicians to differentiate between pre-existing or additional conditions that are relevant to the principal admission from those that are not. Identifying pre-existing conditions from hospital acquired conditions that incur a penalty must remain a clinical decision according to the particular characteristics of the patient. The AMA looks forward to receiving further information on the proposed revisions to the additional diagnoses codes when the consultation paper is released in the second half of 2018.

New classifications

Although the AMA does not oppose the introduction of activity-based classification across as many hospital functions as appropriate – before going 'live' these new classifications must be sophisticated enough to capture the full complexity and costs of providing the services. Failure to do this will lock in an artificially low funding base to the detriment of public hospital financing and patient safety and quality. New classifications and costing weights must not create differential pricing and perverse financial incentives for public hospitals to preference one patient treatment pathway over another, in isolation of patient needs. The independence of public hospital clinicians to decide patient treatments, case by case according to individual patient circumstances, is paramount to good clinical care and patient safety.

There are four new activity-based classifications under development - hospital emergency care, non-admitted care activities, teaching, training and research, and mental health care. These will collectively account for a large proportion of public hospital activity and concurrent implementation will impose substantial, changes to the way public hospitals code and report activity across many aspects of hospital business. It is important the implementation timeframe takes a holistic account of the overall rate of public hospital disruption already in progress due to digitisation and delivering new models of care. New classifications should be rolled out incrementally one at a time in close consultation with hospital administrators. The rollout should also be adequately resourced and it is entirely reasonable the Commonwealth contributes additional resources.

IHPA Data Collection and Release (chapter 5 consultation paper)

Individual Healthcare Identifier and IHPA data release powers

AMA members are acutely aware of their role in protecting the privacy of their patient's sensitive data – a large part of which is created by our members in the process of providing their patients with high quality healthcare.

The AMA supports quality research into public hospital performance and quality of care provided. We understand the practical appeal of incorporating the My Health Record patient identifier into the public hospital data sets used by IHPA to carry out its functions. But this in of itself would potentially create a conduit between the data held in a person's My Health Record and the public hospital data set. As you are aware, sensitive health data in the My Health Record data is patient controlled and subject to very strict limits on secondary use set out in the My Health Record Secondary Use Framework. This includes a prohibition on health insurer access to My Health Record data because of the clear conflict of interest this creates.

Consequently, the AMA would only support the inclusion of the My Health Record Patient Identifier in hospital data sets if the release of public hospital services data for secondary purposes is governed under the same release conditions applied to My Health Record data and managed by the Australian Institute of Health and Welfare –one of the few accredited data integrating authorities in Australia.

As the health eco-system rapidly shifts to increased digitisation it is important to ensure sensitive health data that has been de-identified and disclosed by one government agency in one data environment does not become re-identifiable in a different data environment. In 2018 the Melbourne University published a report that showed de-identified MBS and PBS data could be married with other publicly available government data to re-identify patients. This academic exercise is a salient example of the urgent need to implement a holistic overarching health data governance framework managed by a single organisation with expertise in data science, data security and Australian privacy law to manage the secondary use and disclosure of ***all*** Australian health data. Until this is in place, AMA does not support IHPA's release of sensitive hospital data sets for secondary purposes and similarly have deep concerns about the release of MBS, PBS, TGA and DVA data separate to the framework for the My Health Record. Multiple release processes, procedures and privacy controls for what is often similar, or the same data, will inevitably lead to a similar issue as the 2018 Melbourne University situation.

In the meantime, the AMA would welcome additional published reports by IHPA (excluding the raw data sets). This has potential to increase transparency and broaden the public's understanding of the quantum of Commonwealth funding per local hospital network under the activity-based funding model. It is also the public interest if IHPA published a report to show public hospital costs relative to combined Commonwealth/State revenue and annual growth in hospital service volume at the local hospital network level.

National Benchmarking Portal

Given our data security concerns explained above, we would not support the release of raw hospital data sets via the benchmarking portal unless this disclosure for secondary purposes was managed under the over-arching health data governance framework. Despite the urgent need for this – it is still a work in progress.

Before hospital cost/activity and complications data is made publicly available there needs to be national agreement on the scope and manner of presenting this data. We have many good news stories in our health system and it is important to acknowledge the data that reflects health system activity is clearly different from data that is useful for consumers/patients. If national benchmarking portal data is not presented sensitively, consumer misinterpretation could trigger a demand surge for the nearest alternative public hospital with impacts such as over-crowding, extended waiting periods for 'in-area' patients and cross border funding complications.

Setting the National Efficient Price (chapter 6 in consultation paper)

Remote geographical classification

The AMA is aware the Federal Government has recently moved to the Modified Monash Model for medical workforce distribution policy issues. AMA supports this move. Workforce distribution challenges will also impact public hospital staffing costs with flow on effects to the operating costs for rural and remote public hospitals. The efficiencies gains of moving to a single remote geographical classification for admitted and non-admitted health services is appealing, especially as public hospitals become more involved in post discharge programmes to stabilise chronic and complex disease patients in the primary setting to avoid avoidable readmissions. Having said this, the final decision on the classification should reflect the best fit for rural and remote hospitals.

Fundamental review of the National Pricing Model

The AMA welcomes a review of the National Pricing Model. While activity-based funding provides greater transparency than Commonwealth hospital grants, the settings reflect average cost of hospital service, but not necessarily a high quality service. Current activity-based pricing has contributed to a public hospital system that is chronically underfunded and overloaded.

IHPA reports show growth in reported public hospital recurrent cost per in-scope NWAU since 2011-12 has dropped to 1.6 per cent per annum[1]. The National Efficient Price per NWAU has dropped from $5,007 in 2014-15 to $4,956 (2015-16) and lower still to $4,883 in $2016-17.

We note IHPA advise a large part of the headline decline in hospital operating costs is, in fact, due to hospital improvements in the accuracy and completeness of capturing and reporting hospital activity. An increased volume of hospital services reports for the same cost produces an artificially low cost growth. AMA understands hospital funding is indexed at a rate equal to the per annum increase in hospital costs (currently 1.6 per cent per annum). If real year on year hospital cost increases have not have been properly indexed, it equates to a drop in real Commonwealth funding for every NWAU provided in a public hospital. The AMA would welcome an opportunity to discuss this further and if under-indexation has been occurring this should be examined in the fundamental review.

What is clear is that under the current national efficient price, growth in volume of hospital services is not matching the level of unmet demand. This imbalance translates to unsafe bed occupancy rates, over-crowding, and an inability to treat patients within the recommended clinical timeframes. 2016-17 AIHW data shows patients least likely to leave public hospital emergency within four hours are the sickest. Fifty-seven per cent of resuscitation patients, 58 per cent of emergency patients and

[1] IHPA presentation to AMA, April 2018

only 64 per cent of urgent patients left emergency within four hours. This suggest there are systemic barriers or resource constraints that prevent the most seriously ill patients from being transferred out of a busy public hospital emergency department to an appropriate hospital ward bed for ongoing care.

In some jurisdictions elective surgery waiting lists are also failing to provide access to public hospital surgery within recommended waiting times. On average across all States and Territories - around one in 10 patients in 2016-17 who were clinically indicated to receive treatment within 90 days waited longer than recommended.[2] In some smaller jurisdictions access to elective surgery within clinically recommended timeframes is far worse than the national average performance. The latest AMA Safe Hours Audit of public hospital doctors (2016) shows one in two doctors (53 per cent) are working unsafe shifts that place them at a higher risk of fatigue. Shifts of 72 hours, 59 hours and 53 hours were reported. Although the 2016 Audit results were an improvement on 2001 when 78 per cent of those surveyed reported working high risk hours, the overall ratio of public hospital doctors at significant risk of fatigue has remained at 53 per cent since the AMA audit began in 2001. These combined hospital statistics of delayed patient treatments and unsafe workhours for public hospital doctors are symptomatic of a public hospital funding model under considerable stress.[3] .

The AMA acknowledges States and Territories are responsible for public hospital administration, but funding is a joint Commonwealth/State responsibility. Activity-based funding in its current form excludes Commonwealth contributions to technology advancement costs and the expensive structural reforms that hospitals will need to lift their productivity. In view of the importance of successful structural efficiency reforms, and the high cost of achieving them, Commonwealth contributions toward these costs should be considered in the national efficient price review.

The AMA appreciates there are some conflicting policy objectives that underpin the policy intent of activity-based pricing. Specifically, the dual aim of timely-quality care and hospital efficiency are inherently conflicted. Setting activity-based price equal to 'average cost' has driven efficiency down to 1.6 per cent per annum at the expense of timely-quality care. In AMA's view, it is time to rebalance the priorities in favour of timely access to public hospital treatments and best practice pricing should be considered as a way to achieve this.

It is also timely to address current activity-based funding settings that create the perverse, but rational, incentives for public hospitals to chase alternative revenue streams in out-patient clinics. The incentives are strong, but the inefficiency costs of chasing MBS item numbers is also high. If these incentives were diminished by adjusting the activity-based price to neutralise price incentives in other source revenue streams, the result could be substantial public hospital efficiency gains and significantly improved patient access to public hospital outpatient treatments. The hidden waiting list – the time that patients wait from when they are referred by their general practitioner to seeing a specialist in a public hospital outpatient clinic - is a well understood policy issue that could also be addressed under revised activity-based pricing settings. The AMA requests an opportunity to discuss this proposal with IHPA in more detail.

Wherever the penalty approach applies, back-casting should be maintained.

[2] AIHW Australian Hospital Statistics: Elective Surgery Waiting Times 2016-17.
[3] Australian Medical Association *Managing the Risks of Fatigue in the Medical Workforce* 2016 AMA Safe Hours Audit, July 2017

The AMA is also open to consider other changes to the National Efficient Price if they result in ***increased*** NWAU payments to public hospitals. Given the level of public hospital funding stress and patient access block evident in the latest AIHW data, the AMA would not support any amendments to national efficient price that ratchet up the financial pressure on public hospitals to do more with less - for example, we do not support the exclusion of high cost hospitals or 'avoidable costs' because this would reduce the average cost price. It is incompatible and irrational to alter activity-based funding settings to increase pressure on public hospitals to do more with less funding, and simultaneously reduce funding for HACs and avoidable readmissions.

Adjustments to the National Efficient Price 2019-20

The AMA supports the original intention to adjust National Efficient Price to reflect legitimate and unavoidable variations in the costs of delivering healthcare services.

We note IHPA's preference to phase out adjustments related to hospital input costs but disagree with the premise that all input costs are within the control of hospital administrators. For example, staffing costs comprise around 66 per cent of hospital operating budgets. A model of national efficient price based only on patient characteristics would disadvantage hospitals with appropriate staff to patient ratios and favour hospitals that cut costs by cutting these ratios. The AMA supports the pursuit of incremental hospital efficiencies but it is vital we do not use national price to pursue efficiency at the expense of patient and doctor safety.

Specialist hospitals such as children's hospitals also have higher than average input costs. While some higher costs such as high patient to staff ratios, can *theoretically* be reflected in higher weightings according to the patient characteristics, it is unclear if the methodology to achieve this is yet available. It is also not clear how patient-based cost weights would generate a funding contribution to purchase and update specialised equipment required in specialised hospitals.

Hospital size will also affect hospital costs. A few industries do have cost curves that continue to fall as outputs increase. Most other industries are characterised by operating costs that that start high over low output then decline as output increases – but only up to an optimal output level. Thereafter cost per unit unavoidably starts to increase. If this is also true for public hospitals, very large hospitals will not be able to avoid higher costs per NWAU, beyond a certain capacity and efficiency level. A patient characteristic approach to pricing would under-fund these large hospitals causing them to close beds and/or pair back the range of hospital treatments provided. This will do nothing to help address the current state of patient access block or improve patient safety.

In light of these concerns, the AMA could not support the shift to pure patient-based characteristics as a determinant of efficient price until, and unless, all legitimate higher costs associated with unavoidable variations in wage costs, hospital type, hospital size, hospital specialty and geographic location are fully accounted in the cost weights and subsequent funding levels.

Price harmonisation

While technology advances are increasing the safety of home-based care for some services that historically could only be safely provided in the admitted setting – not all patients will be clinically or cognitively suited to a non-admitted care setting. Not all patients will have a home environment with sufficient support to make this a safe option. Price harmonisation will only benefit patients if it

is nuanced and sophisticated enough to elevate/emphasise clinical judgement above financial incentive as the determinate of appropriate setting. Price harmonisation for dialysis is used below as a fictional illustrative example. If the funding relativity is wrong for home dialysis, there is a financial disincentive to admit patients to that modality even though it is clinically appropriate for that patient. Alternatively, incorrect relativity in the other direction could create a perverse funding incentive to treat patients in a non-admitted setting even though it is not clinically appropriate for the patient.

Cost differentials are likely to vary according to treatment type and setting. It is vital financial drivers do not persist after price harmonisation with the effect of superseding clinical judgement as the determinant of a clinically appropriate setting.

Other treatments *potentially* suited to price harmonisation across care settings include patients on prolonged antibiotics where there are no other patient complications and pulmonary embolus patients starting anticoagulation. However, it must be noted the literature on hospital in the home is not particularly strong. It is imperative patients are not allocated to hospital in the home modalities unless there is strong specific evidence it produces superior patient clinical outcomes. The quality of this evidence must be high.

Setting the National Efficient Price for private patients in public hospitals (chapter 7 consultation paper)

Despite the correction to public hospital funding to neutralise all private patient revenue incentives, the Federal Government seems to consider States and Territories still have sufficient financial incentives to chase private patient revenue. So far this issue has been investigated via a public consultation, the Private Health Ministerial Advisory Committee and more recently deterrent clauses have been added to the 2020-25 healthcare agreements. Some insurers (Bupa) have taken their own steps to remove private patient entitlements for private patient treatment if the admission occurs via emergency.

The ongoing belief by some, that private patient revenue gains remain in the system is limiting the use of private insurance in public hospitals as the Federal government and private insurers take matters into their own hands. The AMA would welcome a frank discussion between insurers, IHPA, the Federal and State Governments to try and resolve this issue as soon as possible.

National Efficient Cost (chapter 9 consultation paper)

The AMA has a representative on the Small Rural Hospital Working Group and we look forward to providing further comments to you via this forum.

Innovative funding models (chapter 10 consultation model)

Block funding for innovative funding programmes - it is hard to argue against innovative funding programmes if they improve patient outcomes, reduce preventable poor-quality patient care, and better co-ordinate patient care across the admitted/non-admitted care boundary– especially for patients with one or more chronic conditions. However, the AMA does not endorse any moves toward managed care. Australia has a long history of trialing coordinated care models and the

evaluations indicate positive patient to cost ratios are very difficult to achieve. Large investments will be needed to refine these models over time. It is also highly likely the cost of keeping a chronically unwell patient out of hospital will require providing these patients with access to an increased range and volume of primary care services to improve or reduce the progression of the chronic disease in the primary care setting.

The AMA does not support the current requirement that requires States and Territories to cash out their admitted patient budget to fund these innovative models. When unsustainable pressure on public hospital budgets is forcing public patients to wait longer than clinically recommended to access hospital services, these trials should instead be recognized as temporary eligible public hospital Tier 2 services to qualify for a Commonwealth contribution. Eligibility for Tier 2 inclusion in the longer term should depend on the results of the trial evaluation.

However, even this funding option creates undesirable outcomes for public hospitals overall. If the volume of Tier 2 services rapidly expands to support successful innovative models of care, or if the range of funded non-admitted services expands to fill current primary health care service gaps such as mental health, drug and alcohol support and others, the additional expenditure will erode a large part of the 6.5 per cent per annum growth cap allowed for in the healthcare agreements. This puts State Governments in an untenable situation. Their choice appears to be: either invest in innovative models and use the available 6.5 per cent per annum growth margin to fund the additional primary care services patients need to avoid avoidable readmission; or allocate the allowed 6.5 per cent per annum growth margin to increase capacity in emergency departments and admitted beds to alleviate over-crowding, treatment delays and 'bed block'.

Funding arrangements to support innovative models of care needs to be re-examined in the context of the relationship between public hospital funding levels and the extent of primary health service gaps and cost barriers that will need to be addressed to reduce re-admissions for chronic and complex disease patients post discharge.

Capitation funding models

The AMA believes that the IHPA should give no weight to, or draw any conclusions about, the efficacy of the Health Care Homes as a funding approach that is worthy of replication. The trial is struggling - having failed to sign up the targeted number of practices and patient interest remains very low. The patient outcomes achieved, and the cost/benefit of these trials will not be known until the program is evaluated, and it is becoming increasingly obvious that the timeframe for the evaluation is too short, it is inherently biased due the profile of practices that have been selected and it may prove meaningless if the level of patient disinterest in the trial persists as well as the high turnover of participating practices.

Bundled pricing for treatments with predictable care pathways

The AMA would not support a rushed introduction of bundled pricing. The AMA considers the example of bundled pricing for maternity services to be seriously flawed. It risks undermining the standard of maternity services because in pursuit of savings, maternity patients could be shifted to lower cost care settings that put them and their baby at risk. Of course, it is important that services are women centred, recognize cultural differences and are equally accessible by all women. There is compelling recent Australian evidence that women accessing 'low risk' models of care delivered by midwife teams and birth centres in large public hospitals units have significantly higher perinatal

mortality rates (2.3/1000) compared to that of women accessing obstetrician led care (1.2/1000)[4].

An obstetrician has broad medical education in addition to the specialty training spanning 15 years. Midwifery training is narrower in scope and much shorter. The AIHW 2016 report on National Core Maternity Indicators stage 3 and 4 results from 2010-13 shows that critical obstetrician assistance is required in almost half of all births amongst mothers from a 'low risk' group.

This example indicates the dangers of shifting to bundled pricing without considering the perverse incentives this generates to downscale the qualifications of treating teams to achieve lower cost but to the detriment of patient safety. Bundled pricing models must be examined carefully, case by case.

Safety and Quality (chapter 11 consultation paper)

Over-arching comments

AMA supports the concept of improved safety and quality of care in Australian hospitals. We also support prophylaxis strategies within hospitals to prevent avoidable patient complications, but as noted in previous AMA pricing framework submissions, we remain critical of safety and quality financial penalties as an effective way to improve patient outcomes. There is no evidence to show this works[5] [6] [7]. The additional costs associated with treating a hospital acquired condition or avoidable readmission are in of themselves an incentive to the hospital to minimise these events without the need for additional penalties on top.

What the evidence does show is the likelihood of an adverse patient safety event escalates with poor staff communication and delayed treatment due to hospital ''bed block'' on general wards or 'bed block' in ICU, unsafe clinician work hours and inadequate patient staff ratios. All these escalated patient safety risk factors are directly affected by inadequate public hospital funding. Safety and quality funding cuts will only increase the likelihood of *creating* the determinants of poor safety and quality.

Penalties also promote a culture of blame. Patient safety improvements are far more likely in 'no blame' hospital reporting cultures[8] and recommended in 2014 by the European Commission.[9]

Efficacious patient safety programmes are more likely to succeed if patient outcome data is collected close to the patient, close to service delivery and supplied directly to the treating clinician so clinician's performance relative to that of their peers is known. Robust patient outcome data can also help clinicians and hospital staff identify the change to clinical pathways and administrative processes to improve patient safety performance within the hospital.[10] Not all patient complications

[4] Permezel m Milne KJ *Pregnancy outcome at term in low risk population: study at a tertiary obstetric hospital*. Journal of Obstetrics and Gynaecology Res. 2015 41(8): 1171-7
[5] Eagar K, Sansoni J, Loggie C et al (2013) *A literature Review on Integrating Quality and Safety into Hospital Pricing Systems*. Centre for Health Service Development, University of Wollongong
[6] *Patient safety without the blame game*, MBJ 2013; 347:f4615
[7] *Reporting and learning systems for patient safety incidents across Europe*, European Commission Patient Safety and Quality of Care working group 2014
[8] *Patient safety without the blame game*, MBJ 2013; 347:f4615
[9] *Reporting and learning systems for patient safety incidents across Europe*, European Commission Patient Safety and Quality of Care working group 2014
[10] Duckett S Jorm C All complications should count – using our data to make hospitals safer Grattan Institute 2018

can be avoided. Health care is complex and patients with limited reserves are vulnerable to complications even in the highest performing hospitals.

Most States and Territories are investing substantial sums of own source revenue to digitise their health and hospital services – in some jurisdictions the investments total hundreds of millions of dollars (New South Wales, Queensland, Victoria, South Australia – perhaps others). The availability of reliable patient data is far more likely than funding penalties to create genuine patient safety improvements. For example, Queensland Health claims data from five of the hospitals with digital systems show an 88 per cent reduction in pressure injuries and a 37 per cent reduction in hospital acquired infections[11].

If the Commonwealth genuinely seeks to work with States and Territories to make meaningful gains in patient safety and quality, additional Commonwealth contributions via activity-based funding should be considered to address access block, over-crowding, dangerous staff work hours and unsafe clinician to patient ratios. Additional dedicated Federal funding to help States build hospital in-house data analytics capability would also be effective.

Avoidable readmissions

The AMA supports better hospital discharge processes and we support improved safety and quality of care during the admitted episode. In the absence of any evidence to show provider incentives[12] or disincentives (funding cuts) leads to improved safety and quality - the AMA cannot support any of the punitive implementation options to reduce avoidable readmissions proposed in the consultation paper. Evidence from North America in support of a penalty approach is weak.

The threat of readmission penalties can perversely motivate public hospitals to implement prophylactic treatments that could cause more harm to patients than good. For example, prescribing antibiotics for lengthy periods post discharge to prevent infection related readmission penalties could instead lead to anti-biotic resistance and mask a deep infection that preventative antibiotics will not treat.

It is misleading to refer to similar avoidable readmission penalty frameworks adopted in the US, UK, Denmark and Germany, without providing stakeholders with robust evaluation findings to demonstrate these models improve patient safety. Nor does the consultation paper describe the penalty approach in the context of the broader health system in these countries. This renders these examples irrelevant as a pointer to inform the approach to reducing avoidable readmissions in Australia with our unique public private mix and known access barriers to primary health services – especially for patients who are most at risk of readmission - those in low socio-economic groups and those with complex and chronic disease.

The emphasis on preventing re-admission is premature when doctors and work units in hospital rarely have access to the clinical data that would empower and enable them to improve their care on their own. Genuine positive gains in patient safety and quality is far more likely in a system that

[11] Minion L *Digital health: it's in our DNA. Queensland Health Minister on the state's high-tech revolution* HealthcareIT June 2018

[12] Doran T Maurer KA Ryan A Impact of Provider Incentives on Quality and Value of Health Care Annual Reviews Public Health 2017 (38) 449-65

funds doctor and unit performance review based on robust patient outcome data, collected close to service delivery units and provided back to the treating doctor.

The AMA is also deeply concerned IHPA has presumed the adoption of the My Health Record Unique Patient Identifier as a tool to track and identify patients who are readmitted within specified timeframes, will highlight poor quality care during the original admission. As explained above (see response to chapter 5) the potential data linkage this will create threatens the security and privacy of sensitive health data. The significance of this requires a full independent examination of all privacy consequences and a separate stakeholder consultation to allow input from stakeholders, similar to the development of the Secondary use of My Health Record, and in concert with the Information and Privacy Agencies. During the consultation on the secondary use of My Health Record consumers strongly opposed private health insurer access to My Health Record data under the Secondary Use Framework. It is unclear if the IHPA proposal to adopt the My Health Record Unique Patient Identifier in hospital data sets (public and private) would contravene this restriction.

The AMA would welcome further information and discussions regarding this issue.

Concluding remarks

The IHPA agenda to pursue improved safety and quality via funding penalties needs urgent review in light of the complete lack of evidence to support its efficacy. It is surprising the IHPA is prepared to favour intuition over the weight of evidence in the pursuit of safety and quality penalties. The result will be nothing more than a funding cut to already overcrowded and underfunded public hospitals. If IHPA has credible evidence safety and quality funding cuts do lead to improved patient safety and higher quality patient care the AMA would like to see this evidence and have an opportunity to discuss it. Until then these penalties should be abandoned.

What the evidence does show is adverse patient safety events escalate with poor staff communication and delayed treatment due to hospital 'bed block' on general wards or 'bed block' in ICU, unsafe clinician work hours and inadequate patient staff ratios. Most of the escalated patient safety risk factors are directly affected by inadequate public hospital funding. Safety and quality funding cuts will only increase the likelihood of *creating* the determinants of poor safety and quality.

Apart from our strong opposition to public hospital funding cuts to improve safety and quality, the AMA is also concerned the pace and number of substantial reforms affecting public hospitals represents too much too fast.

While the benefits of digitised, data enabled public hospitals and State health systems have the potential to substantially increase the quality, safety and efficiency of public hospital patient treatments - public hospitals will need the time, and additional funding to succeed. It will involve integrating the full functionality of the My Health Record into hospital systems and completely re-engineering of previously trusted, well established hospital clinical workflows with new digital clinical workflows. It requires change management, new administrative procedures and processes; new systems of reporting; new data collection and analysis frameworks; data governance; and close monitoring of patient safety and quality.

Simultaneously, public hospitals need to finalise clinical pathways to implement prophylaxis strategies in preparation for the 1 July 2018 hospital acquired complications penalties and divert funding to trial innovative models of care to establish if avoidable readmissions can be reduced - and if so, at what cost.

If IHPA intends to proceed with financial penalties for avoidable readmissions despite the absence of evidence, the penalty framework should be delayed until the evaluation findings of the innovative care trials are known and the resource demands of digital disruption abate.

Apart from our opposition to safety and quality penalties, the AMA calls on IHPA to abandon plans to co-opt the My Health Unique Patient Identifier into hospital data sets until a full impact review is conducted to establish unintended privacy impacts and a public consultation conducted. Once review findings are known, stakeholders should have a chance to comment through a new consultation process based on full information.

Ultimately if positive improvement in patient safety and quality is to be achieved in the hospital setting, it will only be achieved with strong involvement and leadership of clinicians. Not only are clinicians best equipped to understand the systems in which they operate, they have strong ethical and stewardship responsibilities which can be aligned with the safety and quality improvement objectives. A move from punitive financial and administrative mechanisms to one of engagement with clinical leadership is far more likely to deliver long term sustainable improvement in patient safety and quality.

The AMA is happy to discuss the concerns raised in this submission at a mutually convenient time.

Leonie Hull
Senior Policy Adviser
Medical Practice Section
Australian Medical Association
12 July 2018