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AMA submission to Independent Hospital Pricing Authority on the Pricing Framework for Australian Public Hospital Services 2020-2021

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Introduction

The AMA welcomes the opportunity to comment on the ideas proposed in the Pricing Framework 2020-21.

Promoting Value and better patient outcomes through public hospital pricing

In AMA's view IHPA's approach to public hospital pricing to date has aggressively pursued public hospital technical efficiency at the expense of pricing for quality care. The use of averaged costs with no measure of quality of outcomes drives pricing down but actively penalizes quality with long term benefits but short-term costs. We welcome IHPA's recognition that pricing public hospitals must facilitate quality care. However, it is vital IHPA does not repeat the safety and quality pricing reductions to leverage improved quality of care.

The evidence shows funding cuts do not assist already under-funded public hospitals improve safety and quality. New decisions to use funding cuts, on the premise of pricing to incentivise allocatively efficient treatment choices, will also fail and do nothing more than trigger a downward spiral in public hospital quality of care.

Since 2014 when ABF took effect in most public hospitals, public hospital staff (including clinicians and nurses) have achieved a remarkable increase in technical efficiency. Despite the increase in public hospital case complexity, average length of stay has dropped from 3.3 days in 2013-14 to 3.0 days in 2017-18[1] Commonwealth price indexation is also trending at only 1.6 per cent per annum. The capacity of public hospitals to sustain cost growth containment and simultaneously improve quality of care is implausible with current below health inflation budgets in many states and territories.

[1] AIHW *Admitted Patient Care 2017-18*: Australian hospital statistics, Table 2.8

Public hospitals are service organisations with a variable cost curve dominated by staffing costs. Nursing salaries alone currently increase by 2.5 to 3 per cent per annum in most jurisdictions. The greater the magnitude of difference between the annual 1.6 per cent indexation compared to annual hospital input cost increases, the greater the pressure on public hospitals to make up the funding deficit via supposed efficiencies, which are often cuts to quality. For example, having to squeeze more patients into already overcrowded hospitals increases bed occupancy levels with inevitable consequences for poor patient outcomes, increased mortality and delayed elective surgical care.

There is no doubt a hospital admission with a patient complication is more expensive than a hospital admission with no patient complication. A reduction in the number of patient complications would increase the quality of care and further improve hospital efficiency. The latest AIHW Admitted Patient Care Report shows in 2017-18 around 2.6 percent per 100 public hospital separations involved a hospital acquired condition (HAC) event[2]. This includes 13,707 medication complications. A close look at why medication errors occur shows pricing penalties are a poor choice if the aim is to use price to reduce HAC events. For example, an Australian study[3] commissioned by the Australian Commission on Safety and Quality in Health Care (the Commission) found 2-3 per cent of Australian hospital admissions are medication related, but the reason for the errors are complex and include poor hospital staffing levels, skill mixes, excessive work-load, workflow design, inadequate levels of administrative and managerial support, plus patient factors such as the patient's condition and communication ability.

Another Australian study[4] found the quality of shift to shift patient hand-over affects the quality of patient care. The evidence-based recommendations to improve clinical handover include allocating staff for continuity of patient care, face to face meetings for the purpose of handover, a requirement all staff attend hand over meetings and clinicians provide written hand over sheets. These suggestions appear logical but if public hospitals and their staff are operating under high levels of stress due to funding shortages, it is hard to see how clinicians/nursing staff will find the time to implement the suggested evidence based shift to shift hand over processes. Further budget cuts will only make this situation worse.

A similar example of the incompatibility between funding penalties and improved patient outcomes is the HAC event of delirium. Of the 140,896 HAC events in 2017-18, 24,937 separations involved patient delirium[5]. A reduction in the number of delirium complications would simultaneously boost public hospital technical efficiency and improve patient outcomes. Presumably, the adoption of the Commission's Delirium Clinical Care Standard[6] would help achieve this reduction in adverse delirium events. Best practice management of patients at risk of delirium include:

[2] AIHW *Admitted Patient Care 2017-18*: Australian hospital statistics, Table 8.10
[3] https://anzhealthpolicy.biomedcentral.com/track/pdf/10.1186/1743-8462-6-18?site=anzhealthpolicy.biomedcentral.com
[4] https://www.mja.com.au/system/files/issues/190_11_010609/yee11187_fm.pdf
[5] AIHW *Admitted patient care 2017-18*: Australian Hospital Statistics Table 8.10
[6] Australian Commission of Safety and Quality Delirium Clinical Care Standard 2016

On admission:

- Screening is conducted by a clinician trained and competent in delirium diagnoses and the use of a validated, culturally appropriate, cognitive screening tool prior to admission to identify at risk patients;
- Clinicians or nurses consults with the patient and carers, plus the general practitioner and other primary care providers to identify recent changes in the patient's behaviour, mood and observed cognition.
- Findings are documented in the patient's hospital record.

During the admission:

a. Interventions to prevent delirium:
    - Medication review;
    - Correction of pre-existing dehydration, malnutrition and constipation;
    - Mobility activities;
    - Oxygen therapy;
    - Pain assessment and management;
    - Regular reorientation and reassurance;
    - Activities for stimulating cognition;
    - Non-drug measures to help promote sleep;
    - Assistance for patients who usually wear hearing or visual aids.

b. Interventions if a patient experiences delirium during an admission
    - Clinician investigates cause of delirium via a comprehensive assessment including a medication review;
    - Offer the patient emotional support and other non-drug strategies. Involve carers where possible to reassure the patient and de-escalate the situation;
    - Create a safe environment for the patient, noise is minimised and the patient is closely observed;
    - Avoid the use of physical restraints wherever possible;
    - If family and carers are unavailable to be with the patient, provide one on one nursing or a trained support person with specialty training;
    - Reserve antipsychotic medicines for patients who are distressed despite non-drug strategies.

      (see additional recommendations if non-drug strategies are ineffective).

The delivery of best practice delirium care as described by the Commission adds substantial upfront costs to public hospital budgets. These costs include new patient screening instruments to identify at risk patients on admission, additional data collection and processing, a dedicated nurse/carer to be with the delirium patient in order to avoid chemical or physical restraint and lower the risk of falls. Although these upfront costs may well be returned in the future from reduced mortality, reduced LOS and earlier discharges by avoiding delirium associated complications, the current penalty framework does not resource public hospitals to provide best

practice delirium management and may instead perversely deter public hospitals from proactive HAC management.

As explained by Dr Walker in her presentation at the recent IHPA conference in May 2019, early detection of public hospital patients at risk of a HAC event is an essential first step in minimising HAC events during an admission. Yet, the current penalty framework perversely penalises the hospitals that implement screening tools any time after the first year of the HAC penalty framework, because any increase in the detection of HAC events compared to the previous year generates a funding penalty. In the example of delirium, not only does the long list of additional systems and staff needed to provide best practice delirium increase the cost of care provision, the penalty framework rewards hospitals that don't screen, and therefore don't detect delirium in the first place. This is not the way IHPA should use pricing to support public hospitals to lower complication rates and invest in quality patient care.

The AMA is inclined to agree with the points made by Prof Anthony Scott et al (2018) in his submission on the Pricing Framework 2019-20[7]. Public hospitals can be expected to operate as rational production units. It would only be rationale to assign very scarce hospital funding to implement new systems and altered clinical pathways to improve quality patient care if the costs of doing so are fully compensated ***in the short term.***

The new proposal to 'price for quality' proposed in the 2020-21 Pricing Framework must not be more of the same punitive funding cuts. Instead, the AMA strongly urges IHPA to fully review the evidence and remain open to genuine price for quality that reimburses hospitals to cover the additional resourcing costs to deliver quality care. Genuine pricing for quality care will support public hospitals to reduce complication rates, improve patient outcomes, achieve greater technical efficiency and improve allocative efficiency.

This means setting price over and above current pricing levels, investigating the costs of best practice units with better clinical outcomes, and not the usual cost neutral approach whereby funding is reduced for hospitals with poorer patient outcomes in order to pay top up funding to hospitals with better patient outcomes. A cost neutral approach will not achieve the aim of setting pricing to fund *all* public hospitals to deliver best practice patient care.

Patient Reported Outcome Measures & benchmarking

Clinical quality registries are widely recognised as a powerful tool to improve the quality and effectiveness of patient care within a clinical domain. As noted by IHPA, other government work on measuring outcomes for benchmarking is underway elsewhere. In particular, the Clinical Quality Registry – National Strategy, managed by the Department of Health in partnership with the Commission. This work is the initiative of Health Ministers, and consequently involves State and Territory Ministers and public hospital administrators. Many states and territories have also introduced, or are preparing to introduce, PROM instruments and related data collection. Great care is required to ensure IHPA does not simply overlay a different PROM instrument that duplicates existing State efforts, imposes costs and cuts across the clinician buy-in State

[7] Scott, A and Yong, J *Submission to the Independent Hospital Pricing Authority on the Pricing Framework for Australian Public Hospital Services 2019-20*, Melbourne Institute of Applied Economic and Social Research 2018

governments have worked hard to achieve. Research shows learnings from valid clinical indicators **and** patient reported outcomes measurement tools is most effective when it is clinician led. This means the indicators are developed in consultation with clinicians and their clinical colleges, implemented by clinicians in a clinical setting and clinicians also lead the work to change clinical workflows or other changes based on validated patient outcome feedback.

In isolation, an unfunded IHPA PROM instrument imposed as a condition of Commonwealth funding is unlikely to achieve much, if any, improvement in quality care. IHPA involvement in PROMs would certainly not work if PROMs data is weaponised through financial penalties or the publication of de-identified clinical data. Please see AMA's submission to the Clinical Quality Registry – National Strategy for our views on a positive, evidence based approach to measuring and benchmarking patient outcomes to improve the quality of patient care.

The inclusion of individual healthcare identifiers in public hospital data sets and the public disclosure of this linked data

The AMA understands the benefits of adopting the individual healthcare identifier into hospital data sets. This would overcome the current difficulty of tracking patient interactions with the health system across care settings to identify primary care service gaps and access barriers that contribute to emergency presentations, avoidable admissions and avoidable readmissions.

Despite these benefits, all clinicians, including AMA members, have a role in protecting the privacy of their patient's sensitive health data – a large part of which is generated by clinicians in the process of providing patients with high quality healthcare.

Following the shift to My Health Record opt out arrangements in early 2019, around 90.1% of Australians have a My Health Record[8] that includes the patient's unique individual healthcare identifier. The inclusion of the health care identifier in public hospital data sets creates a conduit between hospital data and the data held in a person's My Health Record.

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[9]. This academic exercise was published to raise awareness of the urgent need to implement a holistic overarching health data governance framework to protect sensitive health data in a digitised Australian health system.

The rapid evolution of machine learning means the protection of health data, especially linked data, requires strict privacy protections for all health data released publicly or for research purposes. Responsibility for linked data management and public disclosure should sit with

[8] Australian Government Australian Digital Health Agency, *My Health Record Statistics as at 26 May 2019 accessed 4 July 2019 (*https://www.myhealthrecord.gov.au/sites/default/files/my_health_record_dashboard_-_26_may_2019.pdf?v=1561352401)

[9] Teague, V et al 2018 The simple process of re-identifying patients in public health records, Melbourne University accessed 4 July 2019 (https://pursuit.unimelb.edu.au/articles/the-simple-process-of-re-identifying-patients-in-public-health-records)

agencies who are accredited to carryout data linkage, have staff qualified in data science, data security, ethics and Australian privacy law.

The AMA is not opposed to the IHPA proposal to make IHPA data sets available for research purposes, but it is very important this occurs within a robust data release policy that takes into account the known risk to patient re-identification associated with the open publication of large de-identified data sets. The AMA encourages IHPA to consult the data release experts within the Australian Institute of Health and Welfare as they also release health datasets for research purposes and are the data custodians with responsibility for managing the release of My Health Record data under the Secondary Use Framework.

The AMA's overall position may seem cautious, but our comments recognise the sensitivity of hospital data sets and the technical difficulty of de-identifying health data in a way that removes virtually all risk the data, in a new data environment, becomes re-identifiable. The AMA notes the Information Commissioner reached a similar conclusion in his submission on the Productivity Commission Draft Report on Data Availability and Use[10]:

> *It is very unlikely high value datasets containing sensitive health information can be sufficiently de-identified to enable general, open publication (in a manner that also preserves the integrity of that data).*

Alternative funding models

The AMA is open to new funding models such as bundled payments on a case by case basis. Funding should not prevent public hospitals flexibility to adopt patient pathways that provide best practice post-acute care in the lowest cost setting. However, post-acute care options must be at the discretion of the treating clinician and take account of the patient's clinical needs and their community-based psycho-social supports and housing situation. Great care is required to ensure price adjustment for patient frailty and complexity within innovative care funding models is sufficiently robust to avoid penalising public hospitals with frail and/or complex patient cohorts for whom earlier discharge community-based care is unsuited. Equally important, price incentives must not perversely incentivise public hospital savings by diverting patient care to under-qualified, lower wage health workers. This potential negative impact on quality care is a very real threat given the over-stretched public hospital budgets. The drift to out of scope clinical practice in the pursuit of health savings is of great concern to AMA members and will do nothing to improve quality if it is not very carefully managed. The AMA would welcome additional information on how IHPA intends to manage this risk.

The AMA is also open to value based healthcare. However, value based healthcare has the best chance of success if it is clinician led and clinician implemented based on insights from clinical quality registry/PROMs outcome data. Indeed, the early success of the NSW Leading Better Value Care program summarised in the Pricing Framework 2020-21, is in large part due to the leadership of NSW Health clinicians. The most productive contribution IHPA could make to value based healthcare is to incorporate the costs of implementing a value based care approach into the

[10] 'Data Availability and Use – OAIC submission to Productivity Commission Draft Report' p4 OAIC, December 2016

Pricing Framework. As noted throughout this submission, if these costs are not covered in the IHPA price, public hospitals cannot afford to deliver quality care, or value based care.

AMA will consider proposed capitation models after the patient outcomes and cost benefits of the Victorian Healthlinks trial is available. If not well designed and sufficiently funded, capitation models have many undesirable patient impacts not least of which is cherry-picking.

Avoidable hospital re-admissions

The AMA is pleased IHPA is adopting a cautious approach towards avoidable hospital readmissions. As funding penalties do not help public hospitals improve safety and quality, AMA opposes funding cuts for avoidable hospital readmissions.

AMA is concerned IHPA is proposing to penalise public hospitals for readmissions when the cause is outside of the hospital's control. As well as the risk factors identified by IHPA, (age, DRG type, major diagnostic category, sex, hospital remoteness and Indigenous status) the patient's socio-economic status (employment, occupation, income) should also be risk adjusted. Socio economic status is strongly correlated to health status and health literacy, and directly affects a patient's capacity to access the post discharge treatment they need to stabilise or recover in the primary care setting.

It is reasonable to expect a public hospital to provide a full patient discharge summary to the patient's GP/clinical community support services within 48 hours of patient discharge or sooner according to the patient's clinical circumstances. Public hospitals should also provide the patient, GP, and/or other community-based clinician with a detailed individual care plan covering the post-discharge period. To continue the delirium example, these two discharge processes conform with the Commission's quality of care standard at the point of discharge[11]. If a public hospital has complied with best practice discharge, it is incomprehensible to financially penalise the hospital if a patient readmission is still required.

Instead of improving quality care the re-admission penalty perversely incentives public hospitals to engage in the following behaviours to avoid the penalty:

- avoid or minimise the number of admissions for the sickest patients at most risk of readmission (including the aged);
- delay re-admitting patients who should be readmitted within the penalty timeframe associated with the previous admission;
- unnecessarily increase the admitted length of patient stay on the first admission to reduce risk of readmission. Doing so would slow down patient throughput and further delay treatment for patients still on the waiting lists as well as increasing mortality rates for acute care patients admitted into overcrowded hospitals. The longer patients wait for hospital admission, the poorer the patient outcomes.

[11] Australian Commission of Safety and Quality Delirium Clinical Care Standard 2016, p20-21

Conclusion

The AMA would welcome a shift re-balance public hospital pricing to focus on technical and allocative efficiency. However, this means pricing to cover the additional hospital resource costs to deliver quality care. The clinical care standards for delirium is a clear example of the additional resource costs associated with quality care.

The AMA continues to argue a penalty approach that reduces public hospital funding for adverse safety and quality events lacks evidence and shows no understanding of reasons why adverse safety events occur and how IPHA could use pricing to help prevent them. Broad participation in clinical quality registries and benchmarking has demonstrated far greater improvements in incremental improvement in quality care. To work, benchmarking needs to be clinician led and clinician implemented. Top down approaches attached to IHPA funding is very unlikely to succeed. The AMA urges you to read the AMA submission on Clinical Quality Registries – Strategic Framework for a greater insight into the pre-cursors to using benchmarking to make genuine quality care improvements.

The AMA also strongly urges you to read the work from the Melbourne University (referenced in this submission) and the CSIRO[12] to fully understand the AMA's concern about the privacy of sensitive health data in IHPA data sets.

16 JULY 2019

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[12] CM O'Keefe, S Otorepec, M Elliot, E Mackey, and K O'Hara (2017) the De-Identification Decision-Making Framework. CSIRO Reports EP173122 and EP175702 Available at https://www.data61.csiro.au/en/Our-Work/Safety-and-Security/Privacy-Preservation/Deidentification-Decision-Making-Framework