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

Our Ref: F-AA-56757/3-131
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Via email: submissions.ihpa@ihpa.gov.au

Dear Mr ~~Downie~~ James

CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR PUBLIC HOSPITAL SERVICES 2020-21 – WA SUBMISSION

Thank you for the opportunity to provide a submission to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2020-21.*

Western Australia's consolidated feedback is attached. Overall, Western Australia (WA) supports the IHPA's plans regarding classification refinement and development work, funding model enhancements and innovations, and pricing for safety and quality.

The proposal to phase out the private patient correction factor remains a concern and needs to be carefully considered.

Please note WA will provide further comments during the statutory 45-day Ministerial consultation period when the Draft Pricing Framework 2020-21 is released.

Should your team require further information, they can contact Bing Rivera on (08) 9222 4225 or Bing.Rivera@health.wa.gov.au.

Yours sincerely

Dr DJ Russell-Weisz
DIRECTOR GENERAL

5 July 2019

Attachment: WA Health Submission to the IHPA Consultation Paper on the Pricing Framework 2020-21

WESTERN AUSTRALIA SUBMISSION TO THE

CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2020-21

Introduction

Western Australian (WA) 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 2020-21*.

Pricing guidelines

Consultation Question – Are the Pricing Guidelines (PG) still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?

WA is generally supportive of the current Pricing Guidelines.

Does the proposed addition to the PG appropriately capture the need for pricing models to support value in hospital and health services?

The addition of "promoting value" as a guideline is timely as new models of care and focus on value based care are being considered by States and Territories. Pricing should always support efficient, high-quality care and optimal outcomes for patients. However, it appears the current wording promotes funding innovation rather than value. A suggested refinement is provided below:

> *Pricing should support innovative and alternative funding solutions that deliver safe, efficient quality care with optimised patient outcomes through timely access to quality health services and move towards ambulatory and preventative care away from hospital settings.*

Classifications used to describe & price public hospital services

WA supports the ongoing classification development and refinement for activity based funding (ABF) 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 classification systems before introducing pricing based on that new or revised classification.

Admitted acute care

Consultation Question – What should IHPA prioritise when developing AR-DRG Version11.0 and ICD-10-AM/ACH/ACS 12th edition?

WA supports the development of the subsequent AR-DRG versions and the importance of clinical currency, but changes year on year are becoming challenging. Whilst there is consideration for price stability year on year, we also need to reflect stability on other changes such as DRG/ICD implementation. There is substantial

cost impact to jurisdictions in terms of ICT requirements (deployment across multiple systems), and staff education and re-training.

Specific issues to be prioritised when developing the AR-DRG Version 11.0 include:

- Review of definitions to capture obesity and coding practice interactions with these data to reduce automatic rework such as those applied for influenza.
- In the current AR-DRG version identifying co-morbidities related to diabetes is challenging. It would be good to have the co-morbidities consolidated in a separate chapter.
- More work should be undertaken within surgical DRGs to ensure that the DRG splits more adequately consider resource homogeneity.
- Social problems currently do not affect DRG complexity/ABF funding. However, issues such as homelessness (Z59.0) can significantly increase the patient's length of stay and require significant resources so that the patient may be discharged safely. In addition, patients who live alone (Z60.2) will almost always have a delayed discharge for the same reason. Consideration needs to be given to assigning diagnosis complexity level values to these social issues. In addition, involvement from the Child Protection Unit (CPU) to either investigate suspicious injury or parental/care giver neglect can also significantly increase the resources required to provide care and increase the length of stay. CPU involvement should be accounted for in the pricing model.

Consultation Question - Are there other priorities that should be included as part of the comprehensive review of the admitted acute care classification development process?

Stability of the admitted acute classification and the impact on perverse incentives are key considerations. Potentially major swings in price weights can have a direct impact on patient care which could result in inadvertent under or over servicing.

Emergency care

Consultation Question – Are there any impediments to implementing pricing using the AECC Version 1.0 for emergency departments from 1 July 2020?

WA supports the collection of relevant diagnosis data from all Emergency services, irrespective of size/location, to enable a consistent implementation of the AECC.

WA recommends initial shadow pricing from 2020-21 to enable analysis of funding implications relating to transition from URG to AECC. Monitoring the performance of the new classification system is crucial to ensure any data variations (activity and costing) are addressed in a timely manner.

Mental health care

Consultation Question – Are there any impediments to implementing pricing for mental health services using AMHCC Version 1.0 from 1 July 2020?

Availability of robust data across States and Territories remains an impediment. Some jurisdictions don't have costed data at mental health phase of care level. Whilst WA is supportive of shadow pricing mental health services using the AMHCC, the data source that will be used for pricing needs to reflect actual clinical practice.

Costed data based on a single-phase (i.e., acute only) would be a misrepresentation of the care provided.

There are concerns that the Phase of Care Refinement Project may lead to changes in future years that will impact the interpretation of the revised phases and pricing. IHPA should consider setting price assurances to ensure services to consumers are not unjustly affected.

Comprehensive and robust data should be key consideration when moving non-admitted services from block funding to activity based. Also, consideration needs to be given to price harmonisation of MH services and ensuring incentives for treating patients in non-admitted services rather than in emergency departments or admitted services. Impacts of shadow pricing and ensuring a funding floor and ceiling will also be important for specialised mental health services, particularly non-admitted mental health services.

Setting the National Efficient Price (NEP) for activity based funded public hospital services

As noted in previous years' Pricing Framework submissions, WA is 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 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 an important issue as it would result in more funding being subject to funding guarantee considerations.

Adjustments to the NEP

Consultation Question – Are there any impediments for legitimate and unavoidable cost variations that IHPA should consider for NEP20?

No specific adjustments currently, however further consideration if ABS ASGS-RA is the most appropriate method to describe/categorise remoteness would be welcomed. WA is looking forward to IHPA's feedback on the investigation into alternative geographic classifications in particular the option proposed by Northern Territory.

WA acknowledges the improvements that have been made in recent years to provider and patient-based adjustments within the national ABF model, in response to WA's submission to the IHPA's Legitimate and Unavoidable Cost Variation Framework in 2017. However, WA still faces significant cost disabilities in regional and remote areas, over and above the level of the NEP. The total additional cost borne by the State, year on year, creates a cumulative financial disadvantage relative to other States.

It would be appreciated if IHPA could provide analysis on wages policy and/or other input costs across Australia as per Clause B13 of the National Health Reform Agreement (NHRA).

Setting the NEP for private patients in public hospitals

Consultation Question – Is there any objection to IHPA phasing out the private patient correction factor for NEP20?

WA does not support the proposal to phase out the private patient correction factor in NEP20, as it believes it will lead to the true cost of providing a patient treatment not being captured or understood; and ensure that States that have lower than average private patient proportions are even more underfunded and disadvantaged than is currently. The differential level of private patient billing across jurisdictions is likely to be a significant reason for unexplained cost differences across jurisdictions at present and if the system does not understand the full cost of providing a service, allocative efficiency cannot be achieved. This could lead to some services being prioritised over others simply because of the non-captured funding source, altering the value for money equation.

WA 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 patient 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, jurisdictions with higher private patient utilisation will be advantaged.

Data Collection

Access to public hospital data

Consultation Question – Do you support IHPA making the NBP publicly available, with appropriate safeguards in place to protect patient privacy?

WA supports expanding access to public hospital data held by IHPA to various stakeholders including but not limited to the health sector, private sector and education institutions, on the proviso that appropriate governance and privacy safeguards are in place. This is in line with the current *Responsible Information Sharing* Reform Initiative which seeks to create a legislative privacy framework for WA. Transparency of services aligns with the intentions described in the *WA Sustainable Health Review Final Report.*

WA notes that increased access to public hospital data may encourage the following:

- public hospitals will benefit from wider disclosure of research IHPA undertakes in support of funding adjustments to the national model;
- support and drive benchmarking but also to enhance consumer choice;
- openness in public administration leads to good governance;
- greater public scrutiny will serve to better inform the public of the difficulties and costs of delivering public services in rural and remote locations; and
- Improved reporting efficiency amongst public hospitals.

A key risk however, will be how this data will be interpreted and used. There is a potential "commercial in confidence" concern, particularly affecting the relationship between providers of private and public hospital services and the procurement for private services.

Unique patient identifier

Consultation Questions – What are the estimated costs of collecting the Individual Healthcare Identifier (IHI) in your state or territory?

Estimation of cost to collect IHI is a work in progress and WA may be able to provide an estimate during the Ministerial consultation period when the Draft Pricing Framework 2020-21 is released.

Noting that take up rates for My Health Record vary markedly across jurisdictions would suggest that there will be quite a large discrepancy in implementation costs as shown in Table 1.

Table 1. Percentage of public hospitals and health services connected to the My Health Record system in Australia. [1]

% of Public hospitals and health services connected to the My Health Record system	
ACT	100%
TAS	85%
SA	14%
NT	87%
VIC	35%
WA	61%
NSW	93%
QLD	100%
Total	75%

Would you support the introduction of an 'incentive payment' or other mechanism to assist in covering these costs for a limited time period?

As advised previously (Draft Pricing Framework 2019-20) WA, in principle, supports the inclusion of the Individual Healthcare Identifier (IHI) in the selected national data sets, noting the reporting of this item will be non-mandatory, and further work is required to resolve privacy/disclosure concerns, Information and Communications Technology requirements, and other implementation issues.

WA welcomes any financial support to collect and implement the IHI. However, the proposed IHPA incentive payment as described in the Consultation Paper needs clarification if this is within the remit of IHPA's functions under the NHRA.

[1] Source: https://www.myhealthrecord.gov.au/about/who-is-using-digital-health/public-hospitals-and-health-services-connected-my-health-record (as at 27th Nov 2018)

It should be noted that My Health Record (MHR) was not compulsory and participation rate varies between jurisdictions as presented in Table 2 below. An incentive payment in the form of a funding adjustment for episode records with or without a valid IHI would unfairly penalise jurisdictions that have a high proportion of patients who have opted out of the MHR program. Additionally, a neutral funding adjustment penalises those that cannot provide the new variable and rewards others that do whilst providing no additional funding.

Table 2. Percentage of people eligible for Medicare participating in My Health Record[2].

90.1% National Participation Rate

State	Participation Rate*
ACT	86.7%
NSW	90.2%
NT	93.6%
QLD	91.2%
SA	89.3%
TAS	90.3%
VIC	89.3%
WA	90.4%

*Participation rate is the number of people who chose not to opt out as a percentage of the number of people eligible for Medicare as at 31 January 2019

Block funding will more likely match the expected cost structure with mostly upfront costs to set up the systems and train staff, and less ongoing costs associated with collection on a per patient basis.

Patient Reported Outcome Measures (PROMS)

Consultation Question – What initiatives are currently underway to collect PROMs and how are they being collated?

The WA Primary Health Alliance used PROMs as part of the performance management of primary care service contracts. This included both disease/condition specific as well as patient satisfaction (clinician-patient interactions or interactions with the business generally). Condition specific PROMs (particularly in mental health where qualitative surveys are the norm for clinical assessment) were particularly useful as they provided a validated way to collect patient reported outcomes.

The *WA Sustainable Health Review Final Report* includes recommendations for a phased 10-year digitisation of the WA health system, including initiatives that support

[2]Source:*https://www.myhealthrecord.gov.au/sites/default/files/my_health_record_dashboard_-_26_may_2019.pdf?v=1561352401* (as at 26 May 2019)

transparent public reporting of PROMs and Patient Report Experience Measures (PREMs). Early planning has commenced to progress these initiatives.

WA is involved in national registries e.g. ANZHFR, ANZICs, AOA and is in dialogue with other jurisdictions around sharing of information to benchmark outcomes. Some Health Service Providers have started collecting PROMs, particularly in cancer, but do not consider the data anywhere near mature enough to consider PROMs in the context of funding.

In terms of mental health within WA, the Your Experience of Services (YES) survey has been developed under the purview of the Mental Health Information Strategy Standing Committee. The YES is designed to gather information from consumers about their experiences of care. It aims to help mental health services and consumers to work together to build better services. At this stage the YES is only a 4-week snapshot survey occurring once a year where an individual is meant to only be asked to respond once. Most jurisdictions are implementing YES.

Consultation Question - Should a national PROMs collection be considered a part of national data sets?

While including PROMs as part of national data sets would have the benefit of broad-spectrum benchmarking and visibility of patient/carer reported outcomes, there are concerns that need to be considered.

- It would probably have to be done initially on a best endeavour basis. Patients or carers cannot be forced to complete a 'satisfaction' survey (unless it is the sole clinical assessment used by the clinician for treatment planning i.e., in mental health settings). Therefore, it is challenging to tell whether a particular service just happens to have the majority of patients who do not want to complete a survey or whether the service was not giving patients the opportunity to complete the survey. There is potential for "gaming" if services feel their patient will not be reporting a positive outcome.
- There would need to be a commitment from all parties (States, Territories, Commonwealth and relevant national agencies) towards consistency in collection and reporting using agreed business rules, including clinical governance over data.
- Data collection needs to be balanced with the potential for survey fatigue in both patients and staff. Any PROMs should be specific and targeted, with clear outcomes measured and reported.
- It is suggested that IHPA trial options and support research to examine the efficacy of PROM models as indicators of quality of patient outcome.
- Data on PROMS need to be comprehensive and robust prior to using them for pricing/funding purposes.
- In terms of mental health, caution should be used to avoid excessive burden on consumers (especially the frequent users) and adverse pricing on an individual record level.
- PROMs require a significant amount of administrative effort and cost to implement and maintain. Most PROMs are still collected via paper form (the cost of iPads and risks associated with theft prohibits most services from implementing a digital solution), which presents further costs when entering data

in the database. Transitional funding may be required to implement any national standardised PROM collection.

- If a limited proportion of patients participate in PROM collection, will the data be able to be used for quality improvement purposes (from a pricing perspective)? What is the minimum threshold required for it to be useful?

Setting the National Efficient Cost

Consultation Question – Are there any impediments to shadow pricing the 'fixed plus variable' model for NEC20s?

None at this stage, however it is recommended that the performance of the new model be closely monitored and evaluated to ensure it addresses the cost disabilities experienced by small rural hospitals. The variable component of the model needs to be carefully considered so that Health Service Providers are not required to cross subsidise to meet the true cost.

Alternate funding models

Consultation Question - Are there any additional alternative funding models IHPA should explore in the context of Australia's existing NHRA and ABF framework?

Consideration should be given to funding models which improve coordination and collaboration between the IHPA and the Primary Health Networks (PHN's) to promote hospital avoidance and provision of care in lower cost settings. PHN's are already funding primary health care organisations to provide these services. It is less noticeable in the metropolitan areas, but in smaller remote communities, primary health organisations are competing with hospital outpatient services. The competitive conditions lead to primary health organisations struggling to remain financially viable and justify their capacity to provide funded services to commissioning bodies. Partnerships with these organisations are becoming increasingly important to ensure cost efficient-high value health care is implemented.

Regardless of the specific alternative models that need to be explored and trialled, it is important that IHPA creates an environment that supports States to do so without facing the risk of being financially disadvantaged. This risk may arise in converting for example ABF to block funding to trial hospital avoidance programs. There is benefit for IHPA to consider developing a funding methodology for COAG Health Council approval that supports States to innovate. This is a critical step in evolving the national ABF model away from throughput and towards value. Funding model/s that reward/incentivise good performance, meet S&Q initiatives, hospital avoidance, reduction in inpatient events etc. would be worth exploring.

IHPA proposes investigating bundled payments for stroke and joint pain, in particular knee and hip replacements. Should any other conditions be considered?

Overall, WA supports further exploration and data analysis of bundled payments. It has been suggested that elective surgery where there is a clear treatment path be considered on a case by case basis where data quality and continuity is broadly available within health services.

It is worth noting that the *WA Sustainable Health Review Final Report* recommendation 13 includes implementation of models of care in the community for groups of people with chronic and complex conditions who are frequent presenters to hospital.

WA has previously managed the Premium Payments Program which provided incentive payments for sites for each patient managed when treatment was provided against a bundle of care, in accordance with agreed Clinical Care Standards.

Pricing and Funding for Safety and Quality

Hospital acquired complications

Consultation Question – Is IHPA's funding approach to HACs improving safety and quality, for example through changing clinician behaviour and providing opportunities for effective benchmarking?

Incorporating safety and quality is critical to the long-term viability of the ABF model. The current approach seems appropriate with gradual introduction of additional reporting and adjustments. If too much change is introduced too quickly, it could potentially have the opposite impact on safety and quality (S & Q) where services could fear reporting HACs.

Recently, there is clearly more focus on the understanding of HACs and the associated reporting, however currently no specific evidence that this has translated into improvements in the overall HAC rates as yet. In a few areas, it was noted that although the quality of coding and documentation has improved, it has little to no impact on clinicians' behaviour.

Other stakeholders suggested there is insufficient data as yet to identify whether some HACs have reduced in frequency and/or shifted towards higher risk/complexity patients. Although funding approach to HACs initiated a degree of urgency to better understand and analyse the data and develop strategy for prevention, benchmarking is not something that is being actively explored at the moment.

Figure 4 (page 30 of the Consultation Paper) reflects largely the HAC curation recommendations provided to the Inter-Jurisdictional Committee (IJC), ACSQHC meeting in June 2019 and have not yet been endorsed by AHMAC. Please note issues below.

- While changes to the neonatal birth trauma HAC were proposed, it was also recommended this HAC not be included in the model for funding and pricing at this stage, and this is not mentioned in the document.
- While WA supported the inclusion of risk-adjusted 4th degree perineal tears in IHPA's funding model at IJC, it should be noted that 4th degree perineal tears cannot be adequately risk-adjusted due to small numbers so will not be priced (notwithstanding the identification of some key factors for risk adjustment).
- The addition of the two psychiatric medication complications may be premature at this point and further discussion is required.

One health service commented that the continued refinement and further implementation of the HAC adjustment as part of the ABF model should not be used as a reason to remove funding from a system by back-casting the impact for national

growth purposes. The implementation of the HAC model appears to be seen as an opportunity to apply a further efficiency dividend to funding. IHPA should consider monitoring whether States and Territories are implementing the S & Q strategies in a manner in which they were intended to work. A question was raised whether a system is able to improve the S & Q of its care through the removal of funding. IHPA should also consider the incentives the HAC model creates around reporting this information accurately and whether a punitive funding model may have unintended consequences on incentives to report this information accurately going forward.

The Charlson Score is one of the major risk adjustments for determining whether the HAC for the episode is considered to be low, moderate or high complexity but this score was developed from an adult population and does not take into account any of the chronic paediatric conditions such as congenital syndromes, cerebral palsy, cystic fibrosis etc. Therefore, the risk adjustment results in unfair bias against paediatric hospitals and alternative scores for assessing paediatric comorbidity should be considered.

Avoidable hospital readmissions

Consultation Questions – What should IHPA consider to configure software for the Australian context that can identify potentially avoidable hospital readmissions?

The IHPA has proposed using a 3M application which was used in the US. The relevance of the models of care in the US to Australia need to be examined as this would determine whether the 3M software is valid for the Australian context.