Consultation paper on the pricing framework for Australian public hospital services 2021-22

Victorian Department of Health and Human Services response

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VICTORIA State Government | Health and Human Services

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1. Introduction

Victoria welcomes the opportunity to comment on the Independent Hospital Pricing Authority's (IHPA) *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021-22* (the framework) and is supportive of the continual improvements to the framework. The framework forms part of the IHPA's annual process for establishing a national activity-based system for the pricing of public hospital services in Australia, in support of the efficiency and transparency goals of the National Health Reform Agreement (NHRA).

The framework is an opportunity to further refine and improve the pricing models introduced in 2012-13 and revised in subsequent years. Victoria is generally supportive of the direction of the national pricing framework development and has used its response to provide input into how to further mature aspects of the national pricing model.

2. Addendum to the National Health Reform Agreement 2020-25

Victoria looks forward to working with the IHPA to ensure that the expectations of Governments as detailed in the Addendum to the NHRA are achieved.

3. Impact of COVID-19

Consultation questions

- What changes have occurred to service delivery, activity levels and models of care as a result of COVID-19?
- How will these changes affect the costs of these services in the short and long term?
- What aspects of the national pricing model will IHPA need to consider adapting to reflect changes in service delivery and models of care?

To date in 2020, Victorian health services continue to be more significantly impacted by the direct and indirect effects of COVID-19 than health services in most other states and territories.

From the perspective of impact on system operation and costs, COVID-19 has had a major impact on the delivery of services that are in-scope for the NHRA. This includes:

- Significant changes in activity levels, including:
    - Reductions in elective surgery to enable health services to prepare for and treat patients infected with COVID-19.

    - Lower number of emergency department presentations and patients admitted from emergency.
    - Reduced admitted and non-admitted sub-acute services as a consequence of reduced emergency and elective surgery.
    - Increase in other activity, such as COVID testing and provision of support for private aged care facilities, disability providers, and other supported residential services impacted by COVID-19 outbreaks.

- Changes in models of care. These include:
    - Significant increase in the provision of health services in non-admitted settings.
    - Increased use of shared care arrangements.
    - Remote patient monitoring; development of services for patients with post-acute COVID disease, sequelae of COVID-19 infection and the emergence of chronic COVID-19.
    - Greatly expanded use of telehealth.

In Victoria, COVID-19 related costs have been incurred by health services in the later part of 2019-20 and early 2020-21. These costs have been incurred to support health services in preparing for and managing COVID-19 - including supporting physical distancing and infection control requirements. Examples of these include:

- Increased use of Personal Protective Equipment (PPE).
- Additional training in use of PPE and measures to promote safe PPE use, such as PPE spotters.
- Increased use of temporary staffing to support the delivery of admitted and non-admitted COVID-19 services, resulting from staff furlough, leave, and deployment to other critical services such as aged care.
- Additional security and support staffing to monitor and manage COVID-19 safety measures and public health directions.
- Additional staffing related to increases in Infection Control teams.
- Increased frequency of cleaning, increased cleaning time, and greater use of single use products.
- Provision of support to ensure ongoing care of residents located in residential aged care facilities where outbreaks have occurred.
- Additional staffing costs to support testing of hospital staff, and staffing for public health COVID-19 testing facilities.

The operating environment of Victorian hospitals going forward will be significantly different as hospitals transition out of the current situation and into what will be a COVID normal. Increased infection controls, application of social distancing requirements and changes in the model and location of service delivery will all impact on the cost profile of in-scope services priced under the National Efficient Price (NEP) determination.

The challenge for the IHPA is in determining what is the appropriate price weight and NEP in the COVID-19 normal environment, especially where, for Victoria, the costs associated with the longer-term changes in the hospital operating environment are only now becoming apparent. Without confirmation of a vaccine and its efficacy, it could be envisaged that all health systems will need to maintain higher levels of PPE use than previously experienced, more stringent infection prevention and control measures, and maintain public health measures such as social distancing for many more months.

Victoria is concerned that NEP 21, which will have limited access to 2019-20 COVID costs reported in 2020, will be unable to take into account the extent of additional costs incurred or changes to operating models and patient activity levels. It is highly likely that NEP 21 will significantly under-price activity, when compared to the actual expenditure being incurred by hospitals, without some adjustment being

made by the IHPA on how NEP 21 will be calculated (noting that the reverse, i.e. over price activity may occur in future NEP determinations as COVID patient level costs are reported) to mitigate the financial risk to all jurisdictions.

Victoria recommends:

- That the IHPA work with jurisdictions to determine the cost impact of COVID-19 though use of cost and financial reporting systems to address the impact of COVID-19 on IHPA determinations and classification systems.
- That the IHPA works with jurisdictions to examine the costs and funding of service delivery modes such as home-delivered non-admitted services and telehealth (video) in non-admitted and emergency settings to ensure appropriate price weights for these services.
- That the IHPA considers the addition of a COVID flag to the non-admitted national data collection to allow patients in non-admitted settings who have or have had COVID-19 to be identified.
- That the IHPA review existing reporting requirements, funding models and classifications to support changes to service delivery models e.g. use of telehealth in emergency departments, the treatment of post-acute COVID disease, sequelae of COVID-19 infection and chronic COVID-19.

4. The Pricing Guidelines

Consultation question

- Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?

The Pricing Guidelines provide guidance on IHPA's role in pricing Australian public hospital services. Over the years of operation of consecutive NEP Determinations there may be opportunity for these overarching guidelines to be consolidated. For example, it is unclear whether timely-quality care is achieved through operation of the national funding model, or whether this is through policy settings set by system managers. With the development of innovative models of care, it is also unclear whether Activity Based Funding (ABF) should be pre-eminent.

The introduction of a clause in the NEP Determination as a need for further back casting advice undermines certainty of funding. There is a continued risk that the Commonwealth may adjust funding contributions for services already paid for and delivered by hospitals as a consequence of the adjusted Determination. This new facet of the Determination is contrary to the guidelines associated with efficiency, fairness, transparency and stability. Any future retrospective statistical adjustments must be agreed by parties to the Agreement, and not through this mechanism in the determination.

Consultation question

- Does the change to the public-private neutrality pricing guideline accurately reflect the intent of the Addendum?

Victoria believes that the guideline does not accurately reflect the intent of the Addendum.

Clause A13 of the Addendum says the Commonwealth and States' funding models will be financially neutral with respect to patients, regardless of whether patients elect to be private or public.

Clause A44 says the IHPA will further adjust price to the extent required to achieve overall payment parity between public and private patients in the relevant jurisdiction.

The clauses are crafted to account for differences in incentives between local and national funding models with a focus on the patient decision to elect.

Victoria believes the intent of the Addendum is that the IHPA approach should guide State's to align with the National funding model private patient funding incentives. Specifically, if a jurisdiction adopts the national approach to funding or its funding model is financially neutral with respect to patients, regardless of whether patients elect to be private or public, there should be no adjustment.

The IHPA outlines an approach to reduce the Commonwealth's growth contribution, by adjusting the NWAU paid for private patients for insurer benefits and State private adjustments. This appears to mean there will always be a minimum downward adjustment to the Commonwealth's contribution equivalent to 45 per cent of growth in insurer benefit. The downward adjustment is higher if the State is unable to advise the State private adjustment or it reports a value less than 55 per cent of growth in insurer benefits. The IHPA's approach does not appear to allow for no adjustment. This is a problem particularly if a State achieves financial neutrality.

There is no guidance on the method for a State to estimate its private patient adjustment. This will lead to disparities in method between States and most likely distort the Commonwealth growth calculation. The method could be based on a modelled approach using the local funding model private patient payments, actual payments in budget payment systems or a hybrid. An approach to use actual payments assumes the State can identify actual payments made for private patients in billing systems, but it may not be able to do so. The IHPA is applying a pricing adjustment to meet the objective of the Agreement, without necessarily understanding the basis for why funding differences occur. For example, States maybe supplementing health services, via private patient payments, where private insurers have rejected a claim.

If it is the case that the Commonwealth growth contribution will always be discounted, clarification is sought on the potential for double discounting as the National funding model already adjusts for private patients.

Victoria is concerned about consequences that were unforeseen by signatories to the NHRA when the implementation date of 1 July 2021 was agreed. The IHPA have diligently worked to this deadline and have developed an approach. However, there has been no time to consider unintended consequences or how to mitigate those risks. Victoria believes there is a high risk of significant distortionary impacts on the national funding growth equation impacting health service and private patient behaviours contrary to the intention of Clauses A13 and A44.

Some unintended consequences may arise from:

- Historical differences in States' practices and policies.
    - This may inadvertently lead to flows of national weighted activity unit across borders with no benefit to achieve private patient financial neutrality.
    - These differences relate to private patient insurance rates, admission policy and legacy local funding incentives to support private patient activity.
- Funding neutrality targeted at the service provider level.
    - This may result in incentives to treat certain types of private patient activity at the expense of growth in public activity.

    - Health services and jurisdictions will respond to incentives in the funding model in different ways and over different time periods.
- The application of any pricing adjustment in the current year may over penalise particular LHNs, especially if there is a decline in private patient activity in the intervening years.
    - The role of private insurers to support high cost medical procedures delivered by few providers in select States, such as Car- T and other genetic therapies, raises complex issues about how private patient neutrality should apply.
    - It is likely that the net impact to jurisdictions is private patient rates in public hospitals diminish overall. Therefore, a jurisdiction level adjustment might be more appropriate.

Victoria notes IHPA is expected to make an adjustment by 1 July 2021. In light of the issues raised, it may be appropriate for IHPA to advise jurisdictions on the likelihood of unintended consequences should the adjustment proceed.

Victoria recommends:

- That the IHPA consider the application of no adjustment if a State or Territory demonstrates that its funding model is financially neutral with respect to patients, regardless of whether patients elect to be private or public.
- That the IHPA undertake detailed modelling to provide clarity on its approach.
- That the IHPA consider writing to the signatories of the NHRA providing advice on the risk of unintended consequences.

5. Scope of public hospital services

COVID-19 required jurisdictions to quickly introduce new or expanded approaches to ensure the delivery of services to patients, such as increased use of telehealth, hospital in the home and other home and community-based services.

While some of these services are considered in scope for funding under the NHRA, they are often funded the same as an in-hospital episode. For example, there is no differentiation between hospital in the home and in hospital admitted patient funding, even though the cost structure is totally different.

In some cases, in-scope activity that is provided in a non-hospital setting is considered out of scope for funding under the NHRA.

Victoria believes that the scope of public hospitals (and pricing framework and NEP determination) should be reviewed to ensure that it reflects the changes in the provision of services introduced during COVID-19 and supports the funding of services in all settings.

6. Classifications used to describe and price public hospitals

Consultation question

- What should be included in online education for new editions of ICD-10-AM/ACHI/ACS?

Victoria believes that online education for ICD-10-AM/ACHI/ACS should ideally supplement the documents already produced as education material for an edition change. Examples illustrating the application of changes to classifications should be based on real life documentation (hard copy and electronic medical records that have been seen by clinical coders), as this is where inconsistency in interpreting the educational material arises.

Often, it's not until clinical coders start to apply the education that the deficiencies in/questions around the education are understood. It may be useful if education is developed with the ICD Technical Group (ITG) and distributed to jurisdictional coding committees to provide feedback/questions/comments that inform the final version of the education. These questions/feedback could also form part of the education so that the wider audience can see the issues/questions that were considered, shaped the education, and how the education has addressed these issues/questions.

Victoria recommends:

- That the IHPA seek input from ITG members to develop online education, and that the online exercise book contains real life scenarios sought from ITG members with advice from jurisdictional coding committees.

Consultation question

- How should AR-DRG education be delivered and what should it include?

AR-DRG education should follow the same approach as ICD 10 AM/ACHI/ACS education. Context and rationale should be provided for changes, and the education should also include examples to illustrate the impact of changes e.g. clinical code changes or standard changes that impact on grouping.

While some changes are simpler and may not require further explanation to that contained in the final report (which can be viewed as an education document) there are other more complex changes that do require further explanation and education to fully understand the impact of the change. For example, the changes in partitions over two versions.

Education for a new version should combine what is in the final report and technical report, and the language could be simpler (to explain statistical methods) so that it can be understood by a wider audience.

Also, now with two significant changes over three versions, it would be useful to have dedicated education material on 'how the grouper works' (this could be a detailed extension of the AR-DRG fact sheet).

Consultation question

- What improvements to the content and format of the electronic code lists could be made to enhance their utility?

The addition of the following information against each code would greatly improve the utility of the ECLs for data analysis:

ICD:

- Chapter e.g. Chapter 1 Certain infectious and parasitic diseases (A00-B99)
- first level – Block e.g. A00-A09 Intestinal infectious diseases

ACHI:

- Chapter e.g. Chapter 1 Procedures on nervous system (Blocks 1 – 86)

  First level – anatomical site

  Second level – intervention type

Consultation question

- Is there support to replace the hard copies of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS with electronic versions?

While there are benefits to having manuals electronically, they should not completely replace hard copies of manuals. Changes to mediums for storing information creates a risk that over time previous versions of manuals will no longer be available. This is already the case with electronic versions of previous editions of ICD-10-AM/ACHI/ACS (NCCH eBook for example). Work that requires an understanding of how a condition/disease was coded years ago therefore relies upon the availability of hard copy books. There are also times and circumstances when a laptop/PC or internet are not accessible.

Also, from an education perspective, hard copy books are useful tools for teaching/learning how a code is assigned or DRG is derived.

Victoria believes that hard copy manuals should be stand alone. In the case of the AR-DRG definitions manual, changes to a version should be published within that version's manual so that the manual is complete and is not reliant on a web page being available.

The DCL/ECCS calculator was also a useful tool previously provided by ACCD which is no longer available.

Regarding electronic versions of ICD10AM/ACHI/ACS, there are already e-books on the market for purchase; how would IHPA's electronic version differ from these?

Victoria recommends:

- That the IHPA retain hard copy versions of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS.
- That the DCL/ECCS calculator be provided online along with appendices already available on the IHPA website.

Consultation question

- Are there other suggestions for approaches or measures to assess impact and readiness of ICD-11 for use in the classifications used in admitted care, or more widely?

Consideration should be given to changes required to the Admitted Patient Collection to support the new features of ICD-11. Consideration should be given to any additional Australian Coding Standards that will be required to support the new features of ICD-11 such as clustering and post coordination.

Consultation question

- Are there any other factors that should be considered for the addition of pain management and exercise physiology classes in the clinic nurse specialist/allied health led services of classes in the Tier 2 Non-Admitted Services Classification?
- How would activity that falls under these proposed new classes previously have been classified?

Victoria supports consideration of these new Tier 2 classes and will continue to contribute to their development via IHPA's committees and working groups.

Some of this activity may currently be classified under other Allied Health Tier 2 classes.

Consultation question

- What has been the impact on emergency department data since IHPA commenced shadow pricing using the AECC Version 1.0?

Victoria has not observed an impact on emergency department data since shadow pricing was introduced. This is in part due to the use of local funding models in Victoria, primarily through a volume and expenditure based fixed pool grant for non-admitted emergency activity and the WIES model for admitted emergency activity.

Once Victoria implements the national approach to funding, changes to emergency data reporting may occur over a few years due to health services responding to different incentives in the national funding model.

Consultation question

- Are there any barriers to implementing pricing using the AECC Version 1.0 for emergency departments for NEP21?

Victoria welcomes the use of the AECC as a more clinically relevant classification than the URG classification. The improvement to the classification also leads to some simplification of the national weighted activity unit calculations.

Victoria's 12 Group C emergency departments (service levels 3B to 6) currently report aggregate level activity according to the UDG classification. Victoria considers there is limited scope to adopt the AECC for these hospitals due to the additional administrative burden of reporting at the patient level.

Victoria recommends:

- That the AECC only be implemented for pricing of emergency activity at larger health services (Service Levels 1 to 3A) for NEP 21 and the IHPA establish materiality criteria to allow small agencies to report aggregate totals rather than patient level.

Consultation question

- Are there any impediments to pricing admitted mental health care using AMHCC Version 1.0 for NEP21?

Victoria believes it is premature to move to live funding for admitted mental health using AMHCC Version 1 for NEP 21. The requirement for a full two-year shadow period contained in the Addendum to the NHRA should be adhered to for admitted mental health services. Reasons include:

- If shadowing only occurs in 2020-21, there will be less than six months of activity data available to consider before jurisdictions are expected to finalise responses to the draft NEP.
- The impact of COVID-19 means that Victoria has reduced capacity to assess the available data, consult with the sector, and prepare if pricing was to be implemented for 2021-22.
- While most states and territories have provided linked cost and activity data for admitted mental health to the IHPA, Victoria believes that there are significant gaps and issues with the data that is currently available for pricing purposes. A second year of shadowing should allow for additional time for gaps in the available data to be addressed which should improve the precision of pricing. Victoria has provided detailed feedback directly to the IHPA about issues with the admitted data.
- The Inter-Rater Reliability issues with 3 of the 5 Phase of Care are still present. Current IHPA work to address this should continue and be used to inform any refinements to Phase of Care before live pricing occurs.

Victoria recommends:

- That the IHPA continue to shadow price admitted mental health using the AMHCC in NEP 21.

Consultation question

- How can IHPA further support development of pricing for community mental health services using AMHCC Version 1.0 to transition to shadow pricing?

In section 4.3 of the Consultation Paper, the IHPA state that it "intends to commence shadow pricing community Mental Health using AMHCC Version 1 for NEP21."

While Victoria can identify some improvement in the linked cost and community activity data available to the IHPA to consider for NEP21, the available data is not at a level that would support the introduction of shadow pricing in 2021-22.

Victoria has identified a number of issues that need to be addressed to support shadow pricing of these services:

- The variable quality of the current cost and activity data available to the IHPA for pricing is likely to be less developed than the admitted data.
- The high portion of available phase data in Unknown Phase or Unknown HoNoS classes.
- The unresolved Inter-Rater Reliability issues with three of the five Phases of Care have greater implications for the community arm of the AMHCC than the admitted arm. These three phases represent a significantly higher proportion of the available community data than they do for the admitted data.

Victoria recommends:

- That IHPA continue to work with states and territories in 2020-21 to try and improve Inter-Rater Reliability of Phase of Care.
- That IHPA liaise with Victoria on potential learnings from Victoria's work on a modified version of the AMHCC as the basis for an adult community mental health funding model, and whether similar modifications to the AMHCC could be considered before shadowing occurs.
- That IHPA defer shadow pricing for community mental health until NEP22.

7. Setting the National Efficient Price

Consultation question

- Do you support the adjustment IHPA has proposed for NEP21?

Victoria is supportive of adjustments to the NEP having regard to legitimate and unavoidable variations in costs based on an evidence-based approach.

The IHPA model continues to grow in complexity with a growing array of adjustments. For every additional proposed adjustment, it is recommended that IHPA concurrently examine opportunities to consolidate other adjustments where together those adjustments explain the same variation in costs.

Victoria supports the IHPA investigating the level of evidence to support an adjustment for patient transport in rural areas. It would be expected that creation of a rural transport adjustment would result in a subsequent downward adjustment to existing loadings to ensure that there is no double funding of medical transfers and transport costs in rural areas.

Consultation question

- What evidence can be provided to support any additional adjustments that IHPA should consider for NEP21?

Victoria believes that the current criteria for funding specified Intensive Care Unit (ICU) eligibility should be reviewed. Recent experience with COVID-19 highlights the need for greater flexibility for States and Territories to make rapid changes to the configuration of health services to address patient needs – including ICU capacity and availability in rural areas.

Victoria also continues to believe that mechanical ventilation hours should be used as the most precise proxy for ICU patient complexity rather than patient hours spent in the ICU. This is because mechanical ventilation hours:

- provide the most precise proxy measure of ICU patient complexity that is currently available in hospital administration datasets, and hence offers the best available measure to achieve allocative efficiency and equity in ICU funding;
- provides greater funding equity to more complex, resource-intense activity occurring in Level 2 and smaller ICUs;

- reduce the potential for gaming as mechanical ventilation is an invasive procedure and is unlikely to be performed unless necessary; and
- maintains appropriate funding levels despite recent changes in ICU patient mix and practice (e.g. greater use of non-invasive ventilation or no ventilation).

Victoria believes that the current approach of using ICU hours is problematic for several reasons:

- ICU hours are relatively inefficient in allocating funding because ICU hours encompass a wide range of patient complexity and provides a less precise measure of patient complexity; and
- ICU hours creates an incentive to admit to an ICU and delay discharge and a disincentive to control costs.

In the longer term, Victoria is supportive of the IHPA developing an alternative proxy measure of ICU complexity for funding ICUs that is more precise, robust and supportive of the Authority's pricing guidelines than either of mechanical ventilation or ICU hours (e.g. a composite metric of invasive and non-invasive ventilation that spans a broader range of contemporary clinical practice).

Victoria recommends:

- That the IHPA consider replacing hours that a patient spends in an ICU with hours of mechanical ventilation to calculate the ICU adjustment; and
- That the IHPA investigate the development of an alternative proxy measure of ICU complexity for use in ICU funding that is superior to either mechanical ventilation or ICU hours.
- That the IHPA review the ICU criteria and consider giving states and territories the ability to determine which hospitals operate an ICU.

Consultation question

- Are there any obstacles to implementing the proposed harmonisation of prices for dialysis and chemotherapy for NEP21?

Victoria believes that the introduction of price harmonisation for dialysis and chemotherapy is a significant change that should be carefully considered and planned before any steps towards harmonisation are introduced, including extensive consultation with the sector.

Given the current differences in practice across states and territories there is significant risk of unintended consequences if changes are introduced without detailed consultation and planning. Current and future services models in each state and territory need to be closely considered as part of any work to consider price harmonisation.

Victoria recommends:

- That price harmonisation for dialysis and chemotherapy does not proceed for NEP21.
- That further work occurs to understand the implications of price harmonisation for dialysis and chemotherapy and variation in costs.

Consultation question

- Is there any objection to IHPA phasing out the private patient correction factor for NEP21?

Victoria supports the phasing out of the private patient correction factor where feasible that accords with a timeframe for states and territories to comply with the Australian Hospital Patient Costing Standards Version 4.0.

8. Data Collection

Victoria still has significant concerns with phasing out aggregate non-admitted activity reporting. The majority of our Small Rural Health Services do not have the resources to submit patient level activity data. Further to this, these services do not contribute to the development of the NEP or cost weights.

IHPA's role in determining data requirements is governed by the NHRA. Clause B67e in the NHRA stipulates that in determining data requirements, each body must balance the national benefits of access to the requested data against the impact of jurisdictions providing that data.

Victoria recommends:

- That the IHPA review the decision to phase out patient level activity data reporting for all health services.

9. Setting the National Efficient Cost

Consultation question

- Are there refinements to the 'fixed-plus-variable' model that IHPA should consider?

Previous comments provided by Victoria regarding the "fixed plus variable" model are still relevant – for example, the significant level of volatility at some hospitals from year to year.

As the fixed plus variable model was finalised in 2020-21, Victoria considers that the model should be reviewed in 2 years before considering further changes.

Victoria recommends:

- That no adjustments are made to the model for at least two years.

10. Alternate Funding Models

Consultation question

- What comments do stakeholders have regarding the innovative funding models being considered by IHPA?

Victoria supports trialling of bundled payments and the key design elements specified by the IHPA (namely, patient homogeneity, and reporting against services delivered and outcomes achieved). It should be noted that bundles designed to improve adherence to best practice pathways may create efficiencies but may also lead to an increase in cost. It is unclear why these pathways should be designed from a starting point of AR-DRGs. Victoria is interested in working with the IHPA to trial models (particularly for stroke and orthopaedics, where key enables including capture of outcomes via registries is available) subject to project costs, registry access and sector capacity to participate in 2021.

Consultation question

- What innovative funding models are states and territories intending to trial through bilateral agreements under the Addendum?

Victoria continues to work with IHPA through the Jurisdictional Advisory Committee, to identify and develop sustainable funding models that can support more innovative models of care.

The Department of Health and Human Services is also working with IHPA to ensure the reinstatement of HealthLinks on the General List for 2021-22.

Consultation question

- Are there other factors that IHPA should consider in its analysis to determine which patient cohorts or ADRGs are amenable to certain funding models?

The experience of implementing HealthLinks has shown that there is considerable diversity in the needs of patients with chronic and complex conditions.

Consultation with managers and staff engaged in delivering Victoria's innovative funding model, HealthLinks, identified that the importance of being able to use funds flexibly to better address the behavioural and social determinants of health of those living with chronic conditions.

Flexibility enables a more holistic approach to patients' needs and provides health services with the opportunity to engage with patients who might otherwise not be receptive to receiving support and to integrate service delivery, which is particularly important for patients who are engaged across multiple services.

Consultation question

- Apart from the IHI, what other critical success factors are required to support the implementation of innovative funding models?

The IHI, while important in the evaluation process, is not in itself a critical factor in support of innovative funding models. Victoria acknowledges that the IHI is important to allow patients to be tracked across the system. Victoria is currently working on implementing a Unique Patient Identifier, but it will be some time before this can be incorporated into ABF reporting.

It is critical that the Commonwealth and jurisdiction jointly share the risk and costs of the innovation pathway. Innovative funding models go hand in hand with innovative models of care. A change in the

way health services are delivered, reported and funded is complex and requires the jurisdiction to fund administration, education and the changes in process. Collaborative efforts between patients, doctors and administrators are required during the initiation stage. Funding efficiencies are unlikely to be measured for some time. It is widely acknowledged that innovation involves risk of failure, and even if there is success, the pathway to change is complex and can be marked with setbacks.

The Commonwealth currently does not share the risks or costs of the innovation pathway. States and Territories are expected to bear those costs. Currently, the IHPA can only recognise an innovative model on the general list once it is satisfied the initiative is operationalised, has good prospects of ongoing success and can be mapped into ABF to avoid double funding. At this stage, the innovation pathway is largely complete and those costs have been borne by States and Territories.

The main obstacle to health service innovation is a shared commitment to ongoing funding. The Commonwealth might be expected to share the risk and cost with States and Territories during the project start-up phase. Health service business cases made through State and Territory channels could be assessed by IHPA through a process of shortlisting. Selection criteria could apply to identify proposals with the greatest potential for national uptake, a focus on improvements to quality and safety outcomes and a potential for savings to the health system. The IHPA would approve the proposal to enter the General List for a limited time. The ABF reporting obligation might be relaxed during the start-up phase to focus on stabilising the project's operation. The Commonwealth could in the initial years of operation allow only a certain number of projects or limit its total funding contribution.

Consultation with managers and staff engaged in delivering Victoria's innovative funding model, HealthLinks, identified that health service executive support and leadership from the funding body is essential when implementing innovative funding models. Examples of executive support includes willingness to manage financial risk and to provide the project personnel with decision-making latitude and a general commitment to support their efforts.

Careful planning and a systematic approach, along with ongoing evaluation throughout program rollout, is also critical in implementing innovative models at it enables refinement and therefore potentially greater success.

Building collaborative partnerships across and within sectors is important, particularly for improved engagement with general practitioners and the wider Primary Health Networks. Building collaborative partnerships is an outcome of the innovation pathway, even if the program does not progress to full scale roll-out.

Information technology systems that underpin patient identification, risk stratification and support patient management are also essential. Evaluation, collaborative partnerships, information technology systems are some examples of costs and outcomes that could be addressed in a business case assessed by the IHPA to allow a project to be approved on the General List.

11. Pricing for Quality and Safety

Consultation question

- Do you support IHPA's proposed pricing model for avoidable hospital readmissions, under funding option one at a jurisdiction scope level?

Victoria prefers funding option three at a jurisdiction scope level, noting that the model is still subject to refinement and will provide additional comments as the model develops.

Consultation question

- Are there any refinements to the risk adjustment model and risk factors that IHPA should consider?

Victoria supports a risk adjustment model that includes factors that account for complex patients. Some vulnerable patient groups do not appear to be included in the current risk adjustment model. Victoria would like the following factors to be considered before the risk adjustment model is finalised:

- Socioeconomic factors
- Non-English-speaking background

The impact of socioeconomic factors may have already been considered by the IHPA. However, Victoria strongly suggests that the impact of these factors be re-examined before the model is finalised.

Victoria supports implementation of the best possible risk-adjustment methodology and recommends that the methodology be subject to regular review by jurisdictions and key stakeholders. Further to this, it is important that an independent review of the pricing model for avoidable readmissions occurs at an agreed point to evaluate the outcomes and ensure that there are not unintended consequences.

Consultation question

- What additional aspects does IHPA need to consider when implementing a funding adjustment for avoidable hospital readmissions?

The IHPA may wish to consider a framework or reporting tool through which health services can leverage instances of best practice to reduce hospital readmission rates. Funding incentives alone do not provide feedback to health services that might be performing poorly against peers to improve. This framework might collate case studies with best practice or initiatives tried that succeeded (or failed) that can benefit potential to be rolled out more broadly nationally.

The IHPA may wish also to consider a similar framework for Hospital Acquired Complications (HAC). Currently instances of best practice leading to real reductions in HAC due to a targeted initiative at a hospital cannot be identified in the national reporting summaries. It is timely to evaluate whether the reforms to the national funding model to HAC is leading to a real reduction in HAC, or variances relate to changes or improvements to reporting. The real benefit from this reform will be if other health services can leverage off instances of best practice as identified initially in national reporting for certain HACs and hospitals.

Victoria requests that the following items are considered when implementing a funding adjustment for avoidable hospital readmissions:

- The role of public reporting to incentivise behaviour change to promote improvements in the quality of care.
- Funds from any penalties imposed should be directed into funding improvement activities at a hospital and community level to improve care transitions and coordination.
- Clinical and health system-based interventions for unplanned readmission reduction are also implemented to support improvements in quality of care.