RESPONSE ON CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPTIAL SERVICES 2016-17

3. Scope of public hospital services

- *What additional evidence exists to support the inclusion or exclusion of specific services from the General List in 2016-17?*
    - Data repositories through Patient Management Systems and Activity data both Inpatient and Non Inpatient would provide required evidence.

- *Should posthumous organ procurement activities be in-scope for pricing under the National Health Reform Agreement?*
    - Yes but the direct communication of each hospital with the organ authority should remain.

- *Is posthumous organ procurement adequately accounted for in activity and cost data collections and, if not, how could it be improved?*
    - Not currently, although there has been work undertaken in some jurisdictions to enhance the collection and reporting of organ procurement
    - Still a need to improve data capture through internal training with ICU and ED staff, particularly clerical, around the data capture for these items

6. The National Efficient Price for Activity Based Funded Public Hospital Services

- *Should IHPA consider any further technical improvements to the NEP pricing model for 2016-17?*
    - The NEP at present is not totally transparent. There is a Commonwealth price, State and Local health District price and a price then allocated to hospitals within a district. The price allocated to some hospitals appears based on what funding the Local health District has to allocate based on additional growth funding not the NEP. How the price is arrived at is unclear and not transparent. At present we continue to have a hybrid system of funding. Historical and ABF funding. One principle of ABF funding was to provide incentives to those services that were efficient. Services have not been allocated any incentives from LHD's for delivering activity above target and below the LHD's ABF price. One of the pricing guidelines in determining the NEP was Fairness. This has yet to be achieved.
    - We do not want to change the underlying principles of the model as stands now
    - ICU adjustment for those ICUs who are not level 3 – or an alternate funding model. If the ICU adjustment is applied at patient level why does it matter what level the ICU is.
    - Labour market adjustment – there is a need for an adjustment in the pricing model for different prices of labour within each jurisdiction, this would account for differing EBA across jurisdictions – this is currently done in USA models
    - Neither the ED classification system or the price weighting system within the current pricing model allows for adjustment on the basis of age as a determining factor in cost of care – as it does in inpatients settings

- *What are the advantages and disadvantages of changing the geographical classification system used by IHPA?*
    - If it better informs the definition of remoteness then it needs to remain.

- *What are the priority areas for IHPA to consider when evaluating adjustments to NEP16?*
    - ICU adjustment for patients
    - Private patient service
    - Multidisciplinary Clinic adjustment
    - Specialist Psychiatric Age adjustment
    - Patient Remoteness adjustment
    - Tele-health
    - Non Admitted Services funding, how will highly technical services such as Radiation Oncology be funded as a Non Admitted activity, will there be a loading or weighting for complexity?
    - Sub-Acute Funding for patients undergoing acute interventions during their sub-acute stay

- *What patient-based factors provide the basis for these or other adjustments? Please provide supporting evidence, where available.*
    - ICU – hours in ICU, hours per mechanical ventilation, haemodialysis
    - Private patient service – funding source, correlation of MBS rates (DRs paid and funded by this) and ICD-10 codes (determines public hospital funding)
    - Multidisciplinary Clinic adjustment- – too early at this stage to determine patient factors
    - Specialist Psychiatric Age adjustment – capture of age, care-types for mental health, psychiatric diagnosis
    - Patient Remoteness – geo-classification, accurate addresses recorded
    - Tele-health is an emerging model of service that has improved the delivery of health care programs to patients and provided equity of access for people who may otherwise be disadvantaged particularly those in rural and remote areas. It has eased the burden on patients and their families and allowed in many cases the patient to be able to either stay at home or in their local hospital. The incentive at present is to provide good care for the patient and ease the burden of travel but needs to be incentivised to the hospitals through adequate funding reimbursement. There are numerous success stories and evidence related to the delivery of care through Tele-health.

9. Bundled Pricing

- *Do you support IHPA's expanded policy intention for bundled pricing in future years?*
    - Only if it is introduced after appropriate and robust consultation which includes clinicians. The risk of bundling is that it may stifle innovation in healthcare because the funding will be based on historical costing (2 years old) and innovation is often more expensive in early stages
    - Shouldn't confuse IHPA's role as bundling suggests the use of best practice pathways to achieve a particular patient outcome…Is that IHPA's role?

    - Maternity – difficult to determine uncomplicated until baby is delivered so how will you unbundle if complications arise. For care provided under CMCS there would need to be a price weighting added as a higher cost service
    - Stroke – too many different variables that affect individual patient rehabilitation and outcomes. Too many pathways.
    - Joint replacement - too many different variables that affect individual patient rehabilitation and outcomes – with age being a factor of recovery. Can be potential complexity for procedures to go wrong and infection which can affect recovery

- *What services or patient episodes of care would most benefit from this expanded bundled pricing approach?*
    - Cannot see any benefits to patient care or funding for hospitals using bundled pricing

- *What issues should IHPA consider prior to implementing a bundled price and how can these issues best be resolved?*
    - The need for care plans and pathways in place for the bundling to occur
    - Would need to be able to separate the bundles if items outside the care plan and be funded differently or with supplement payments

10. Pricing for safety and quality

- If feasible, would you support a best-practice pricing approach for hip fracture care in future years?
    - Best-practice needs to be defined and supported by evidence. Robust consultation regarding pricing for any quality and safety initiatives must occur with jurisdictions and clinicians
    - Who determines best practice for health care to patients? Best practice comes at a higher cost – Isn't the aim for better care in all our patient care? Are we talking best practice or best evidence?
    - Is this an increase in overall funding or at the expense of other patients, i.e. are incentives for best practice care additional to current funding

- What implementation issues should IHPA consider when further investigating the feasibility of applying a best-practice pricing approach in future years?
    - The total funding package available
    - How to determine best practice
    - Clarity and transparency on what is included and excluded in the ABF pricing framework and methodology.

11. The Evaluation of the Impact of the Implementation of National Activity Based Funding for Public Hospital Services

- <u>*When should IHPA undertake 'Phase two' of the evaluation of the impact of the implementation of national Activity Based Funding for public hospital services?*</u>
    - We suggest July 2016 which provides six months to explain the framework and methodology

Public Hospital Funding

We believe that funding should be provided on a nationally consistent basis using ABF type principles with adjustments for local issues and specific costing pressures. Block funding limits growth, both new and additional services or volume growth in current services within a system. It needs to be based around population health issues of each jurisdiction.