

Queensland feedback on the Pricing Framework for Australian Public Hospital Services 2016-17 Consultation Paper

Queensland welcomes this opportunity to provide a submission to the Independent Hospital Pricing Authority (IHPA) to inform the further refinement of the national pricing framework for public hospital services.

This state continues to support the major reform agenda agreed to by the Commonwealth and all states and territories through the August 2011 *National Health Reform Agreement* (NHRA).

The NHRA is intended to deliver a broad range of benefits to patients, the community and governments. Key positive NHRA benefits anticipated to occur at a variety of levels include: additional patient services, improved health system sustainability, increased hospital efficiency, enhanced transparency, localised management responsibility and the availability of national benchmarking cost data at the patient level.

In the pursuit of these objectives, Queensland has implemented, with a limited number of localisations, the Activity Based Funding (ABF) model for identified ABF funded hospitals and National Efficient Cost model for block funded hospitals.

Queensland supports IHPA continuing to undertake analysis and refinement of the national hospital funding models, to improve its methodologies and provide appropriate incentives for public hospital services

Queensland's response to IHPA on its Pricing Framework for Australian Public Hospital Services 2016-17 Consultation Paper is largely structured around the specific consultation questions posed in the document.

3. Scope of public hospital services

Consultation question

What additional evidence exists to support the inclusion or exclusion of specific services from the General List in 2016-17?

In regards to Box 2: Scope of Public Hospital Services and General List of Eligible Services – Category B: Other non-admitted patient services and non-medical specialist outpatient clinics (Tier 2 Non-Admitted Services Class 40) where Jurisdictions have been invited to propose services that will be included or excluded from Category B:

- Exclusion of Primary Health Care (40.08) from Tier 2 is a major issue in explaining the cost of service provision at smaller rural facilities. Most Telehealth services for recipient facilities fall under this, as well as a variety of general community health (school immunisations) or primary health attendances. These are often synonymous with emergency department attendances where there is a single practitioner providing both emergency and outpatient care. Provision of these primary care clinics are funded by the Hospital and Health Service and were in place well before 2010 as long standing arrangements. In many smaller towns, the local hospital and doctor is the sole health care provider employed by Queensland Health. These would meet the third criteria for inclusion “expected to improve the health or better manage the symptoms” although frequent hospital admissions are unlikely.

3.2.1 Pricing posthumous organ procurement activities

Consultation question

Should posthumous organ procurement activities be in-scope for pricing under the National Health Reform Agreement?

In principle, posthumous organ procurement activities should be in-scope for pricing under the NHRA. Supporting organ donation uses extensive resources and should be recognised with an appropriate price as it would make the additional activity involved in organ donation more visible for the organisations and possibly Organ Tissue Authority.

Consultation question

Is posthumous organ procurement adequately accounted for in activity and cost data collections and, if not, how could it be improved?

Posthumous organ procurement costs are not adequately accounted for in activity and cost data collections. Some costs are embedded in the current inpatient care, where the posthumous organ procurement activity occurs within the same facility as the previous care through the linking of the theatre utilisation. Other services in support of organ procurement such as grief counselling provided by social workers to bereaved relatives cannot always be linked to the activities.

There are complex issues to be considered, such as the need to consider whether transplant team retrieval costs are aligned with pre-mortem donor inpatient episode, a specific Care Type 9 donation episode or the transplantation episode. Further, the following risks should be addressed:

- There would be difficulties applying standardised nationally efficient pricing to a funding model. Donation is unique among surgical procedures in that a surgical team travel from a central location to the donor's hospital. In the current system the Commonwealth (via the Organ and Tissue Authority) pays \$10,000 to a hospital for each organ donor, which is intended to contribute to related costs such as anaesthetist time, Intensive Care Unit (ICU) bed and operating theatre. This cost may sometimes be appropriate or other times insufficient, but rarely would it be excessive. There does not appear to be a process to review or index that sum, as there would be with other activity based funding.
- There is significant variation in costs depending on the donor hospital, transplant unit and geographical variation. For example, in Queensland, there is only one transplant team unit and donor hospitals can be in remote locations, and therefore the cost of retrieval could be higher than for other jurisdictions. In addition, a fixed price would not take into account the changing nature of technology, such as the use of perfusion boxes, which increases retrieval costs. A national efficient price could discriminate against geographically dispersed states, even if taking into account adjustments to the funding formula.
- Commonwealth activity based funding would not be accessible to private hospitals where there is no Medicare item number for donation.
- The low volume of cases may not justify the cost of changes to embedded hospital practices and workload required for costing to inform the pricing.

4. Classifications used by IHPA to describe public hospital services

Consultation question

Do you support IHPA's intention to defer pricing mental health services using the Australian Mental Health Care Classification until 1 July 2017?

Queensland supports the deferral of pricing mental health services using the Australian Mental Health Care Classification until 1 July 2017.

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

Consultation question

Should IHPA consider any further technical improvements to the National Efficient Price (NEP) pricing model for 2016-17?

Tier 2 Non-admitted Patient Services pricing:

- Inclusion of a complexity measure within the non-admitted patient care classification would be desirable. Without a coding system equivalent to that used for inpatients there is no indication of primary diagnosis or other comorbidities for ambulatory patients.

Emergency Care pricing:

- Emergency Department (ED) Classification and pricing is poor due to poor quality source data on medical, nursing and specialist consultant labour used for each ED presentation. This is not routinely recorded and does not drive costing. ED data collections lack accurate durations for face-to-face treatment. Prescription of a minimum dataset including more accurate treatment timings is needed to improve the NEP pricing.

Mental Health pricing:

- Again, a per diem pricing model is preferred due to Length Of Stay (LOS) variations for the same Diagnosis Related Group (DRG) between facilities and individual clinicians. Episodic based payments are not robust while clinical treatment protocols are at the clinician's discretion, rather than using evidence based best practice. Queensland Health Variable Life Adjustment Display (VLAD) reporting shows great LOS variability within DRGs dependent upon comorbidities, availability of regional services and other factors not reflected in the acute DRG classification.

Subacute and Non-Acute Patient (SNAP) Pricing

- Queensland has been using a per diem payment methodology for a number of years, and to date the comparison of the episodic payment by v3 SNAP class is less robust than per diem payments as shown by total episode versus daily treatment cost analysis. This shows per diem payments are more robust and a better match for "resource homogenous" than episodic SNAP class rates. Often length of stay for SNAP patients is dependent upon external factors such as Residential Aged Care Facility (RACF) bed availability, transport, community support or home medical aids outside the control of the providing health service.

- In addition, lack of access to RACF beds has been impacted by Commonwealth Aged Care model changes, which are exacerbated with the ageing population. Increasing provision of community services will improve patient outcomes and result in overall less cost.

Neonatal pricing

- The neonatal intensive care unit (NICU) pricing is currently bundled into the neonatal DRGs. Evidence presented at the technical advisory committee suggested that patients within these DRGs that receive care in a NICU have a price disadvantage. This is inconsistent with the treatment of other ICUs and should be unbundled.

6.1.1 Alternative geographical classification systems

Consultation question

What are the advantages and disadvantages of changing the geographical classification system used by IHPA?

The analysis provided by IHPA to the Technical Advisory Committee in June on the Monash Medical Model indicated that there was no improvement to the NEP.

6.2 Adjustments to the National Efficient Price

Consultation question

What are the priority areas for IHPA to consider when evaluating adjustments to NEP16?

What patient-based factors provide the basis for these or other adjustments? Please provide supporting evidence, where available.

Private Patient pricing adjustments are problematic where the facility pays the clinician labour in whole or part, as in Queensland. There are also various inconsistencies in billing practice, for example, pensioners as a private patient may be exempt from prosthetic charges.

The analysis of the adjustments for private patients requires further work. Papers provided by IHPA to the Technical Advisory Committee in June 2015 indicated that the significant variation in medical labour payments does have an impact on the adjustments by jurisdiction and Queensland would see this as a priority in the development of the NEP16.

8. Treatment of other Commonwealth programs

Under Clause A6 of the NHRA, IHPA is required to discount funding that the Commonwealth provides to public hospitals through programs other than the NHRA to prevent the hospital being funded twice for the service. The two major programs are blood products (through the National Blood Agreement) and Commonwealth pharmaceutical programs

At the hospital level, Pharmaceutical Benefits Scheme (PBS) revenue is not offset against cost. The cost is calculated whether or not any revenue is received. Frequently, revenue is received in later financial periods and is problematic to match back to the consuming episode. Care should also be taken not to conflate revenue with cost.

9. Bundled pricing

Consultation question

Do you support IHPA's expanded policy intention for bundled pricing in future years?

Queensland has previously stated its position regarding the role of IHPA versus the role of the States and Territories as system manager. Queensland continues to consider that, while the use of pricing mechanisms to drive service improvement may be valid, that this is not the role of IHPA.

We do however provide views on bundled pricing in order to inform IHPA's deliberation. In principle Queensland supports the view that bundled pricing may have a role in supporting provider flexibility, however the reality is that while the bundle only covers hospital services this does not confer significant benefit, i.e. the opportunity for real improvement and efficiency is through maximising activity in the non-hospital setting.

Bundling introduces more complexity within the pricing model. For example, different National Weighted Activity Units (NWAUs) or a defined adjustment factor would be required to price an emergency presentation that is subsequently admitted, than a planned admission for the same DRG.

In regards to section 9.2 Bundling uncomplicated maternity care', Stroke and Major Joints:

- Bundling maternity services is problematic unless there is agreement on the number of pre and post visits representing best practice. If mother subsequently does not give birth in the facility providing pre and post care, these clinics will not be funded. There are also a number of differing models of care around obstetrics, from GP led care, specialty led care and midwifery models. Bundling would be an inflexible tool to support a variety of patient friendly models. There are already counting issues where IHPA does not recognise more than one Tier 2 Maternity nursing presentation on a single day.
- Bundling stroke care is dependent upon ability to place in RACF with minimal delay.
- Bundling joint replacements is problematic, for example some patients placed on surgical waiting lists are diverted early to physiotherapy clinics and do not progress to surgery. Other patients are treated across multiple health services, creating a problem with linking the bundled payment to that care.
- Bundling pre & post outpatient clinics with the acute episode may effectively unfund diversionary initiatives as the joint replacement DRG will not occur. In general, bundling will reduce resource homogeneity, and result in more underfunding/overfunding than component pricing.

Gaining clinical agreement on best practice, and being able to identify best practice within the data collections to meet those conditions, make implementation difficult.

Some services operate under a 'hub and spoke' model. Under this model, inpatient and outpatient care to the same patient may be delivered by multiple facilities using different patient identifying numbers with which Queensland is currently unable to link together. Further, Queensland does not have unit record outpatient data for all outpatient services for all hospitals, especially as some of the service providers may be in the private hospital setting.

Consultation question

What services or patient episodes of care would most benefit from this expanded bundled pricing approach?

High volume, clinically homogenous patient groups/services with highly predictable care pathways. The rationale being that the bundled price then adequately covers cost for the vast majority of patients, e.g. high volume elective surgery such as cataracts.

We consider that services such as stroke have a higher level of variation and there would need to be a mechanism of risk stratification to address this. Outliers would also need to be excluded

Consultation question

What issues should IHPA consider prior to implementing a bundled price and how can these issues best be resolved?

A key issue will be that any bundled price that will rely on the historical cost data to form the basis for the price is unlikely to reflect best practice. A methodology would have to be established which identified best practice (there would need to be consensus on that, i.e. national guidelines as mentioned above to gain clinical agreement) and which then costed the patient pathway according to implementation of that pathway.

10. Pricing for Safety and Quality

Consultation question

If feasible, would you support a best-practice pricing approach for hip fracture care in future years?

Queensland has previously stated its position regarding the role of IHPA versus the role of the States and Territories as system manager. Queensland continues to consider that, while the use of pricing mechanisms to drive service improvement may be valid, this is not the role of IHPA.

Queensland has already implemented best practice pricing for fractured neck of femur, based on consultation within our jurisdiction.

Consultation question

What implementation issues should IHPA consider when further investigating the feasibility of applying a best-practice pricing approach in future years?

Queensland considers that IHPA could gather the evidence on the effectiveness of best-practice pricing. Any best practice pricing approach would need to be flexible and move with the evidence, where found, in a timely manner as there is a potential to act as a perverse driver and curtail innovation.

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

Consultation question

When should IHPA undertake 'Phase two' of the evaluation of the impact of the implementation of national Activity Based Funding for public hospital services?

The evaluation needs to be completed and provided to the states for comment prior to development of the 2017-18 pricing model and Federal budget.

Approved Philip Davies 3 August 2015