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SA Health

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Dear Mr Downie

Thank you for the opportunity to provide feedback in relation to the Consultation Paper on the Pricing Framework 2016-17.

SA Health believes it is important that the Independent Hospital Pricing Authority (IHPA) work constructively with jurisdictions and other stakeholders to ensure that the national Activity Based Funding (ABF) system reflects best practice in health care and is as robust as possible. In this spirit, I am pleased to provide the following comments, outlined below. Where feedback is not provided about a particular aspect of the Pricing Framework, it can be assumed that SA Health does not have any strongly held comments or position to note, based on the detail as provided in the Consultation Paper. If there is any further elaboration or specific options put forward by the IHPA, SA Health can engage further on the matter.

Scope of public hospital services and General List of eligible services (pg 9)

SA Health is satisfied with the services that are currently included on the General List and with the criteria for inclusion or exclusion of additional services. We are not seeking to have any additional services added and therefore have no further comments to make at this stage.

Pricing posthumous organ procurement activities (pg 9)

SA Health recognises that there are some gaps in the collection and costing of posthumous organ procurement activity. However, it was shown in a recent Technical Advisory Committee (TAC) meeting that the total cost of posthumous organ procurement activity is less than $2 million, which is immaterial in the context of national health expenditure. SA Health is not opposed to making changes in this area, but the cost and effort required in doing so would need to be carefully evaluated in the context of the relatively low activity cost and volumes.

If it is determined that an adjustment is required to better account for this activity, it would be more appropriate to broaden the extent to which the Organ and Tissue Authority is responsible for data collection and funding, rather than incorporating it into the ABF funding model. It is also noted that NSW is currently undertaking some investigative work in relation to the potential feasibility of collecting and costing this activity. SA Health recommends that the outcomes of this work be used to inform any decisions that the IHPA takes in this area.

Multidisciplinary Case Conferences without a patient present (pg 13)

This is not supported by SA Health. Introducing a requirement to collect activity and cost data about Multidisciplinary Case Conferences (MDCCs) where the patient is not present raises a

number of concerns. It will result in additional administrative burden through the need to modify existing information systems and processes to capture activity where there is no patient present. SA Health is also likely to have difficulties in implementing the required system changes to be ready to commence data collection on 1 July 2016.

The introduction of MDCCs without a patient present is also inconsistent with the "Administrative Ease" pricing guideline, which states that "funding arrangements should not unduly increase the administrative burden on hospitals and system managers". In addition, it may create perverse incentives for clinicians to provide more of this type of service event than necessary, because under the current definition, each patient discussed in the MDCC would constitute an additional service event. For example, an MDCC that lasted for 10 minutes and in which 20 patients were discussed would constitute 20 service events.

Technical improvements and alternative geographic classification systems (pg 17)

SA Health does not wish to make any particular suggestions about further technical improvements to the National Efficient Price (NEP) pricing model for 2016-17. In relation to the geographical classification system used in the NEP model, SA Health does not have a preference for either the current ASGS classification or the proposed Modified Monash Model and supports IHPA's intention to evaluate the Monash Model. However, any proposal to change from the current approach should be supported by evidence-based analysis and considered on its merits.

Stability of adjustments

While it is accepted that changes to adjustments in the NEP model may need to be made from time to time to reflect changing practices and knowledge, SA Health advocates a period of relative stability for the NEP model, particularly in the components that have been well established and refined since the model's inception, such as acute admitted. It is in the interests of all jurisdictions to have elements of the pricing model that are consistent across years to provide stability and predictability in funding levels from year to year. SA Health accepts that in the less refined components of the model, changes are necessary and we support the development activities, including the classification work, in these areas.

In relation to specific adjustments, such as those proposed for Culturally and Linguistically Diverse (CALD) patients and fly-in fly-out adjustments, SA Health believes it is too soon to incorporate these adjustments into the NEP for 2016-17. While not strictly opposed to these adjustments, further analysis is required to demonstrate that they are warranted and materially add value to the pricing model.

Bundled pricing (pg 24)

A significant benefit of bundled pricing is that, implemented correctly, it can act as an incentive for a more consistent approach to the delivery of hospital services across care types and service delivery settings. Accordingly, SA Health has supported the investigation of bundled pricing as part of previous Pricing Framework consultation processes and continues to support it. However, it is

very important that strong clinical engagement is undertaken to ensure that any adopted bundling model is appropriate and supported.

There are a number of challenges that must be resolved before additional bundled pricing can be introduced as part of the national ABF system, including:

- reaching national agreement on appropriate clinical pathways and counting rules for bundled services;
- determining the treatment of related services that are provided across different hospitals and/or LHNs;
- ensuring that each of the component services can be individually linked back to its 'native' episode or service event; and
- the adequate capture of ambulatory sub-acute services within the AN-SNAP classification.

Pricing for safety and quality (pg 25)

SA Health supports the further evaluation of a best-practice pricing approach for hip fracture care in future years of the NEP model. This work complements SA Health's current reform processes, with similar approaches likely to be able to be extended to other procedures in the future. However, it is critical that there is a high level of clinical engagement in the design of the pricing methodology as without it, there will not be the support required for a successful implementation.

Evaluation of the impact of national ABF for public hospital services (pg 26)

SA Health believes that 2016-17 is the most appropriate time to undertake Phase Two of this evaluation. This is an important evaluation that will improve the design and implementation of ABF systems and is supported. In addition, an evaluation in 2016-17 is likely to be timely in the context of current Commonwealth Government timeframes for the conclusion of the national ABF system, maximising the possibility that the benefits of ABF will be more widely known and accepted, which will help to ensure that the Commonwealth continues to support and fund the key elements of the program well into the future.

Should you require further information, please contact Phillip Battista, Senior Manager, Funding Models on 08 7425 3582.

Yours sincerely

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SA Health
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