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AMA submission: Draft IHPA Work Program 2017-18

As in previous years, the AMA appreciates IHPA's effort to document its proposed activities as part of its Work Program 2017-18 and the opportunity for stakeholders to provide comments.

The AMA's comments follow.

General

The AMA notes the commitment made in the Heads of Agreement by Australian governments for continued use of Activity Based Funding (ABF) arrangements for the period to June 2020 to determine Commonwealth funding and pricing for public hospitals.

The AMA also notes the agreement includes the development of a longer-term public hospital funding agreement to commence 1 July 2020, to be developed by the Commonwealth and all jurisdictions and be considered by COAG before September 2018.

IHPA's Work Program for 2017-18 must be framed in the context of informing and supporting decisions about the continued use of ABF, with necessary enhancements, as the foundation of hospital funding and pricing in the longer term hospital funding agreement to operate from July 2020.

This work must include opportunities for input by the AMA and other stakeholders.

While the continued use of ABF is clearly preferred to alternative models (including grant funding arrangements as applied before ABF, and the Commonwealth's previous decision to switch to hospital funding based on annual indexation by CPI and population growth only), ABF and the NEP as currently implemented have shortcomings.

The AMA has consistently advocated these shortcomings should be addressed. They include the need for ABF arrangements to give appropriate regard to rewarding quality, performance and outcomes, not penalising hospitals for failing to meet arbitrary levels, and for the NEP and NEC to be determined in a way that provides adequate indexation of funding year on year, and does not lock in the historically low costs of an underfunded and underperforming system.

Key points

The AMA has consistently advocated for the appropriate recognition of safety and quality in the framework of activity based funding and the NEP. However, any approach that sets out to improve safety and quality by financially penalising hospitals that are already under-resourced to achieve safety and quality standards is mis-conceived.

Achieving improved safety and quality for public hospital services requires a framework of positive incentives for the achievement of relevant targets, supported by the full range of quality and safety mechanisms in place and available to public hospital system operators, doctors, nurses and other hospital staff**.**

These include improvements in data quality and information available to inform clinicians' practice, whole-of-system efforts to deliver improved patient outcomes, and incentives that work to the level of the clinical department to focus efforts and effect change, with local implementation, monitoring and information sharing needed.

An essential pre-condition for all such improvements is adequate funding for public hospitals. Overall funding for public hospitals under the National Efficient Price (NEP) has been and continues to be inadequate.

This inadequate funding is demonstrated in key aspects of hospital performance against the targets set by governments, as documented over time in the *AMA Public Hospital Report Card*. The starting point for public hospital funding under the ABF and the NEP framework was the historic costs of an underperforming and underfunded system, since continued though the NEP methodology.

Inadequate funding levels are a key factor in poor safety and quality. Further reducing resources to hospitals will further compound existing problems. Reducing funding should not be confused with positive, supporting measures to encourage and deliver safe, high quality care.

Program Objective 1 - Development of the pricing framework 2018-19

Pricing for safety and quality

<u>Not funding episodes that include a sentinel event</u>

As the AMA has previously advised, this measure involves an element of 'retrospectivity' (ie if the costs of care provided up until the sentinel event occurred are not funded). It is difficult to justify the removal of funding for all the costs incurred, given that in many if not all cases at least some of those costs were for services legitimately provided up to the point of the sentinel event occurring.

Not funding for sentinel events effectively becomes a punitive measure, disconnected from the treatment actually provided. Such measures do nothing to promote a culture of improvement in safety and quality, instead they tend to foster a cynical approach and encourage gaming of the rules.

The AMA notes that sentinel events are not currently reported in national data sets, and as a consequence IHPA will work with jurisdictions on the identification of sentinel event episodes.

Given 102 sentinel events were reported in 2013-14, it is assumed IHPA's work with jurisdictions will identify a comparable number. If the identified number is materially different, this measure should be immediately reviewed.

Hospital acquired complications (HAC)

The AMA notes the Direction to IHPA in respect of hospital acquired complications directs IHPA to have regard to the Parties intention to:

> *"…(b) implement a model for an agreed set of preventable hospital acquired conditions not before 1 July 2018, with a preceding shadow year."*

The AMA reiterates its position that more time is required to develop a robust approach to HACs, one that is properly integrated with the more productive safety and quality approaches referred to in the AMA's submission on the Pricing Framework. The HAC list and its use should be refined and tested over a longer period, for example, with the aim of implementing a fully developed approach from 2020 as part of the proposed longer term hospital funding agreement to operate from that date.

Reporting to COAG Health Council by 30 November 2017 with an outline of the theoretical impact of this measure may or may not be informative and helpful, in the absence of actual, real experience, but must in any case be supplemented by later reports based on real experience. This is particularly important as, regardless of the process to develop the current HAC list, there is no certainty of its appropriateness or correctness for the specific pricing and funding purpose for which it is now to be used. For example, complications that are poorly defined, of variable or ambiguous causation, or that may be pre-existing but are not recognised until after treatment has commenced (for example, delirium), should not be included.

Avoidable readmissions

The AMA notes the work yet to be done to define and identify avoidable readmissions. The work to be done by the Safety and Quality Commission (ACSQHC) and IHPA must be done in close and direct consultation with the AMA and other stakeholders.

Program Objective 2 - Determination of the NEP and NEC

NEP Model Refinement

Bundled pricing for maternity care

The AMA made a number of comments on this proposal in its submission on the Pricing Framework 2017-18, including that the starting point should be the patient cohort with the least significant variations, ie should not include women having complex vaginal births requiring operating room procedures. Shared care arrangements and women using public hospital services for only some of their care should not be included.

The final design of the bundled pricing approach must include provision for monitoring and evaluation, including to ensure there are no unintended consequences, such as artificially constraining maternal care services to 'fit' within the bundled price.

In relation to the Work Program, the AMA notes the Advisory Group convened in 'early 2016' will continue its work 'throughout 2017-18'. The AMA also notes IHPA's undertaking in the Pricing Framework 2017-18 to 'consult further once a draft model is designed'. This is less specific than the Deliverables and Timeframes table on p13 of the Work Program. It would be useful to clarify the actual deliverable and actual timeframe that applies, and/or to provide information on the progress of this work, such as a progress report.

Program Objective 3 – ABF Classification System Development

Mental Health Services

The AMA notes the work on ongoing development of the Australian Mental Health Classification.

AMA members have reported feedback that implementation of ABF may be placing pressure on psychiatrists in their daily work in public hospitals, increasing overhead time and costs at the expense of services and treatment, eg through the need to code activities exactly to match the classification list.

The AMA also understands the costing study undertaken in 2014-15 to inform the Mental Health Classification may not have included private psychiatry services using Medicare.

The Work Program should ensure activities are undertaken ion 2017-18 to address these matters, including implementation and other support strategies to reduce pressure on clinicians, and consideration of private psychiatry services in costings development.

This should include the need for the AMHCC to recognise and address the activities of Consultation Liaison Psychiatry and Forensic Psychiatry services.

Teaching, Training and Research (TTR)

The AMA notes the development of a classification for teaching and training is listed as the TTR deliverable in the 2017-18 Work Program, and that a teaching and training classification system is expected to be completed in early 2018.

The AMA looks forward to the realisation of the substantial development work in TTR to date, including significant involvement of the AMA and other stakeholders.

The benefits of ABF for TTR will be delivered if ABF appropriately and comprehensively prices the work done on teaching and training (with feasibility and design for application of ABF to research to be undertaken separately). ABF for TTR should account for the activities of both teachers and "the taught", as both incur costs to public hospitals, unlike other education models.

Program Objective 6 - Support ABF Research and Evaluation

Evaluation of ABF

There is insufficient public information and analysis of the impacts of ABF implementation on the delivery of public hospital services.

The AMA understands some of the constraints operating in this area. But the AMA also believes the public release of any evaluation information and other 'state of play' material on the impact of the ABF and Pricing Framework that may be readily available will assist public understanding in this area.

Other elements of work program

The AMA notes the other elements of the work program address IHPA's objectives and provide useful information across the range of proposed activities in 2017-18.

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