



2 November 2016
Independent Hospital Pricing Authority

RESPONSE TO CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2017-2018

Thank you for the opportunity to contribute to the consultation for the pricing framework for Australian public hospital services 2017-2018. Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for around 10% of hospital based healthcare in Australia. Our members also provide around 30% of private hospital care, 5% of public hospital care, 12% of aged care facilities, and 20% of home care and support for the elderly.

The following comments relate to the Consultation paper on the pricing framework released by IHPA and our responses to the consultation questions listed in the document.

Adjustments to the NEP and setting the price for private patients in public hospitals

- *Should IHPA further restrict year-on-year changes in price weights?*
 - CHA recognizes there should be a balance between stability and the risk of having weights move too far away from actual costs as very few DRGs appear to move more than 20% between years. CHA does not consider there is a need to change current arrangements.
 - Contemplating a more than a 2 year costing cycle would see wider swings in relativities between weights and subsequently between specialties, producing funding outcomes that are difficult to manage at an operational level (as seen in the private sector where shifts from old to more contemporaneous costing studies have produced significant changes in revenue streams in specialties). Additionally, new technology that is used in any volume needs to be fully captured, and with some immediacy to reflect actual cost incurred.
- *Should IHPA phase out the private patient correction factor in 2018-19 if it feasible to do so?*
 - The private patient correction factor should be removed when IHPA is confident that private patient costs are being fully reported across all jurisdictions. CHA is not in a position to know whether this criterion has been satisfied.





Bundled pricing for maternity care

- *Do you support IHPA's intention to introduce a bundled price for maternity care in future years?*

CHA recognizes there is potential for care bundling for maternity services in addition to a range of other areas [e.g. Palliative Care, Chronic Mental Health, Long Term Conditions, etc].

Care need to be taken to avoid the potential for a bundled funding model to act as a disincentive to the provision of optimal care given the range and nature of antenatal complications and their complexity – particularly where a hospital is located in an area with higher rates of social complexity, chronic disease, obesity, and primary languages other than English, which all incur cost.

There also needs to be more evidence and clarity on the parameters for:

- Weighting and which services are included in the bundle
- Whether bundling accounts for complex cases with coverage for a complicated pregnancy or patients with comorbidities both during the antenatal and post-natal periods
- Whether the proposal for bundling maternity services only applies to unqualified babies
- How popular alternative models of care might fit into maternity bundle models (e.g. doctor or midwife led models) in metro, regional and rural settings
- Whether bundling will include nursery services for newborns and how to account for complications after birth and postnatal care
- How training and research functions might be supported

Pricing and funding for safety and quality

Catholic Health Australia strongly supports policies that promote the attainment of the highest standards of safety and quality by hospitals to the benefit of improved patient outcomes. Whilst our hospital members currently have rigorous systems in place to provide and review safety and quality in their provision of services, we recognise there is always room for improvement.

CHA members share the view expressed by the Australian Commission for Safety and Quality in Health Care on its web-site in 2015 that administrative data sets that have been developed to assist clinicians and hospital administrator's focus on areas where enhancements can be made to improve clinical outcomes are not suitable for use in hospital payment systems.

Whilst that commentary has now been removed from the Commission's web-site, CHA is unclear as to what has changed - other than the decision of COAG to implement a system of pay for performance.

The attainment of the highest standards of safety and quality requires the development of a culture of trust and openness – one that allows mature and careful consideration of all deviations from expected clinical pathways – even those that do not result in harm to the patient.

CHA acknowledges there are some overseas jurisdictions that are implementing pricing for safety and quality - with variable results. The introduction of new payment models into Australia's public hospitals needs to be evidence-based to avoid unintended adverse consequences.





The discussion paper is not clear how any risk adjustment methodology would take into account the higher risk of adverse events due to factors such as patient's age, presence of comorbidities and patient complexity. Often the onset of complications related to these factors is beyond the control of the hospital. Attempts to measure these issues in some sort of "complexity index" will often be subjective rather than objective (and therefore open to manipulation).

Any pay for performance scheme introduced into Australia's public hospitals needs to be undertaken with care and based on evidence.

Table 2: List of Hospital Acquired Complications - CHA has concerns regarding the content of the complications listed, including to the extent to which they are preventable, and whether these should qualify as an HAC that could result in reduced funding for hospitals. Any list used as the basis for hospital funding, including penalties, should be determined by independent experts, such as the Australian Commission for Safety and Quality in Health Care, in the knowledge that it will be used for funding.

Differences in demographics e.g. age of local population, all influence the existence of co-morbid conditions that increase the likelihood of a HAC, even prior to an intervention. Experience of funding consequences related to HACs in the private sector suggests these issues are very influential in determining rates of HAC. What is a 'good' rate of HAC by hospital type is yet to be understood.

If governments are going to introduce pricing for safety and quality – notwithstanding the potential pitfalls, CHA makes the following comments on the options proposed:

Option 1 is potentially the easiest to monitor and report against and appears to be the most administratively feasible. Whilst the Consultation paper indicates 15% of incidents with an HAC achieve a higher DRG, the experience of this model in the private sector suggests that specific specialties may be subject to as high as a 27% DRG change, when extracting HAC related codes. The impact on hospitals where the patient cohort is more highly predisposed to complications will need to be taken into account.

This option, combined with an independent clinical peer review mechanism, is most likely to link the penalty to a specific event rather than Options 2 and 3, which require comparisons among hospitals and groupings.

Option 2 requires more evidence regarding its efficacy and will need robust data collection and auditing before CHA would be prepared to support this approach. This option is designed to be based on risk adjustments for age and patient complexity, but the methodology is not specified and there is currently no statistical validity to such approaches.

Under **Option 3**, CHA shares concerns regarding the efficacy of *payment for performance* mechanisms that offer financial incentives to meet performance targets. Due to mixed and incomplete evidence, it is unclear whether these financial incentives directly improve patient outcomes, particularly with chronic disease and high-risk patients. There is also a greater potential for under-reporting. This option has the potential to negatively impact hospitals that most need investments in safety and quality as well as those hospitals where the patient cohort is more highly predisposed to complications. Incremental improvements in these hospitals may go unrecognized if they remain below the incentive threshold. Penalties should be balanced with incentives for improvement.





- *What factors should be considered in risk adjustment for safety and quality in pricing and funding models for hospital care?*
 - The public sector admits a high proportion of high risk patients. These patients arrive with complex conditions and comorbidities that put them at a greater risk of developing complications. New pricing and funding models could prevent some high-risk patients, in the greatest need of public services, from getting the adequate care they need. CHA proposes further debate and consultation with groups of quality and safety specialists across a range of settings to develop the most suitable approach.
- *Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing and funding for safety and quality?*
 - CHA agrees with the proposed criteria while recommending additional consultation with safety and quality specialists. We support hospitals having the opportunity to access an independent clinical peer review process where hospitals consider that a high standard of clinical care was provided notwithstanding the onset of an adverse outcome.
 - Hospitals should only be penalised for adverse outcomes that are reasonably attributable to the quality of care provided by the hospital.
- *Do you support the proposal to include a sentinel events flag to improve the timeliness and consistency of data that is used for funding purposes?*
 - The use of a sentinel events flag may assist in capturing these episodes in a timely manner for better reporting and analysis. However, there should be a consideration as to how this could occur in practice. If the intention is for a clinical coder to assign a 'sentinel event' flag during the coding of a medical record in the same way a 'condition onset flag' is assigned for a HAC, then in most instances this would not be possible.
 - The information relating to determining if an event was in fact a fundamental breakdown in system or process - a Sentinel Event, requires a thorough and complete investigation. Such documentation is held in many instances separately to the clinical record in electronic risk systems and in some cases legal files. The availability of this information that clearly determines the category of event e.g. 'Sentinel event', 'SAC 1/2', may not be available to the coder.
- *Do you agree with IHPA's assessment of this option (not funding episodes with a sentinel event)?*
 - CHA agrees that these relatively rare events can signal a need for improved hospital safety and quality and should not be funded. We note that certain sentinel events (e.g., suicide in an in-patient unit) are more likely to occur in an acute tertiary care setting with high-risk patients. This also carries the risk of penalising facilities that accommodate high-risk patients.
- *What approach is supported for setting timeframes within which avoidable hospital readmissions are measured?*
 - CHA has strong concerns about establishing a 28 day hospital readmission window as a measure of hospital quality and safety. CHA points to a [US study that was recently published](#) to examine readmission levels for elderly patients for three common conditions. This study determined after day 7 post-discharge, hospital





readmissions were a result of community and household-level factors rather than hospital services and quality of treatment. CHA would propose that the future pricing framework not exceed the current recommended 5 days as readmissions after this date will not be reflective of hospital quality and safety and risk penalising hospitals for influences beyond their control.

- Readmission rates are not necessarily confined to the performance of the hospital as they can also reflect the state of the health system. This is most apparent in regions experiencing rapid growth and change where hospitals face increasing demands due to inadequate community and primary care resources. This can lead to supply side constraints on hospitals who then discharge patients into clinical institutions or community programs that are inadequately resourced to cope with the current demand.
 - The environmental circumstances and patient compliance with treatments outside of hospital cannot be underestimated in the assessing determinants for readmission.
- *Is there support for pricing and funding models to be based on avoidable hospital readmissions within the same LHN?*
 - For hospitals that are located close to boundaries or borders, patients may be readmitted to a hospital different from the same group where they initiated their care. This may result in hospital readmissions that are difficult to track across boundaries/borders.
 - *When should a pricing and funding approach for avoidable readmissions be implemented?*
 - CHA recommends that no time frame be set until there is a rigorous evidence base to draw from.
 - *What do you think are the most important considerations for implementation of pricing and funding approaches for safety and quality?*
 - A pricing and funding approach for safety and quality will need to incorporate independent clinical peer review and evidence for reforms.
 - Some evidence may be available from the private sector in assessing readmission causative factors, as early adopters of pricing and funding related measures.
 - The pricing framework should also foster clinical innovation. There has been a shift towards integrated models of care that encourage hospitals to collaborate with specialists and allied health organisations outside of their facilities that encourage more innovative approaches to care. The pricing framework will need to account for events that occur outside of the hospitals, including how to coordinate or partner with organisations outside the hospital.
 - *Do you agree that IHPA would need to back-cast the impact of introducing new measures for safety and quality into the pricing and funding models?*
 - CHA agrees that any new models should be back-cast given the potential consequences for hospitals resulting from the introduction of new funding arrangements for safety and quality.
 - Transition processes should be carefully considered by hospital type and location.

