



Independent Hospital Pricing Authority

# **THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2017-18**

March 2017

## The Pricing Framework for Australian Public Hospital Services 2017-18

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The Hon Jill Hennessy  
Chair, COAG Health Council  
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MELBOURNE VIC 3001

Dear Minister

On behalf of the Independent Hospital Pricing Authority (IHPA), I am pleased to present the *Pricing Framework for Australian Public Hospital Services 2017-18*.

The Pricing Framework is the key strategic document underpinning the National Efficient Price (NEP) and National Efficient Cost (NEC) Determinations for the financial year 2017-18. The NEP Determination will be used to calculate Commonwealth payments for in-scope public hospital services that are funded on an activity basis, whilst the NEC Determination covers the services which are block funded.

This is the fifth Pricing Framework issued by IHPA. The nature of the comments received in response to the Consultation Paper on the Pricing Framework for 2017-18 demonstrates that IHPA has developed a clear and stable methodology that guides the annual determination of the NEP and NEC. IHPA will continue to develop and refine its classification systems, counting rules, data, coding and costing standards which underpin the national activity based funding system.

In April 2016 the Council of Australian Governments agreed to implement pricing and funding reforms in order to improve health outcomes, avoid funding unnecessary or unsafe care and decrease avoidable demand for public hospital services.

Subsequently, the Hon Sussan Ley MP, the then Commonwealth Minister for Health and Aged Care, acting under subsection 226(1) of the National Health Reform Act 2011 directed IHPA to advise on an option or options for a comprehensive and risk adjusted model to determine how funding and pricing can be used to improve patient outcomes across three key areas; sentinel events, hospital acquired complications and avoidable hospital readmissions, with advice to be provided to the COAG Health Council by 30 November 2016.

IHPA consulted on this as part of the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2017-18*. On 30 November 2016 IHPA provided advice to the COAG Health Council on options for the integration of safety and quality into public hospital pricing and funding. In this advice, IHPA proposed one approach for sentinel events, one approach for hospital acquired complications (HACs), and one initial approach on avoidable readmissions.

In February 2017, the Hon Greg Hunt MP, the Commonwealth Minister for Health, acting under section 226 of the *National Health Reform Act 2011* directed IHPA to undertake implementation of three recommendations of the COAG Health Council relating to sentinel events, hospital acquired complications (HACs) and avoidable readmissions. These recommendations are reflected in the *Pricing Framework for Australian Public Hospital Services 2017-18*.

I would like to affirm the commitment of IHPA to transparency and continuous improvement in how it undertakes its delegated functions, grounded in an open and consultative approach to working with the health sector in the implementation of activity based funding for public hospital services.

Yours sincerely



Shane Solomon  
Chair  
Pricing Authority

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# GLOSSARY

<b>ACHI</b>	Australian Classification of Health Interventions
<b>AN-SNAP</b>	Australian National Subacute and Non-Acute Patient classification
<b>AR-DRG</b>	Australian Refined Diagnosis Related Groups
<b>COF</b>	Condition Onset Flag
<b>DRG</b>	Diagnosis Related Group
<b>HAC</b>	Hospital Acquired Complication
<b>ICD-10-AM</b>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
<b>IHPA</b>	Independent Hospital Pricing Authority
<b>LHN</b>	Local Hospital Network
<b>NEC</b>	National Efficient Cost
<b>NEP</b>	National Efficient Price
<b>The Commission</b>	Australian Commission on Safety and Quality in Health Care

# 1. INTRODUCTION

The implementation of a national activity based funding system is intended to improve the efficiency and transparency of funding contributions of the Commonwealth, state and territory governments for each Local Hospital Network (LHN) across Australia.

To achieve this, IHPA is required under the National Health Reform Agreement and the *National Health Reform Act 2011* to determine the National Efficient Price (NEP) to calculate Commonwealth activity based funding payments for in-scope public hospital services and the National Efficient Cost (NEC) covering those services which are block funded.

IHPA released the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2017-18* for a 30-day public comment period on 30 September 2016. The *Pricing Framework Consultation Paper* set out the key issues for consideration in preparation of the *Pricing Framework for Australian Public Hospital Services 2017-18*.

Stakeholder feedback has informed the development of the *Pricing Framework* which sets out the policy rationale and decisions regarding IHPA's program of work and the decisions in the NEP and NEC Determinations for 2017-18 (NEP17 and NEC17).

Submissions on the *Pricing Framework Consultation Paper* were received from 44 organisations and individuals, including all state and territory governments and the Commonwealth. These submissions are available on the [IHPA website](#).

Work to develop options for incorporating safety and quality into the pricing and funding of public hospital services originated from the [April 2016 Council of Australian Governments' Heads of Agreement on Public Hospital Funding](#). IHPA provided options regarding this work to the COAG Health Council on 30 November 2016, as required by the Commonwealth Minister for Health in a Direction to IHPA on 29 August 2016. In February 2017, the Commonwealth Minister for Health directed IHPA to implement a number of recommendations of the COAG Health Council relating to safety and quality. These recommendations and the supporting work are discussed in Chapter 11 of the *Pricing Framework*.

The *Pricing Framework* builds on the Pricing Frameworks from previous years ([2012-13](#), [2013-14](#), [2014-15](#), [2015-16](#) and [2016-17](#)). For simplicity, where IHPA has reaffirmed a previous principle, the supporting argument has not been restated in this year's paper.

This year the *Pricing Framework* has been released alongside the NEP17 and NEC17 Determinations. This revised timeframe reflects the detailed work IHPA has undertaken to identify and investigate a variety of options for incorporating safety and quality into the pricing and funding of public hospital services for NEP17. IHPA anticipates returning to releasing the *Pricing Framework* ahead of the Determinations in future years.

## 2. PRICING GUIDELINES

### 2.1 OVERVIEW

The Pricing Guidelines signal IHPA's commitment to transparency and accountability in how it undertakes its work (see **Box 1**). The decisions made by IHPA in pricing in-scope public hospital services are evidence-based and utilise the latest costing and activity data supplied to IHPA by states and territories.

In making these decisions, IHPA must balance a range of policy objectives including improving the efficiency and accessibility of public hospital services. This role requires IHPA to exercise judgement on the weight to be given to different policy objectives.

Whilst these Pricing Guidelines are used to explain the key decisions made by IHPA in the annual *Pricing Framework*, they can also be used by governments and other stakeholders to evaluate whether IHPA is undertaking its work in accordance with the explicit policy objectives included in the Pricing Guidelines.

#### Feedback received

Jurisdictions and other stakeholders were broadly supportive of the Pricing Guidelines.

IHPA considers that the Pricing Guidelines remain appropriate. For this reason, IHPA has not made any changes to the Pricing Guidelines in 2017-18.

#### IHPA's decision

IHPA has developed, and will use, a set of Pricing Guidelines (**Box 1**) to guide its decision making where it is required to exercise policy judgement in undertaking its legislated functions. IHPA has not made changes to the Pricing Guidelines for 2017-18.

#### Next steps and future work

IHPA will continue to actively monitor the impact of the implementation of activity based funding. This will include monitoring changes in the mix, distribution and location of public hospital services, consistent with its responsibilities under Clause A25 of the National Health Reform Agreement. IHPA will continue to work with the Jurisdictional Advisory Committee and the Clinical Advisory Committee to analyse any changes evident in the data.



## Box 1: Pricing Guidelines

The Pricing Guidelines comprise the following overarching, process and system design guidelines.

**Overarching Guidelines** that articulate the policy intent behind the introduction of funding reform for public hospital services comprising activity based funding and block grant funding:

- **Timely–quality care:** Funding should support timely access to quality health services.
- **Efficiency:** Activity based funding should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.
- **Fairness:** Activity based funding payments should be fair and equitable, including being based on the same price for the same service across public, private or not-for-profit providers of public hospital services.
- **Maintaining agreed roles and responsibilities of governments determined by the National Health Reform Agreement:** Funding design should recognise the complementary responsibilities of each level of government in funding health services.

**Process Guidelines** to guide the implementation of activity based funding and block grant funding arrangements:

- **Transparency:** All steps in the determination of activity based funding and block grant funding should be clear and transparent.
- **Administrative ease:** Funding arrangements should not unduly increase the administrative burden on hospitals and system managers.
- **Stability:** The payment relativities for activity based funding are consistent over time.
- **Evidence-based:** Funding should be based on best available information.

**System Design Guidelines** to inform the options for design of activity based funding and block grant funding arrangements:

- **Fostering clinical innovation:** Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes.
- **Price harmonisation:** Pricing should facilitate best-practice provision of appropriate site of care.
- **Minimising undesirable and inadvertent consequences:** Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.
- **Activity based funding pre-eminence:** Activity based funding should be used for funding public hospital services wherever practicable.
- **Single unit of measure and price equivalence:** Activity based funding pricing should support dynamic efficiency and changes to models of care with the ready transferability of funding between different care types and service streams through a single unit of measure and relative weights.
- **Patient-based:** Adjustments to the standard price should be, as far as is practicable, based on patient-related rather than provider-related characteristics.
- **Public-private neutrality:** Activity based funding pricing should not disrupt current incentives for a person to elect to be treated as a private or a public patient in a public hospital.

# 3. SCOPE OF PUBLIC HOSPITAL SERVICES

## 3.1 OVERVIEW

In August 2011 governments agreed to be jointly responsible for funding efficient growth in 'public hospital services'. As there was no standard definition or listing of public hospital services, the Council of Australian Governments assigned IHPA the task of determining whether a service is ruled 'in-scope' as a public hospital service, and therefore eligible for Commonwealth Government funding under the National Health Reform Agreement.

The scope of 'public hospital services' is broader than public hospitals or hospital-based care. For example, private hospitals and non-governmental organisations may provide public hospital services when these services are contracted out by governments or public hospitals. Conversely, while many public hospitals provide residential aged care services, these are not regarded as public hospital services.

## 3.2 SCOPE OF PUBLIC HOSPITAL SERVICES AND GENERAL LIST OF ELIGIBLE SERVICES

Each year, IHPA publishes the 'General List of In-Scope Public Hospital Services' which defines public hospital services eligible for Commonwealth funding, except where funding is otherwise agreed between the Commonwealth and a state or territory.

In accordance with Section 131(f) of the *National Health Reform Act 2011* and Clauses A9-A17 of the National Health Reform Agreement, the General List defines public hospital services eligible for Commonwealth funding to be:

- All admitted programs, including hospital in the home programs. Forensic mental health inpatient services are also included if they were recorded in the 2010 Public Hospital Establishments Collection.
- All Emergency Department services provided by a recognised Emergency Department service; and
- Other non-admitted services that meet the criteria for inclusion on the General List.

A public hospital service's eligibility for inclusion on the General List is independent of the service setting in which it is provided (e.g. at a hospital, in the community, in a person's home). This policy decision ensures that the *Pricing Framework* supports best practice provision of appropriate site of care.

The Pricing Authority determines whether specific services proposed by states and territories are in-scope and eligible for Commonwealth funding based on decision criteria and through reviewing supporting empirical evidence provided by jurisdictions.

The process IHPA follows in assessing services and the decision criteria and interpretive guidelines used by the Pricing Authority are outlined in the [Annual Review of the General List of In-Scope Public Hospital Services](#) policy. The policy was updated in early 2016 to clarify that the service must already be in operation prior to being considered under the policy by IHPA.

The criteria and interpretive guidelines are presented in **Box 2**. The General List and A17 List were published as part of the [NEP16 Determination](#) in early March 2016.

IHPA has not made any changes to the criteria and interpretive guidelines for 2017-18.

### **IHPA's decision**

IHPA does not propose any changes to the criteria which it uses to determine whether in-scope public hospital services are eligible for Commonwealth funding under the National Health Reform Agreement in 2017-18. Full details of the public hospital services determined to be in-scope for Commonwealth funding will be provided in the NEP17 Determination.

### **Next steps and future work**

The General List policy provides a mechanism for jurisdictions to apply to IHPA for additional services to be included or excluded from the General List. IHPA periodically reviews the General List to ensure that all in-scope services continue to meet the criteria to be eligible for Commonwealth funding under the National Health Reform Agreement.

## **Box 2: Scope of Public Hospital Services and General List of Eligible Services**

In accordance with Section 131(f) of the *National Health Reform Act 2011* and Clauses A9 – A17 of the National Health Reform Agreement, the scope of “Public Hospital Services” eligible for Commonwealth funding under the Agreement are:

- All admitted programs, including hospital in the home programs and forensic mental health inpatient services.
- All Emergency Department services.
- Non-admitted services as defined below.

### **Non-admitted services**

This listing of in-scope non-admitted services is independent of the service setting in which they are provided (e.g. at a hospital, in the community, in a person's home). This means that in-scope services can be provided on an outreach basis.

To be included as an in scope non-admitted service, the service must meet the definition of a ‘service event’ which is:

An interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record.

Consistent with Clause A25 of the Agreement, IHPA will conduct analysis to determine if services are transferred from the community to public hospitals for the dominant purpose of making those services eligible for Commonwealth funding.

There are two broad categories of in-scope, public hospital non-admitted services:

- A. Specialist Outpatient Clinic Services
- B. Other Non-admitted Patient Services and Non-Medical Specialist Outpatient Clinics

### **Category A: Specialist outpatient clinic services – Tier 2 Non-Admitted Services Classification – Classes 10, 20 and 30**

This comprises all clinics in the Tier 2 Non-Admitted Services classification, classes 10, 20 and 30, with the exception of the General Practice and Primary Care (20.06) clinic, which is considered by the Pricing Authority as not to be eligible for Commonwealth funding as a public hospital service.

### **Category B: Other non-admitted patient services and non-medical specialist outpatient clinics (Tier 2 Non-Admitted Services Class 40)**

To be eligible for Commonwealth funding as an Other Non-admitted Patient Service or a Class 40 Tier 2 Non-admitted Service, a service must be:

- directly related to an inpatient admission or an Emergency Department attendance; or
- intended to substitute directly for an inpatient admission or Emergency Department attendance; or
- expected to improve the health or better manage the symptoms of persons with physical or mental health conditions who have a history of frequent hospital attendance or admission.

Jurisdictions have been invited to propose services that will be included or excluded from Category B “Other Non-admitted Patient Services”. Jurisdictions will be required to provide evidence to support the case for the inclusion or exclusion of services based on the three criteria above.

The following clinics are considered by the Pricing Authority as not to be eligible for Commonwealth funding as a public hospital service under this category:

- Commonwealth funded Aged Care Assessment (40.02)
- Family Planning (40.27)
- General Counselling (40.33)
- Primary Health Care (40.08).

#### **Interpretive guidelines for use**

In line with the criteria for Category B, community mental health, physical chronic disease management and community based allied health programs considered in-scope will have all or most of the following attributes:

- Be closely linked to the clinical services and clinical governance structures of a public hospital (for example integrated area mental health services, step-up/step-down mental health services and crisis assessment teams);
- Target patients with severe disease profiles;
- Demonstrate regular and intensive contact with the target group (an average of eight or more service events per patient per annum);
- Demonstrate the operation of formal discharge protocols within the program; and
- Demonstrate either regular enrolled patient admission to hospital or regular active interventions which have the primary purpose to prevent hospital admission.

#### **Home ventilation**

A number of jurisdictions submitted home ventilation programs for inclusion on the General List. The Pricing Authority has included these services on the General List in recognition that they meet the criteria for inclusion, but will review this decision in the future once the full scope of the National Disability Insurance Scheme is known.

# 4. CLASSIFICATIONS USED BY IHPA TO DESCRIBE PUBLIC HOSPITAL SERVICES

## 4.1 OVERVIEW

In order to determine the National Efficient Price (NEP) for services funded on an activity basis, IHPA must first specify the classifications, counting rules, data and coding standards as well as the methods and standards for costing data.

## 4.2 CLASSIFICATION SYSTEMS

Classification systems provide the hospital sector with a nationally consistent method of classifying all types of patients, their treatment and associated costs in order to better manage, measure and fund high quality and efficient health care services.

The use of these systems is a critical element of activity based funding as they group patients who have similar conditions and cost similar amounts per episode together (i.e. the groups are clinically relevant and resource homogenous).

## 4.3 AUSTRALIAN REFINED DIAGNOSIS RELATED GROUPS CLASSIFICATION

For NEP16 IHPA used the Australian Refined Diagnosis Related Groups (AR-DRG) Version 8 classification to price admitted acute patient services. The new version of the classification better recognises the impact of principal diagnosis and comorbidities on case complexity and was more reflective of the actual cost of treating admitted acute patients. IHPA used the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) and the Australian Classification of Health Interventions (ACHI) 9th edition for the diagnosis and procedure coding.

IHPA will continue to use AR-DRG Version 8 to price admitted acute patient services in NEP17 underpinned by ICD-10-AM 10th edition, to be implemented on 1 July 2017.

IHPA has completed the development of AR-DRG Version 9, and expects to release this version in early 2017 for use for pricing from 1 July 2018.

### Feedback received

Stakeholders were broadly supportive of IHPA's ongoing development of AR-DRG Version 9.

### IHPA's decision

IHPA has determined that the ICD-10-AM and ACHI 10th edition diagnosis and procedure codes and the Australian Refined Diagnosis Related Groups Version 8 classification will be used for pricing admitted acute services in NEP17.

### Next steps and future work

IHPA has completed development of Version 9 of the AR-DRG classification system which will be released in early 2017 and will be used for pricing admitted acute patients from 1 July 2018.

## 4.4 AUSTRALIAN NATIONAL SUBACUTE AND NON-ACUTE PATIENT CLASSIFICATION

For NEP16 IHPA used the Australian National Subacute and Non-Acute Patient (AN-SNAP) Version 4 classification to price admitted subacute and non-acute services. The new version of the classification better reflects current and evolving clinical practice and introduces classes for subacute paediatric services.

Whilst paediatric classes were introduced in AN-SNAP Version 4, IHPA advised in the *Pricing Framework 2016-17* that per diem pricing for subacute paediatric patients would be retained for NEP16 on the basis that there was insufficient data. IHPA has since considered whether there is sufficient data to price subacute paediatric services using the classification from 1 July 2017.

In developing AN-SNAP Version 4, cognitive impairment was identified as a significant cost driver for geriatric evaluation and management services. Clinicians recommended the Standardised Mini-Mental State Examination as the preferred tool to assess the degree of cognitive impairment for these patients.

IHPA collected data on patient cognitive measures (including the Standardised Mini-Mental State Examination) and other clinical information from a sample of older persons' medical records from the subacute care type in 2015. While this analysis demonstrates that the Standardised Mini-Mental State Examination provides a superior differentiation in cost for some patients, a small sample size precludes a classification change at this time.

IHPA has retained a Standardised Mini-Mental State Examination data item in the data collection for 2017-18 for future consideration in classification development.

IHPA will use AN-SNAP Version 4 to price subacute services in NEP17.

IHPA will review all areas of the classification in 2017 ahead of commencing development of AN-SNAP Version 5. This work will consider incorporating comorbidities and a case complexity process into the admitted branches, further refinement of the cognitive measures for geriatric evaluation and management and reviewing the paediatric palliative care and rehabilitation branches. IHPA will also review the non-admitted and psychogeriatric care branches as new classification systems are developed for these patients.

### Feedback received

Children's Healthcare Australasia (CHcA) supported the pricing of paediatric rehabilitation services using the new classification from NEP17, but that per diem pricing should be retained for paediatric palliative care services due to insufficient data. New South Wales recommended that pricing subacute paediatric services using the AN-SNAP classification should be deferred until NEP19 when cost and activity data for the new paediatric classes will have been collected.

IHPA also sought feedback in the *Pricing Framework Consultation Paper* on the proposed considerations for AN-SNAP Version 5 and any other variables which should be explored in that work.

Stakeholders were supportive of the development of AN-SNAP Version 5 and suggested a variety of additional areas for IHPA to consider.

The proposal to consider incorporating comorbidities and case complexity into the admitted branch of the AN-SNAP classification was supported by the Commonwealth, Children's Health Queensland Hospital and Health Service (HHS) and Alfred Health.

South Australia, the Metro North HHS, the Society of Hospital Pharmacists of Australia (SHPA) and the Health Care Consumers' Association (HCCA) supported IHPA considering whether to incorporate the Standardised Mini-Mental State Examination into AN-SNAP as different levels of cognitive impairment in patients impacts on the nature and cost of care.

However, New South Wales queried if this was still appropriate given that the Standardised Mini-Mental State Examination was not suitable for some groups of patients. Western Australia supported consideration of other cognitive measures, with Austin Health suggesting the Westmead Post Traumatic Amnesia Scale for Brain Dysfunction Impairments.

New South Wales and Queensland suggested that IHPA consider whether the AN-SNAP classification can better reflect new and emerging models of care, such as palliative care in the home. Queensland, Western Australia and Tasmania also suggested that additional definitional work is required to differentiate between ambulatory same-day admitted activity and non-admitted activity.

IHPA will refer this feedback to the Subacute Care Working Group for consideration in the development of Version 5 of the AN-SNAP classification.

### **IHPA's decision**

IHPA has determined that the Australian National Subacute and Non-Acute Patient (AN-SNAP) Version 4 classification will be used for pricing admitted subacute and non-acute services in NEP17.

IHPA has sufficient activity and cost data to determine price weights for paediatric rehabilitation and non-acute classes.

IHPA will retain per diem prices for paediatric palliative care services for NEP17.

Subacute and non-acute services not classified using AN-SNAP Version 4 will be classified using Diagnosis Related Groups.

### **Next steps and future work**

IHPA will consider stakeholder feedback in its review of the classification ahead of commencing development on AN-SNAP Version 5.

## **4.5 TIER 2 NON-ADMITTED SERVICES CLASSIFICATION**

The Tier 2 Non-Admitted Services classification categorises a public hospital's non-admitted services into classes which are generally based on the nature of the service provided and the type of clinician providing the service.

IHPA acknowledges that the existing classification is not ideal in the longer term for pricing non-admitted patients as it is not patient centred. However, there are no non-admitted classifications in use internationally which could be suitably adapted to the Australian setting.

For this reason, IHPA is continuing its work to develop a new Australian Non-Admitted Care Classification that will be better able to describe patient complexity and more accurately reflect the costs of non-admitted public hospital services. This work is expected to conclude in December 2018.

For NEP17, IHPA will continue to use the Tier 2 Non-Admitted Services classification for pricing non-admitted services. It is anticipated only minor amendments will be made to the classification as work continues on the new non-admitted classification.

### **4.5.1 Multidisciplinary case conferences where the patient is not present**

IHPA has received support from clinicians and other stakeholders for counting, costing and classifying non-admitted multidisciplinary case conferences where the patient is not present.

IHPA is working with jurisdictions to consider the introduction of additional data items in the non-admitted data sets for future years. This has included undertaking a study in 2016 to obtain a sample of cost and activity data on multidisciplinary case conferences where the

patient is not present, with a view to building an understanding of the prevalence of these events and to enable the development of a pricing approach.

IHPA will not introduce a price for non-admitted multidisciplinary case conferences where the patient is not present for NEP17. Informed by the conclusions of the study, IHPA will consider whether additional data elements are necessary for national collection from 2017-18 to enable the development of a pricing approach for future years.

### **Feedback received**

Victoria and Western Australia supported the development of a new Australian Non-Admitted Care Classification as it is expected to better describe patient complexity and more accurately reflect the costs of non-admitted services. Queensland, Sunshine Coast HHS, Children's Health Queensland HHS and Metro North HHS suggested a variety of issues which should be considered in developing the new classification including differentiating between new and review patients and between adult and paediatric patients, as well as accounting for online service delivery such as maternity antenatal education classes.

IHPA will refer this feedback to the Non-Admitted Care Advisory Working Group for consideration in the development of the new Australian Non-Admitted Care Classification.

Women's Healthcare Australasia (WHA), SHPA, CHcA and Metro North HHS supported work to count, cost and classify non-admitted multidisciplinary case conferences where the patient is not present as this activity is a vital adjunct to the clinical care of patients with conditions that are long-term and complex. Developing separate price weights for these services was not supported by South Australia, instead suggesting this activity be costed to the related non-admitted service event which had involved the patient.

### **IHPA's decision**

IHPA has determined that the Tier 2 Non-admitted Services classification Version 4.1 will be used for pricing non-admitted services in NEP17.

### **Next steps and future work**

IHPA will continue to develop the new Australian Non-Admitted Care Classification. IHPA will also consider whether to count, cost and classify non-admitted multidisciplinary case conferences where the patient is not present to support a possible future pricing approach.

## **4.6 EMERGENCY CARE CLASSIFICATION**

IHPA currently uses the Urgency Related Group and Urgency Disposition Group classification systems to classify presentations to emergency departments and emergency services for activity based funding purposes.

IHPA acknowledges that the classification systems require improvement for classifying emergency care in the medium to long term. There is a need for an emergency care classification with a stronger emphasis on patient factors, such as diagnosis, compared to the current focus on triage category in the existing classification. Work commenced on the new emergency care classification systems in 2015 and is expected to be completed in late 2017.

The development of the new emergency care classification includes a costing study which has captured clinician time per patient to allow for more accurate cost allocation. The costing study data collection was undertaken by 10 public hospitals across four jurisdictions from April to June 2016. The final report of the study will be completed in early 2017.

For NEP17 IHPA will price emergency activity using the existing Urgency Related Group Version 1.4 and Urgency Disposition Group Version 1.3 classifications.



#### **4.6.1 Emergency Department Principal Diagnosis Short List**

IHPA is also undertaking the development of an Emergency Department Principal Diagnosis Short List to improve the consistency of diagnosis reporting across jurisdictions. IHPA completed the list in late 2016 and will seek endorsement to include the list for national data collection from 2018-19.

##### **Feedback received**

Victoria, WHA and CHcA supported the work to develop a new emergency care classification. New South Wales suggested telehealth services that support outreach service delivery should be incorporated into the new classification.

##### **IHPA's decision**

IHPA has determined that Urgency Related Groups Version 1.4 and Urgency Disposition Groups Version 1.3 will be used for pricing emergency activity in NEP17.

##### **Next steps and future work**

IHPA will continue to develop a new emergency care classification for implementation in 2018-19. IHPA will seek stakeholder input through a public consultation paper in 2017.

### **4.7 TEACHING, TRAINING AND RESEARCH**

Teaching, training and research activities represent an important role of the public hospital system alongside the provision of care to patients. However, there is currently no acceptable classification system for teaching, training and research, nor are there mature, nationally consistent data collections for activity or cost data which would allow for the activity to be priced.

IHPA is continuing its development of the key technical requirements to introduce activity based funding for teaching, training and research. This has included a comprehensive costing study at a representative sample of public hospitals in 2015-16. The study concluded that it is feasible to develop a teaching and training classification, but the results relating to research capability were insufficient for use in classification development.

Work has commenced on the development of a teaching and training classification system which is expected to be completed in 2017-18.

Until such time as the classification is developed, IHPA will continue to block fund teaching, training and research activity in activity based funded hospitals including in NEC17. The block funding amounts will be determined on the advice of jurisdictions.

##### **Feedback received**

Victoria supported IHPA's work to develop a teaching and training classification. New South Wales and Western Australia considered that the teaching, training and research costing study is a reasonable starting point for the development of a classification, while noting the study's limitations such as the small sample sizes of midwifery and dentistry trainees and reservations regarding excluding embedded teaching and training costs from the classification development. IHPA and the Teaching, Training and Research Working Group are considering strategies to address these limitations in the development of the teaching and training classification.

Universities Australia requested that hospitals partnering with universities for health and medical research be acknowledged in the development of the research classification. IHPA will consider this issue if it is considered feasible to use activity based funding for research.

### **IHPA's decision**

In 2017-18 IHPA will determine block funding amounts for teaching, training and research activity based on jurisdictional advice.

### **Next steps and future work**

IHPA will continue to develop a teaching and training classification in 2017, informed by a comprehensive costing study conducted in 2015-16, as well as further assessing the feasibility of activity based funding for research.

## **4.8 AUSTRALIAN MENTAL HEALTH CARE CLASSIFICATION**

IHPA has developed the Australian Mental Health Care Classification to classify and price mental health services on an activity basis across both the admitted and non-admitted settings. The classification provides a clinical meaningful way of classifying mental health care and is more predictive of the actual costs of delivering mental health services. The classification includes a new clinician rated measure of 'mental health phase of care'.

The development of the classification was informed by the outcomes of a costing study in 2014-15 of a cross-section of Australian public and private mental health services including the admitted, community and residential settings. This study collected costs for mental health services which enabled the design of the classification.

The draft classification was released for public consultation in late 2015, with Version 1 finalised in early 2016. More details about the classification can be found [here](#).

The new classification was also piloted in late 2015 at a small number of sites nationally to test its clinical acceptability and explanatory power, as well as to identify the system changes necessary for implementation. Feedback from the pilot enabled the activity based funding Mental Health Care Data Set Specification and supplementary materials to be further refined, and identified areas for further review. IHPA has since commenced work on an inter-rater reliability study to test and refine 'mental health phase of care' with clinicians across Australia and has convened a clinical reference group to review and support implementation of the child and adolescent mental health branch.

IHPA is continuing to refine the classification and supporting materials based on the findings from the inter-rater reliability study. IHPA will develop a work program for further refinements to the classification in 2017 which will examine areas such as refinement of classes, incorporating clinical complexity and comorbidities, recommendations from the child and adolescent mental health clinical reference group and options for the refinement of the older persons' mental health branch.

### **Feedback received**

WHA recommended that perinatal mental health care be incorporated into the Australian Mental Health Care Classification and CHcA requested that further costing is required for child and adolescent mental health services as the original study sites did not include a sizable volume of these services. IHPA will work with the Mental Health Working Group and the Child and Adolescent Mental Health Clinical Reference Group to address these issues in order to appropriately describe the full range of mental health care through the classification.

**IHPA's decision**

The Australian Mental Health Care Classification will continue to be implemented for data collection in 2017-18.

**Next steps and future work**

Findings from the inter-rater reliability study and the child and adolescent mental health clinical review will inform the continued development of Version 2 of the Australian Mental Health Care Classification over 2017-18.

# 5. DATA COLLECTION

## 5.1 NATIONAL HOSPITAL COST DATA COLLECTION

IHPA primarily relies on the National Hospital Cost Data Collection to develop the National Efficient Price and the price weights for the funding of public hospital services on an activity basis, as well as to develop the National Efficient Cost for block funded hospitals. Data submissions by jurisdictions to the collection are informed by the *Australian Hospital Patient Costing Standards*.

IHPA published [Version 3.1 of the Standards](#) in late 2014. IHPA has since undertaken a comprehensive review to identify the priority areas for improvement, to evaluate alternative cost allocation methods and determine a preference hierarchy of methods for the Standards. The review included consultation with all jurisdictions and other stakeholders, with the release of a public consultation paper in late 2015.

The findings of the comprehensive review have informed the development of Version 4 of the Standards and of supporting materials to assist system and hospital managers in undertaking costing activities in public hospitals.

Version 4 of the Standards is expected to be released in 2017 for use in future rounds of the National Hospital Cost Data Collection. It is intended that the new Standards and the accompanying educational materials will result in greater consistency and improve comparability for future rounds of the collection.

### Feedback received

The Federation of Ethnic Communities' Councils of Australia and Austin Health noted the importance of improving cost allocation for language service provision in public hospitals as the higher cost of culturally and linguistically diverse patients is not currently reflected in the data. IHPA is developing business rules as part of Version 4 of the Australian Hospital Patient Costing Standards which will seek to improve cost allocation for interpreter services.

Austin Health and the Sunshine Coast HHS proposed changes to the National Hospital Cost Data Collection to increase the specificity of where and when costs are incurred, such as the separate reporting of intermediate products (such as the number of pathology tests), facility management and patient costs per day. The focus of the collection is the costing of patient products to support national activity based funding and IHPA considers that the added complexity of these proposals would place an undue administrative burden on jurisdictions.

Medtronic advised that IHPA should support public hospitals in better understanding their cost of care and how it compares nationally. IHPA has developed the [National Benchmarking Portal](#) for this purpose. The Portal is a secure web based application which provides system and hospital managers with access to public hospital cost data for benchmarking purposes.

### IHPA's decision

The Australian Hospital Patient Costing Standards Version 3.1 are to be used in Round 20 of the National Hospital Cost Data Collection.

### Next steps and future work

IHPA intends to release Version 4 of the Australian Hospital Patient Costing Standards in 2017 for use in future rounds of the National Hospital Cost Data Collection. IHPA will make an assessment of the magnitude of system changes required for Version 4 once they are finalised. This will inform the final implementation timeline.

# 6. THE NATIONAL EFFICIENT PRICE FOR ACTIVITY BASED FUNDED PUBLIC HOSPITAL SERVICES

## 6.1 TECHNICAL IMPROVEMENTS

IHPA has developed a robust pricing model that underpins the determination of the National Efficient Price (NEP). The model is described in detail in the [National Pricing Model Technical Specifications](#) on IHPA's website.

IHPA has not made any significant modifications to the National Pricing Model for 2017-18.

### 6.1.1 Pricing non-admitted services

Since 2012, the price weights for non-admitted services have been derived from a [comprehensive costing study of non-admitted services](#), which IHPA has calibrated against total expenditure reported by jurisdictions in the National Hospital Cost Data Collection.

IHPA adopted this approach due to deficiencies in the accuracy and consistency of costs for non-admitted services reported in the National Hospital Cost Data Collection by states and territories.

The reporting and accuracy of non-admitted costs in the National Hospital Cost Data Collection has improved over recent years and IHPA has considered whether the cost data collection is sufficiently mature to determine non-admitted price weights in NEP17.

### 6.1.2 Pricing mental health services

In the *Pricing Framework 2016-17*, IHPA foreshadowed its intention to use the new Australian Mental Health Care Classification for pricing mental health services from 1 July 2017. The classification includes the new data concept of 'mental health phase of care' which is a prospective assessment of a patient's needs defined by patient characteristics and the associated goals of care.

Reporting of activity and cost data for 'mental health phase of care' varies across jurisdictions. IHPA expects that phase level cost data will be reported by all jurisdictions for the 2017-18 National Hospital Cost Data Collection, which forms the basis for NEP20.

IHPA has undertaken work on an approach to pricing a subset of mental health care using the new classification for NEP17. IHPA's focus at this time is on pricing admitted mental health care as there is very limited community mental health data in the National Hospital Cost Data Collection.

Pricing admitted mental health care using the new classification from NEP17 is reliant on IHPA identifying a suitable proxy for 'mental health phase of care' which was not collected in the 2014-15 National Hospital Cost Data Collection, which forms the basis of the NEP17 Determination.

IHPA has linked National Outcomes and Casemix Collection data with Admitted Patient Care National Minimum Data Set activity and cost data in order to identify many of the clinical and outcomes measures necessary to classify admitted mental health consumers. However, this

data collection does not include 'mental health phase of care' and IHPA has since investigated the feasibility of determining an appropriate proxy for this data element for the purpose of pricing admitted mental health consumers using the classification.

### **Feedback received**

#### Pricing non-admitted services

New South Wales, Victoria, the Northern Territory and South Australia supported using non-admitted costs as reported in the National Hospital Cost Data Collection to determine price weights for non-admitted services in NEP17. Given significant improvements in the completeness and accuracy of non-admitted costs as reported in the National Hospital Cost Data Collection in recent years, IHPA considers that it is fit for use to determine price weights for the vast majority of non-admitted services in NEP17.

#### **IHPA's decision**

In 2017-18 IHPA will use the National Hospital Cost Data Collection as the primary source of cost data to determine most of the price weights for non-admitted services for NEP17.

#### Pricing mental health services

New South Wales, Western Australia, South Australia, the Australian Capital Territory and the Western Australian Mental Health Commission (WA MHC) did not consider that a suitable proxy for 'mental health phase of care' had been identified which could support pricing a subset of admitted mental health consumers in NEP17. In the absence of identifying a suitable proxy, pricing in 2017-18 could lead to a large number of episodes grouping to the unknown end-classes and it may deter providers from implementing the phase of care variable.

New South Wales supported ongoing work to identify an appropriate proxy for 'mental health phase of care.' Victoria suggested the IHPA should review the merits of conducting further investigation into pricing mental health services using a proxy for 'mental health phase of care.'

New South Wales, Western Australia, Tasmania and Victoria support retaining the approach to pricing mental health service used in 2016-17.

#### **IHPA's decision**

IHPA's approach to pricing mental health services in 2017-18 will remain unchanged from 2016-17. Admitted mental health services will continue to be priced using the Australian Refined Diagnosis Related Groups classification system, whilst non-admitted mental health services will be block funded.

### **Next steps and future work**

IHPA will continue to investigate an appropriate proxy for 'mental health phase of care' in 2017 to inform NEP18, ahead of full implementation of the Australian Mental Health Care Classification for pricing once phase-level cost and activity data is available from states and territories.

## **6.2 ADJUSTMENTS TO THE NATIONAL EFFICIENT PRICE**

### **6.2.1 Overview**

Section 131(1)(d) of the *National Health Reform Act 2011* requires IHPA to determine "adjustments to the NEP to reflect legitimate and unavoidable variations in the costs of delivering health care services". Clause B13 of the National Health Reform Agreement

additionally states that IHPA “must have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery including hospital type and size; hospital location, including regional and remote status; and patient complexity, including Indigenous status.”

IHPA tests whether there are empirical differences in the cost of providing public hospital services in order to determine whether there are legitimate and unavoidable variations in the costs of service delivery that may warrant an adjustment to the NEP. IHPA’s decisions are based on national data sources.

IHPA will examine patient-based characteristics in the cost of providing public hospital services as a first priority before considering hospital or provider-based characteristics. This policy reinforces the principle that funding should follow the patient wherever possible.

IHPA will continue to review its existing adjustments, with the aim of discontinuing adjustments associated with input costs or which are facility-based when it is feasible.

IHPA developed the [Assessment of Legitimate and Unavoidable Cost Variations Framework](#) in 2013 to assist state and territory governments in making applications for consideration of whether a service has legitimate and unavoidable cost variations not adequately recognised in the National Pricing Model. If agreed, IHPA then determines whether an adjustment to the NEP is necessary to account for the variation. Jurisdictions may continue to propose potential unavoidable cost variations under the Framework on an annual basis.

## **6.2.2 Adjustments to be evaluated for NEP17**

HPA has analysed the proposals for adjustments which were identified and canvassed in the *Pricing Framework Consultation Paper*. IHPA’s position on the proposals and stakeholder feedback is provided below.

### **Patient Remoteness Area Adjustment**

The Northern Territory proposed that costs relating to emergency medical inter-hospital transfers to interstate hospitals constitute a legitimate and unavoidable cost variation and could be better recognised through amending the current adjustments to the NEP. These interstate transfers to other hospitals may be required where a jurisdiction lacks the facilities to treat a complex patient due to economies of scale or other factors relating to remoteness.

IHPA notes that these costs do not appear to be adequately recognised due to the trimming of some high cost outlier episodes when calculating the NEP, price weights and adjustments.

In the *Pricing Framework Consultation Paper*, IHPA proposed that all high cost outlier episodes be included in the calculation of the Patient Remoteness Area Adjustment for NEP17. This will marginally increase the size of the adjustment to reflect the very high costs incurred by some regional and remote patients.

IHPA has also investigated altering the methodology used to determine patient remoteness. Specifically, IHPA considered if patient location as defined using the Australian Bureau of Statistics’ [Statistical Area 2](#) classification would be a more accurate initial indicator of patient remoteness than postcode given that some postcodes encompass an expansive area, particularly in remote and very remote areas of Australia.

### **Feedback received**

The Queensland Health Services Chief Executive (HSCE) Forum, North West HHS, WHA and CHcA supported IHPA’s proposal to include high cost outlier episodes in the calculation of the Patient Remoteness Area Adjustment. While they were not opposed, New South Wales, Western Australia and the Australian Healthcare and Hospitals Association (AHHA) considered that this would have a minimal impact on addressing the issue of unavoidable costs incurred by hospitals in transferring patients interstate or long distances.

The Northern Territory considered that the proposed approach of including high cost outlier episodes in the calculation of the Patient Remoteness Area Adjustment fails to fully recognise large unavoidable costs associated with interstate hospital transfers. In response, the Northern Territory have proposed that interstate transfer hospital episodes be removed from the calculation of the NEP and associated adjustments and instead be funded on a block funded basis. IHPA notes that under the National Health Reform Agreement services are to be subject to Activity Based Funding wherever practicable. IHPA will review this, and other approaches for NEP18.

Given stakeholder support, IHPA will include all high cost outlier episodes in the calculation of the adjustment in NEP17. IHPA will consider other unavoidable cost variations if jurisdictions provide submissions under the *Assessment of Legitimate and Unavoidable Cost Variations Framework*.

Queensland, Western Australia, South Australia, North West HHS, CHcA and the AHHA supported IHPA's proposal to use a patient's Statistical Area 2 as an initial indicator of patient remoteness, rather than postcode. The Northern Territory noted that recognising appropriate geography is central to appropriate funding. Given stakeholder support, IHPA will adopt this initial indicator of patient remoteness for NEP17.

#### Other proposed adjustments

Metro North HHS requested that IHPA consider an adjustment for admitted patients who undergo hyperbaric treatment as the additional cost of this specialised service is not adequately reflected in the price weights for the Diagnosis Related Groups which these patients group to. IHPA has examined this issue and identified that there is no cost differential at the national level for these patients.

The SHPA requested that IHPA consider adjustments based on patient age or comorbidities to reflect the additional cost of providing admitted patients with their other regular medicines. IHPA notes that the costs of these medicines, if supplied by the public hospital to the patient, should already be captured and reflected in the price. The Australian Refined Diagnosis Related Groups classification considers patient complexity and comorbidities when grouping admitted acute patients and this would likely account for the costs of other regular medicines.

Queensland noted that ICD-10-AM 9th edition for 2015-16 includes supplementary codes for chronic conditions which could be used to inform price weights and associated adjustments. An assessment of the impact of these new codes will be part of future Australian Refined Diagnosis Related Groups classification development once sufficient cost data is available.



### **IHPA's decision**

For NEP17 the Pricing Authority has determined to apply these evidence-based adjustments:

- Paediatric Adjustments for a person who is aged up to and including 17 years and is admitted to a Specialised Children's Hospital for admitted acute patients or treated in any facility for admitted subacute patients;
- Specialist Psychiatric Age Adjustment for a person who has one or more psychiatric care days during their admission, with the rate of adjustment dependent on the person's age and whether or not they have a mental health-related primary diagnosis;
- Remoteness Area Adjustment for a person whose residential address is within an area that is classified as being outer regional, remote, or very remote in the Australian Bureau of Statistics' Australian Statistical Geography Standard, with the rate of adjustment dependent on the person's geographical classification;
- Indigenous Adjustment for a person who identifies as being of Aboriginal and/or Torres Strait Islander origin;
- Radiotherapy Adjustment for a person with a specified ICD-10-AM 10th edition radiotherapy procedure code recorded in their medical record;
- Dialysis Adjustment for an admitted acute patient who receives dialysis whilst admitted to hospital for other causes (and are not assigned to the AR-DRG L61Z Haemodialysis or AR-DRG L68Z Peritoneal Dialysis);
- Intensive Care Unit Adjustment for an admitted acute patient who has spent time within a Specified Intensive Care Unit;
- Private Patient Service Adjustment and Private Patient Accommodation Adjustment for admitted private patients;
- Multidisciplinary Clinic Adjustment for patients which have a service event involving three or more health care providers (each of a different specialty) in the non-admitted setting; and
- Emergency Care Age Adjustment is for patients who present to an Emergency Department or Emergency Service, with the rate of adjustment dependent on the person's age.

Specific details for these adjustments are included in the NEP17 Determination.

### **Next steps and future work**

IHPA will continue to undertake a program of work to establish the factors resulting in legitimate and unavoidable variations in the costs of providing public hospital services. IHPA will continue to review its existing adjustments as classification systems improve, with the aim of discontinuing adjustments associated with input costs or which are facility-based when it is feasible to do so.

## **6.3 STABILITY OF THE NATIONAL PRICING MODEL**

Price weights vary across years for many reasons, such as changes in the cost of services. IHPA generally restricts year-to-year changes in price weights to 20 per cent in recognition that large fluctuations in price weights between years can have a negative impact on the stability of funding for public hospital services.

IHPA considers that the National Pricing Model is relatively stable across years. For example, the vast majority of Diagnosis Related Group price weights did not fluctuate by more than 10 per cent between NEP14 and NEP15 (see [Table 1](#)).

**Table 1: Change in price weights between NEP14 and NEP15**

Percentage change in inlier price between NEP14 and NEP15	Number of DRGs
Less than -20%	7
-20% to -10%	61
-10% to 0%	407
0% to 10%	159
10% to 20%	13
Over 20%	10

However, IHPA has considered whether movements in price weights from year-to-year should be further restricted and sought stakeholder feedback through the *Pricing Framework Consultation Paper*. This may improve the stability of funding for health services across years, but would mean that the price weights may be less reflective of the actual cost of those services.

### Feedback received

Queensland, Western Australia, South Australia, Tasmania, the Northern Territory, the Australian Capital Territory, Austin Health, Gold Coast HHS and Catholic Healthcare Australia (CHA) supported IHPA's current approach of restricting year-on-year movements in price weights only where they exceed 20 per cent. Stakeholders noted that further restrictions would prevent prices from reflecting meaningful shifts in actual patient costs.

Queensland, Sunshine Coast HHS and Medtronic noted that there could be circumstances where year-on-year changes in price weights of greater than 20 per cent is justified, such as due to changes in clinical practice. It was proposed that IHPA could consider provide explanatory notes for increased clarity where a decision was made to allow for a significant variance in price weights between years due to these circumstances.

Metro North HHS, AHSA, WHA, CHcA and the AHHA supported greater restriction on year-on-year changes in price weights to reduce the volatility of funding for health services. Stakeholders were concerned that the volatility can have an unintended adverse impact on health service delivery and that allowing significant yearly changes in price weights does not consider the lack of visibility at the frontline and the time it takes to enact change or innovate.

Victoria supported broader application of the national pricing model stability policy to services with a high patient volume such as renal dialysis, chemotherapy, lens procedures and obstetrics in response to concerns regarding variation in some national price weights. Under the current [National Pricing Model Stability Policy](#), classes with greater than 1,000 episodes are not stabilised. [IHPA will review this threshold in future years to ensure that variations in price weights reflect legitimate changes in actual costs of service provision.](#)

Victoria and the National Health Funding Body (NHFB) also provided circumstances where greater restriction on changes in price weights could be justified. These included where it unfairly impacts on one jurisdiction or a small group of hospitals, the impacted Diagnosis Related Groups are high volume or cost, or where it is due to a new classification version.

### **IHPA's decision**

IHPA will continue to stabilise year-on-year changes in price weights where they exceed 20 per cent in accordance with its [National Pricing Model Stability Policy](#).

### **Next steps and future work**

IHPA will undertake work in 2017 to better understand the drivers behind year-on-year fluctuations in Diagnosis Related Group price weights of greater than 20 per cent and the impact this may have on individual LHNs.

# 7. SETTING THE NATIONAL EFFICIENT PRICE FOR PRIVATE PATIENTS IN PUBLIC HOSPITALS

## 7.1 OVERVIEW

The National Health Reform Agreement requires IHPA to set the price for admitted private patients in public hospitals accounting for payments made by other parties including private health insurers (for prosthesis and the default bed day rate) and the Medicare Benefits Schedule.

Under the terms of the Agreement (Clause A6 and A7), IHPA does not price private non-admitted patient services.

## 7.2 COSTING PRIVATE PATIENTS IN PUBLIC HOSPITALS

The collection of private patient medical expenses is problematic in the National Hospital Cost Data Collection. For example, there is a common practice in some jurisdictions of using Special Purpose Funds to collect associated revenue and reimburse medical practitioners.

These funds do not always appear in hospital accounts used for costing in the National Hospital Cost Data Collection. This leads to an under attribution of total medical costs across all patients as costs associated with medical staff are applied equally across public and private patients.

In NEP15 IHPA corrected for this issue by inflating the cost of all patients (the ‘private patient correction factor’) to account for missing costs using data from the Hospital Casemix Protocol which enables more specific identification of missing private patient medical costs.

The use of the correction factor assumes that all private patient costs are missing and that these costs are spread across both private and public patients which is not always the case. For example, some hospitals appear to report specialist medical costs for private patients, whilst others may have costs missing from both public and private patients.

In order to improve the accuracy of the correction factor, IHPA sought advice from states and territories on which public hospitals report private medical costs in the National Hospital Cost Data Collection. IHPA was advised that 67 hospitals included private patient costs in the collection and did not require application of the correction factor. This advice was taken into account in calculating the correction factor for NEP16 and NEP17.

### 7.2.1 Phasing out the private patient correction factor

The private patient correction factor was introduced as an interim solution for the issue of missing private patient costs in the National Hospital Cost Data Collection. Submissions in response to the *Pricing Framework Consultation Paper 2016-17* supported the phasing out the correction factor when it is feasible to do so.

IHPA released Version 3.1 of the Australian Hospital Patient Costing Standards in late 2014 for states and territories to use from Round 18 (2013-14) of cost data collection. This version of the standards allows for a significant improvement in the way private patient costs are

captured. Full compliance with the standards would allow for phasing out of the correction factor in the future.

IHPA intends to phase out the correction factor for NEP18 if it is feasible to do so. This date reflects two years after the implementation of Version 3.1 of the Standards and should provide enough lead time for states and territories to fully comply with the requirement to report private patient medical costs in the cost data collection.

IHPA also continues to develop Version 4 of the Standards with an expected completion date of 2017. This will include supporting materials which should assist states and territories in interpreting the standards, including in the reporting of private patient medical costs.

### 7.3 PRICING PRIVATE PATIENTS

IHPA deducts payments made by insurers and the Medicare Benefits Schedule for services delivered to private patients. This revenue is deducted to prevent the hospital being paid twice for each private patient – once by the revenue source and a second time by the Commonwealth under the Agreement. IHPA will continue this approach for NEP17.

IHPA also works with jurisdictions to regularly review activity data to examine the utilisation of public hospitals by private patients in order to detect any emerging trends. IHPA notes that the growth in private patient utilisation of public hospitals does not appear to have varied significantly from the historical growth trend. In late 2016 IHPA commissioned an independent review of historical activity data and jurisdictional approaches to pricing private patients to empirically assess what impact, if any, the national activity based funding model has had on the utilisation of private health insurance by patients in public hospitals.

The independent review of the utilisation of private health insurance in public hospitals has been completed. The review has concluded that:

- Separations in public hospitals where patients utilised their private health insurance have increased by an average of 10.3 per cent per annum resulting in an increase of 4.4 per cent in the proportion of public hospital separations funded by private health insurance between 2008-09 and 2014-15.
- There is considerable variation in the proportion of public hospital separations funded by private health insurance between jurisdictions, with strong growth in Queensland and Tasmania since 2008–09, noting also that New South Wales have historically had a higher rate of private health insurance utilisation in public hospitals than other jurisdictions.
- Jurisdictional private patient targets and their promotion of the benefits of private patient election in public hospitals appears to be a contributor to the growth in privately funded public hospital separations.
- The national activity based funding model has not been a significant driver in the upward trend in privately funded public hospital separations, particularly as a number of jurisdictions have not implemented or have mitigated the size of the Private Patient Service Adjustment and the Private Patient Accommodation Adjustment.

#### Feedback received

The Commonwealth, Victoria, Queensland, Western Australia, the Northern Territory, Sunshine Coast HHS, Metro North HHS, the AHHA, Alfred Health, CHcA and WHA supported phasing out the private patient correction factor in 2018-19 if it is feasible to do so.

New South Wales, South Australia, Tasmania, the Australian Capital Territory and Austin Health supported retaining the private patient correction factor until Version 4 of the

Australian Hospital Patient Costing Standards has been implemented or when private patient medical costs are fully captured in the National Hospital Cost Data Collection.

**IHPA's decision**

IHPA will continue to apply the private patient correction factor for 2017-18.

**Next steps and future work**

The costing of private patients is a priority area for improvement in the development of Version 4 of the Australian Hospital Patient Costing Standards and IHPA will work with jurisdictions to further refine the approach for capturing these costs in the future.

# 8. TREATMENT OF OTHER COMMONWEALTH PROGRAMS

## 8.1 OVERVIEW

Under Clause A6 of the National Health Reform Agreement, IHPA is required to discount funding that the Commonwealth provides to public hospitals through programs other than the Agreement 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 including:

- Highly Specialised Drugs (Section 100 funding)
- Pharmaceutical Reform Agreements – Pharmaceutical Benefits Scheme Access Program
- Pharmaceutical Reform Agreements – Efficient Funding of Chemotherapy (Section 100 funding)

IHPA will not change the treatment of these programs for NEP17.

IHPA continues to work with jurisdictions to investigate how blood costs can more accurately be captured in the National Hospital Cost Data Collection for future years.

### **IHPA's decision**

IHPA will maintain the existing approach of removing blood costs and Commonwealth pharmaceutical program payments from the National Hospital Cost Data Collection prior to determining NEP17.

### **Next steps and future work**

IHPA will continue to work with jurisdictions and other stakeholders to develop an improved approach to the treatment of blood and blood products costs in future years.

# 9. BUNDLED PRICING FOR MATERNITY CARE

## 9.1 OVERVIEW

Like many activity based funding systems internationally, IHPA has generally adopted an approach to pricing hospital services based on discrete episodes of care. IHPA recognises that there is potential to move to bundled pricing approaches for some services, where a single price across settings of care is determined. This potentially gives hospital managers greater room to develop innovative models of care for these patient groups, without being deterred by pricing models based around traditional care settings.

IHPA also recognises that bundled pricing for chronic conditions can significantly reduce the bureaucratic overhead associated with reporting activity on a regular basis. Therefore IHPA introduced bundled pricing for a number of home-delivered chronic disease services in NEP15 and these price weights will be retained for NEP17.

In the *Pricing Framework 2016-17*, IHPA advised that it would investigate bundled pricing as an alternative approach for pricing public hospital services.

Following consideration of feedback on the *Pricing Framework Consultation Paper 2016-17*, IHPA decided to consider the potential for a bundled price for maternity services. In 2016, an advisory group was established comprised of representatives of jurisdictions, clinicians and representatives from Women's and Children's Healthcare Australasia, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Australian College of Midwives and Maternity Choices Australia.

IHPA is proposing to continue work on the development of a bundled pricing approach for maternity services during the year with a view to implementation in NEP18.

IHPA considers that maternity care is amenable to bundled pricing as it has relatively predictable service utilisation with clear starting (at ten weeks gestation) and concluding (at six weeks postpartum) points to episodes, and is high volume with over 220,000 admitted acute separations in public hospitals for birth and over two million antenatal or postnatal visits to the non-admitted midwifery and obstetrics clinics in 2014-15, totalling \$1.5 billion in the admitted setting and \$413 million across non-admitted services.

Bundled pricing approaches for maternity care are being implemented in New Zealand, Canada, the United States of America and England. The models vary across jurisdictions and whilst these schemes are in their infancy and evaluation has been limited, there is emerging evidence that bundled pricing provides an incentive for service delivery redesign which can improve patient outcomes and lead to efficiencies for the health system.

### Feedback received

IHPA sought feedback through the *Pricing Framework Consultation Paper* on its proposal to introduce a bundled price for maternity care in NEP18 if feasible.

The Medtronic and the HCCA supported IHPA's intention to introduce a bundled price for maternity care in NEP18 if feasible, noting that a bundled price could provide the financial flexibility to support the introduction of innovative models of patient care, reduce unwarranted variation and provide safe, high quality maternity care at a lower cost to the public hospital system.



New South Wales, South Australia, the Metro North HHS, the Queensland Nurses Union (QNU) and WHA provided in-principle support for the introduction of a bundled price for maternity care. This support was conditional on clarification on the scope of patients and services in the bundle, as well as the resolution of implementation issues. The Commonwealth, Victoria, CHA, Tasmania and the Australian Medical Association (AMA) provided their support for further exploratory work.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the AHHA, the Gold Coast HHS and the HSCE Forum did not support the introduction of a bundled price due to concerns regarding whether it would lead to meaningful change in clinical practice and as it could lead to the underfunding of complex maternity patients.

Queensland and the Australian Capital Territory recommended caution regarding the introduction of a bundled price for maternity care given limited evaluation of these approaches overseas and difficulty in identifying the complete service delivery profile of maternity patients.

Queensland, Western Australia, Medtronic, the AMA and the QNU advised that the bundled price for maternity care should reflect evidence-based models of care, rather than setting the bundled price at the average cost of a maternity patient, and it could include quality measures.

IHPA received a variety of responses on the scope of bundled price for maternity care, as well as implementation issues which should be addressed prior to introducing a bundled price. These responses will be referred to the Bundled Pricing Advisory Group for its consideration.

#### **IHPA's decision**

IHPA will continue to develop a bundled pricing approach for maternity care, with a target date for introduction of 1 July 2018.

#### **Next steps and future work**

IHPA will work with the Bundled Pricing Advisory Group to develop appropriate bundled pricing models, taking into account the feedback received on the *Pricing Framework Consultation Paper*. IHPA will consult further once a draft model is designed.

# 10. SETTING THE NATIONAL EFFICIENT COST

## 10.1 NATIONAL EFFICIENT COST 2017-18

IHPA developed the National Efficient Cost (NEC) for hospitals with activity levels which are too low to be suitable for funding on an activity basis, such as small rural hospitals. These hospitals are funded by a block allocation based on their size, location and the type of services which they provide.

For NEC15, IHPA introduced new 'low volume' thresholds to determine whether a public hospital is eligible to receive block funding. IHPA considered the underlying data to be sufficiently robust to include all activity in the low volume threshold and not just the admitted acute activity. IHPA will retain this approach for NEC17.

IHPA uses the public hospital expenditure reported in the National Public Hospital Establishments Database to determine the NEC for block funded hospitals.

This data collection predated the introduction of activity based funding nationally and its existing structure (up to and including 2013-14) did not differentiate between expenditure considered in-scope under the National Health Reform Agreement and other expenditure.

For past NEC Determinations, IHPA has carried out significant modelling to identify out of scope expenditure in the data collection. This was problematic in developing NEC16 due to significant volatility in the proportion of in-scope compared to out of scope expenditure across years. To ensure a consistent block funding growth rate across years, IHPA held the proportion of in-scope expenditure stable between NEC15 and NEC16 as an interim measure.

In 2013, IHPA commissioned the Australian Institute for Health and Welfare to redevelop the data collection to allow for clearer reporting of in-scope expenditure by care stream, which means that modelling by IHPA is no longer required. This work has been completed and will be reflected in the 2014-15 National Public Hospital Establishments Database.

IHPA expects that the improvements to the data collection will lead to some block funded hospitals changing their group, which is used to determine their efficient cost in NEC17.

## 10.2 TEACHING, TRAINING AND RESEARCH

For NEC16, IHPA determined block funding amounts for teaching, training and research activity in activity based funded hospitals based on jurisdictional advice. IHPA will continue this approach in NEC17 and until such time that an activity based funding is implemented for teaching and training or research.

## 10.3 NON-ADMITTED MENTAL HEALTH SERVICES

For NEC16, IHPA determined block funding amounts for non-admitted mental health activity in activity based funded hospitals based on jurisdictional advice. IHPA will continue this approach in NEC17 and until such time that non-admitted mental health services are incorporated into the Australian Mental Health Care Classification.

### Feedback received

Stakeholders were generally supportive of minimal changes to the NEC for 2017-18.

The South West HHS recommended that IHPA create a hospital grouping for small rural hospitals which are in remote areas as their cost of clinical service provision is higher than for block funded hospitals in coastal and metropolitan areas. IHPA considers that the type of services which the block funded hospital delivers is more reflective of their costs, with the exception of very remote hospitals which have their own efficient cost grouping in the NEC.

#### **IHPA's decision**

IHPA will continue the methodology used in NEC16 for determining NEC17.

For NEC17 IHPA will continue to block fund teaching, training and research expenditure in activity based funded (ABF) hospitals, non-admitted mental health services and non-ABF services on the 'A17 List'.

#### **Next steps and future work**

IHPA will continue to explore refinements to the NEC model in future years, with the intention of further improving the model's stability and predictability within and between hospital groupings.

# 11. PRICING AND FUNDING FOR SAFETY AND QUALITY

## 11.1 CONTEXT AND DEVELOPMENT OF PRICING FOR SAFETY AND QUALITY

In April 2016 all Australian governments signed a Heads of Agreement that committed to improve Australians' health outcomes and decrease avoidable demand for public hospital services through a series of reforms including the development and implementation of funding and pricing approaches for safety and quality.

Subsequently, the then Commonwealth Minister for Health and Aged Care, acting under subsection 226(1) of the National Health Reform Act 2011 directed IHPA to advise the COAG Health Council on an option or options for a comprehensive and risk adjusted model to determine how funding and pricing could be used to improve patient outcomes across three key areas: sentinel events, hospital acquired complications and avoidable hospital readmissions (see **Appendix A**).

The *Consultation Paper on the Pricing Framework for Public Hospital Services 2017-18*, released on 30 September 2016, contained analysis and proposed options for stakeholder comment. Over the consultation period IHPA received 44 submissions from a range of interested parties including the Commonwealth, states and territories and the Australian Commission on Safety and Quality in Health Care (the Commission). On 30 November 2016 IHPA provided advice to the COAG Health Council on options for the integration of safety and quality into public hospital pricing and funding models.

In February 2017, the Commonwealth Minister for Health, acting under section 226 of the National Health Reform Act 2011 directed IHPA to undertake implementation of three recommendations of the COAG Health Council relating to sentinel events, HACs and avoidable readmissions. The provisions of this Ministerial Direction (**Appendix B**) are reflected in the *Pricing Framework for Australian Public Hospital Services 2017-18*.

The commitment by governments to pricing for safety and quality follows a four-year work program jointly undertaken by IHPA and the Australian Commission on Safety and Quality in Health Care to undertake research and develop options for incorporating safety and quality into the Pricing Framework. One of the outcomes of this collaboration was the development, through a clinician-led process, of an agreed Australian list of HACs.

In developing and implementing funding and pricing models that respond to the Heads of Agreement and Ministerial Directions, IHPA has made it clear that pricing and funding models are only one element and that improvements to the safety and quality of health care require action on many fronts. IHPA's responsibility is to implement models that incorporate safety and quality into the pricing and funding of public hospital services. These pricing and funding approaches should complement other existing strategies to improve safety and quality under the leadership of the Commission and with the active participation of many other groups including clinical colleges, clinicians, state governments and health services.

## 11.2 SCOPE, CRITERIA AND RISK ADJUSTMENT

IHPA identified three core issues that underpin the development of all proposals to incorporate safety and quality into pricing.

The first issue is the scope of application of pricing for safety and quality. The pricing and funding approaches that have been developed reflect IHPA's intention that these models should be applied as broadly as possible across all types of public hospitals (ABF and block-funded), all services, all patients and all care settings.

The second issue is the criteria used to assess proposals for incorporating safety and quality into pricing. IHPA developed the following five criteria: preventability, equitable risk adjustment, proportionality, transparency and ease of implementation.

The third issue is the objective and basis of risk adjustment. IHPA notes the need to balance the perspectives of both hospitals and patients in incorporating safety and quality into pricing. Hospitals that treat high-risk patients should not be disadvantaged compared to hospitals that treat fewer such patients. Equally, high-risk patients should be able to have confidence that hospitals take all necessary action to manage their risks and mitigate the occurrence of adverse events. Risk adjustment can be implemented at the level of individual patient episodes (through adjustments for factors such as age and patient complexity) or at the level of hospitals (through stratifying hospitals into peer groups or states).

### Feedback received

#### *Scope of application of pricing for safety and quality*

There was general support for pricing for safety and quality to apply as comprehensively as possible (Commonwealth, Australian Capital Territory, AMA, Tasmania). Some states suggested deferring the application of pricing for safety and quality for emergency, outpatient and mental health services pending implementation of new classifications and investment in health data systems (South Australia, New South Wales, Victoria).

Some submissions raised questions about how pricing for safety and quality would be operationalised for block funded hospitals (the National Health Funding Body (NHFB), South Australia, Tasmania, AMA). The NHFB noted that safety and quality funding adjustments would require reconciliation of block funded hospitals. Queensland favoured consideration of applying pricing for safety and quality to block funded hospitals, as this would signal that quality of care is important in all hospitals, regardless of size. Victoria supported limiting the application of pricing for safety and quality to the admitted acute setting in the short to medium term on the basis that there is variability in the level of implementation of ABF across jurisdictions.

### **IHPA's decision**

Consistent with the Ministerial Direction, the scope of measures for sentinel events will include all episodes of care (all streams) in both ABF and block funded hospitals while the scope of measures for HACs will include acute admissions across all public hospitals.

#### *Criteria for assessing options for pricing for safety and quality*

Many submissions supported the five criteria that IHPA had used in assessing options for incorporating safety and quality into pricing (Commonwealth, Western Australia, Queensland, Australian Capital Territory, New South Wales, Children's Health Queensland, SHPA, AMA).

Organisations also identified other potentially important factors in developing and assessing pricing options including: the evidence-basis (Catholic Health Australia); the level of consumer engagement (Health Care Consumers' Association ACT); the actionability by clinicians (New South Wales); supporting hospitals to accurately report patient-level quality

and safety data (Victoria); the need to harmonise the financial impact with the cost of unacceptable patient health outcomes (Australian Capital Territory); budget certainty and predictability of resource allocation for states (Victoria); funding certainty for hospitals and LHNs (Queensland); the extent to which options integrate with broader safety and quality measures (AMA, the Commission); whether options drive value-based care (New South Wales); and the appropriateness of metrics of safety and quality to the setting and care type (the Commission).

### ***IHPA response***

IHPA has refined the criteria slightly in response to the feedback. The box below includes the final assessment criteria that IHPA will use in the development and assessment of options for pricing for safety and quality, both in the 2017-18 Pricing Framework and in the future.

#### **Assessment Criteria**

**Preventability:** Pricing and funding approaches should be based on good evidence of the preventability of each safety and quality measure being considered.

**Equitable risk adjustment:** Pricing and funding approaches should balance the likelihood that some patients will be at higher risk of experiencing an adverse event while recognising that all hospitals have scope to improve safety and quality.

**Proportionality:** Adjustments to the pricing and/or funding of public hospital services should be commensurate with the additional costs incurred as a result of diminished safety and quality.

**Transparency:** The design of pricing and funding approaches to safety and quality should be transparent to encourage action by clinicians, hospital management and governments and to support engagement by consumers and patients.

**Ease of implementation:** The implementation of pricing and funding approaches should be straightforward, and not result in undue administrative burden on any part of the system (for example, jurisdictions or the Administrator of the National Health Funding Pool).

#### *Risk adjustment of pricing for safety and quality*

States and health provider organisations wanted to ensure that pricing for safety and quality did not create incentives for hospitals to avoid treating high risk patients. Victoria suggested that a nuanced approach to risk adjustment may be required with consideration given to different risk adjustment thresholds for each type of HAC.

Submissions identified many patient-specific factors for possible incorporation in risk adjustment including: age, gender, Indigenous status, ethnicity, rural and remote location, principal diagnosis, patient complexity (through, for example, episode clinical complexity scores), co-morbidities, health behaviours, functional ability and socio-economic status.

Many states and health provider organisations supported stratification of hospitals within peer groups in order to minimise funding risk for hospitals that treated more high-risk patients (South Australia, Victoria, Commonwealth, SHPA). Queensland commented that it did not support stratification of hospitals within a state as this implied that it would be acceptable to have differences in patient outcomes between states.

### ***IHPA response***

Issues about the most suitable approach to risk adjustment are examined for each of the safety and quality measures in the following sections.

## 11.3 SENTINEL EVENTS

Sentinel events are a subset of adverse events that result in death or serious harm to patients. The national set of eight sentinel events, agreed to by Australian Health Ministers in 2002 and reported annually since 2004-05, comprise of:

- procedures involving the wrong patient or body part resulting in death or major permanent loss of function;
- suicide of a patient in an inpatient unit;
- retained instruments or other material after surgery requiring re-operation or further surgical procedure;
- intravascular gas embolism resulting in death or neurological damage;
- haemolytic blood transfusion reaction resulting from ABO [blood type] incompatibility;
- medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs;
- maternal death associated with pregnancy, birth and the puerperium; and
- infant discharged to the wrong family.

Sentinel events are not currently reported in administrative datasets. Jurisdictions will be required to separately report any episode including a sentinel event to IHPA and the Administrator. IHPA further notes that the Commission is currently reviewing sentinel events to improve consistency in their reporting.

### Feedback received

There was broad support from many governments (the Commonwealth Government, New South Wales, Victoria, Queensland, the Northern Territory and the Australian Capital Territory) and peak organisations (the Commission, AMA, AHHA and Catholic Health Australia) for the proposal to not fund episodes that include a sentinel event. In support of not funding sentinel events, the Commission, New South Wales, the Australian Capital Territory and Queensland Health Services Chief Executives cited the extremely serious patient outcomes and severe medical consequences associated with sentinel events, while the Northern Territory noted the important signal sent by implementing a policy of not funding sentinel events.

The preventability of some sentinel events including maternal death and/or inpatient suicide was questioned by Western Australia, Women's Healthcare Australasia, Queensland Nurses' Union and AHHA. Queensland suggested that at least half of sentinel events are not preventable. However, Victoria noted that while some sentinel events such as suicide may be impossible to eliminate, hospitals can reasonably be expected to take action to prevent sentinel events. Tasmania, Queensland, South Australia and Western Australia suggested that the Commission review might narrow the list of sentinel events to those that are wholly preventable.

Two submissions (Western Australia and Queensland Metro North HHS) proposed that funding adjustments should only relate to the costs incurred from the time that the sentinel event occurred during an episode of care, with prior care in the episode continuing to be funded.

Feedback was also provided on implementation issues including IHPA's proposal that in the longer term that jurisdictions apply a flag to any episode including a sentinel event to IHPA and the Administrator. Jurisdictions identified issues with this approach (South Australia, New South Wales). Victoria canvassed different approaches to the supply of these data in the short-term (manual offline submission), medium-term (inclusion of a flag in national minimum datasets) and long-term (supply of new data files).

The Commission noted that its current review was intended to improve consistency in national reporting of sentinel events. It suggested that implementation of a policy of not

funding sentinel events would be assisted by the release of a guide including definitions and rules. Most jurisdictions were strongly supportive of improving consistency in defining and reporting sentinel events.

### ***IHPA response against the assessment criteria***

The following table shows IHPA’s final assessment of the sentinel events funding option, informed by consultation feedback, against the refined Assessment Criteria.

### **IHPA assessment: No funding for episodes with a sentinel event**

Criteria	Assessment
<b>Preventability</b>	<b>Fully meets this criterion</b> – sentinel events are wholly preventable
<b>Equitable risk adjustment</b>	<b>Fully meets this criterion</b> – risk adjustment is not required; sentinel events have serious consequences for patients; hospitals should take action to reduce sentinel events across all patients, irrespective of patient-based risk factors
<b>Proportionality</b>	<b>Partially meets this criterion</b> – the funding reduction is for the whole episode, not just the sentinel event; current data systems do not support splitting costs within an episode according to the timing of a sentinel event
<b>Transparency</b>	<b>Fully meets this criterion</b> – it is easy for clinicians and consumers to understand that there is no funding of a hospital event when a sentinel event occurs
<b>Ease of implementation</b>	<b>Partially meets this criterion</b> – there will be some initial work to identify how best to report episodes with a sentinel event; however, total number of sentinel events reported nationally is small

### **IHPA’s decision**

Consistent with the decision by COAG Health Council, there will be no funding for public hospital episodes that include a sentinel event that occur on or after 1 July 2017. This will apply to all episodes of care (all streams) in both ABF and block funded hospitals.

In implementing this approach, IHPA will have regard to the Australian Commission on Safety and Quality in Health Care’s review of sentinel events and monitor and review the reporting of sentinel events by States and Territories to ensure those events are adequately reported for the purposes of funding adjustments.

### **Next steps and future work**

IHPA will apply a funding adjustment to episodes with a sentinel event at both ABF and block funded hospitals. For block funded hospitals, the funding deduction associated with a sentinel event will be calculated by multiplying the National Efficient Price 2017-18 (NEP17) by the National Weighted Activity Unit 2017-18 NWAU(17) for that episode. For episodes that occur at ABF hospitals the NWAU(17) for episodes with a sentinel event will be set to zero.

Consistent with the National Pricing Model used to calculate NEP17, funding adjustments for sentinel events will be based on data from the 2014-15 financial year.

IHPA will continue to work with jurisdictions to identify the most effective approach for states and territories to report sentinel events to IHPA and the Administrator.



IHPA is participating in the Commission review of sentinel events. IHPA will consider the outcomes of this review including any refinements that improve national consistency in the definition and reporting of sentinel events.

## 11.4 HOSPITAL ACQUIRED COMPLICATIONS

HACs are complications which occur during a hospital stay and for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of their occurrence. Identification of most HACs is dependent upon the use of the Condition Onset Flag (COF). The COF is used to indicate whether a diagnosis was present on admission or hospital or occurred during an episode of care.

IHPA and the Commission established a Joint Working Party in 2012 which developed an agreed Australian list of HACs through a clinician-led process. HACs were selected using the criteria of preventability, patient impact (severity), health service impact and clinical priority. There has been subsequent field-testing in selected public and private hospitals, as well as further clinical refinement of the HACs list. The list of HACs (including a detailed specification of ICD-10-AM codes) is available on the Commission website.

In the Consultation Paper, IHPA put forward three alternative options for incorporating HACs into pricing and funding models:

- **Option 1:** The HAC would be 'removed' so it does not contribute to DRG assignment. This option would apply to the approximately 15 per cent of episodes with a HAC which would otherwise be assigned to a more complex DRG due to the presence of one or more HACs. As a result, funding for these episodes would be reduced. Risk adjustment would not be incorporated in this option. This is an episode-level funding approach that does not change the NEP.
- **Option 2:** Funding adjustments would be made on the basis of differences in HAC rates across hospitals. Funding reductions would be calculated for hospitals that exceed a specified threshold HAC rate. Risk adjustment would be incorporated in this option. This is a hospital-level funding approach that does not change the NEP.
- **Option 3:** This option includes both funding reductions and positive funding incentives that are calculated through a two-stage process. In the first stage, a new quality-adjusted NEP is calculated that is based on removing all episodes with HACs so that these do not feed into the determination of the NEP. This results in the NEP being reduced for all public hospital services. In the second stage, the funding reduction is used to provide funding incentives to hospitals with the best performance on HAC rates. This option combines an episode-level pricing approach that changes the NEP with a hospital-level funding approach.

Option 3 was discounted on the basis that it had limited stakeholder support, with many stakeholders arguing that the determination of a quality-adjusted NEP (through removing all episodes with HACs) was inequitable and not transparent, and that reliance on hospital-level HAC rates is inconsistent with IHPA's Pricing Framework in which pricing and funding are determined at the level of individual patient episodes.

In their submission, NSW proposed an alternate episode-level option. IHPA has since give consideration to a variation of this proposal in which all HACs across every hospital would have a reduced funding level, referred to as Option 3 from this point forward.

### Feedback received

#### *Basis of the HAC list*

In general, the HAC list was well-received with most stakeholders recognising the clinician-led process to develop the list over the last four years. While acknowledging this process,

Tasmania stated that there were significant issues with the HACs list and it should be subject to a detailed review. The AMA also proposed that the implementation of HAC pricing and funding models should be delayed until 2020 in order to allow further refinement and testing of the HAC list and that, at a minimum, there should be continuous assessment and evaluation of the HAC list.

Some stakeholders proposed that further work was required on the preventability of HACs. Western Australia proposed that there needed to be clinically informed refinement and definitive AR-DRG coding of the HAC list to capture only those conditions that are clearly and wholly preventable. A few submissions disagreed with, or queried, the inclusion of particular complications in the HAC list including neonatal birth trauma, third and fourth degree perineal lacerations (Women's Healthcare Australasia) and delirium (Professor Close).

Another identified issue was the interrelationship between preventability and risk assessment. Queensland suggested that risk adjustment should not be applied for events where there was a high level of preventability, citing never events and third and fourth stage hospital acquired pressure injuries as examples. Similarly, Victoria noted that not all risks (including pressure ulcers) should be risk-adjusted.

In relation to preventability, it was suggested that there may be benefit in an independent clinical peer review process that would essentially determine whether hospitals should be penalised for adverse outcomes if they were reasonably attributable to the quality of care provided by the hospital (Catholic Health Australia).

### ***IHPA response***

IHPA notes that the development of the HAC list was a clinician-led process and that this list was based on the best available evidence and clinical judgement on preventability. While not all HACs will always be preventable for all patients, the inclusion of complications on the HACs list sends a clear signal that action should be taken to reduce the occurrence of HACs.

Ongoing management of the HAC list is the responsibility of the Commission. IHPA will use the HAC list as published by the Commission.

The next sections provide feedback on two HAC options included in the Consultation Paper as well as the new episode level option based on the proposal by NSW. IHPA's response to these options against the assessment criteria is presented at the end of the consolidated feedback on all three options.

#### *Option 1: Remove the HAC so that it does not contribute to DRG assignment*

This option had reasonable support on the basis of its transparency, simplicity and relative ease of implementation for jurisdictions (Victoria, South Australia, Australian Capital Territory, Northern Territory, Catholic Health Australia), although several stakeholders suggested that this option could be improved by incorporating risk adjustment.

South Australia noted that states could monitor the incidence of HACs and likely associated costs and that this option was simple to understand and explain. Similarly, NSW noted that there was a clear linkage with clinical services as funding adjustments were made at the episode level. Medibank advised that Option 1 was most similar to its approach to contracting with private hospitals for safety and quality. Medibank observed that early trends had shown a declining trend in complication rates after the introduction of quality terms in its contracts, but noted that this had not yet been formally evaluated or assessed in terms of correlation and causality.

The most significant disadvantage of this option was that removing HACs only reduced payment for about 15 per cent of episodes with a HAC (Commonwealth, Australian Capital Territory, Children's Health Queensland HHS, Lorica Health). Queensland noted that this situation would result in no transparency for clinicians as to whether particular HACs would

result in a Commonwealth funding reduction or not. Since releasing the Consultation Paper, IHPA has undertaken further analysis of the approximately 85 per cent of episodes with a HAC that are not regrouped and do not experience a direct funding reduction under Option 1. This analysis has demonstrated that these episodes already have cost ratios great than one, meaning that hospitals incur costs above the NEP for these episodes.

Some groups queried whether the 'removal' of the HAC would lead to reduced transparency if hospital staff were not able to analyse hospital conditions at the local level (Children's Healthcare Australasia) or result in a loss of integrity for the NWAU as an activity measure (Peninsula Health). AHSA wanted to ensure the integrity of DRG weights across both the public and private sectors.

There was also direct or implicit support for this option to include some form of risk adjustment to ensure that hospitals that treated patients at high risk of HACs were not biased (South Australia, Victoria, New South Wales, Queensland).

#### *Option 2: Funding adjustments on the basis of differences in HAC rates across hospitals*

Supporters of this option believed that hospital-level funding adjustments could drive quality improvement as hospitals sought to reduce their HAC rates relative to other hospitals (Health Care Consumers' Association ACT). The Commonwealth suggested that hospital ranking would encourage innovation and competition while setting a benchmark for preventability. The RACP similarly noted that this option builds upon behavioural economics in using ranking and loss aversion to incentivise clinicians.

Other submissions supported measuring hospital HAC rates but suggested that any funding adjustments should relate to improvement over time in HAC rates for individual hospitals (Victoria, Melbourne Institute of Applied Economic and Social Research). The Commission also noted that options based on measuring HAC rates at the level of hospitals did not distinguish whether a patient has one or more HACs and that it would be important to communicate this information to hospital staff.

There were three frequently cited disadvantages of this option. The first disadvantage was that this option represented a fundamental shift away from IHPA's Pricing Framework in moving from episode-level and patient-centric funding adjustments to funding adjustments that were based on hospital-level differences in HAC rates (Australian Capital Territory). NSW suggested that hospital-level funding adjustments were too far removed for clinicians to see the linkage with their actions.

The second cluster of related disadvantages was that this option was particularly sensitive to differences in jurisdictional and hospital coding practices (Tasmania, Metro North HHS) and resulted in considerable funding and budgetary uncertainty for hospitals and jurisdictions (Victoria, Austin Health). This option creates considerable uncertainty for hospitals as each hospital's funding is linked to the unknown performance of other hospitals (both their actual level of HACs and the maturity of their coding systems in reporting HACs).

The third set of disadvantages relates to the basis on which the funding threshold would be determined. Without a scaled approach to funding adjustments, the use of funding thresholds would penalise hospitals above the threshold which may not differ significantly from hospitals just below the threshold (South Australia, Queensland). Setting a threshold of either the lowest quartile or the average HAC rate was viewed as arbitrary and did not necessarily bear any relationship to standards as to what comprised acceptable HAC rates (Queensland). Funding uncertainty also arose as the benchmark below which funding adjustments would be made is not absolute, but is relative to other hospitals (Northern Territory).

*Option 3: All HACs across every hospital would have a reduced funding level*

The Consultation Paper sought proposals for any other options by which HACs could be incorporated into pricing and/or funding models. One alternative option was received from New South Wales.

New South Wales proposed that HAC adjustments to the NWAU should be made, similar to existing adjustments for Indigenous status, geographic location and paediatrics. New South Wales proposed that this would involve calculating an adjustment factor for each DRG based on the cost difference between HAC and non-HAC episodes. This adjustment factor would be used to reduce the NWAU for episodes with one or more HACs within a particular DRG and increase the NWAU for episodes without a HAC within the same DRG.

New South Wales suggested that this approach was already risk-adjusted as it relied on DRG complexity rates, but it could be further risk-adjusted through incorporating age and complexity factors. New South Wales noted that additional refinements to this model were possible including capping adjustments (in line with IHPA's stability policy) and applying the adjustor only after an unacceptable rate of HACs has been reached (in line with the ongoing Commission work on preventability rates for each HAC).

Several jurisdictions (South Australia, Northern Territory, Queensland) expressed preliminary interest in this model. South Australia suggested that the model might meet its objectives of an administratively simple approach that provided clear price signals to clinicians. Queensland suggested that the New South Wales model could effectively risk adjust for casemix differences between hospitals and provide suitable incentives at the level of individual episodes of care.

***IHPA response against the assessment criteria***

Each option has its own advantages and disadvantages and no single option currently outperforms the other options on all of the assessment criteria.

IHPA notes the complex issues around the preventability and risk adjustment criteria, with these issues being common and reasonably similar across all four options. Not all HACs are wholly preventable for all patients with all conditions. While the HAC list was developed on the basis of preventability, there is no consensus on when and for which patients, HACs are preventable and the Commission is undertaking further work on this issue. On risk adjustment, IHPA has commissioned expert advice and has tested different risk-adjustment models.

IHPA has summarised the options using the assessment criteria outlined on page 38.

Criteria	Option 1	Option 2	Option 3
<b>Preventability</b>	<b>Partially meets</b> – Not all episodes change DRG, but those that do change DRG may not have been preventable.	<b>Potential to meet</b> – With appropriate clinical advice, preventability could be addressed in this option.	<b>Potential to meet</b> – With appropriate clinical advice, preventability could be addressed in this option.
<b>Equitable risk adjustment</b>	<b>Does not meet</b> – Difficult to risk adjust this approach, however as only one in seven episodes move DRG, risk adjustment may not be a necessary.	<b>Potential to meet</b> – A comprehensive risk adjustment approach is possible, though inter-jurisdictional coding practices are a significant challenge for this option.	<b>Potential to meet</b> – A comprehensive risk adjustment approach is possible.
<b>Proportionality</b>	<b>Partially meets</b> – Funding reductions for HACs assigned to a lower DRG are proportionate; the remaining episodes with a HAC do not receive a proportionate funding adjustment as costs are already higher than the NEP.	<b>Potential to meet</b> – Allows funding reductions to be targeted at hospitals with higher HAC rates, so there is a direct and proportionate relationship between incidence of HACs and funding penalties.	<b>Partially meets</b> – Good alignment between HACs and their costs; the NSW model increases the price of non-HAC episodes which significantly breaches the proportionality criterion as the price of non-HAC episodes would exceed their actual costs.
<b>Transparency</b>	<b>Partially transparent</b> – Price signal is inconsistent (as only 16% of episodes change DRG) and has the potential to be viewed as a “black box” approach. Also retrospective as the impact on DRG assignment is unknown until coding is completed following patient discharge.	<b>Potential to meet</b> – This option supports transparent reporting of HAC rates across hospitals and creates a clear link between hospital performance and funding reductions.	<b>Transparent</b> – Clear prospective price signal linking a funding reduction to the occurrence of each and every HAC.
<b>Ease of Implementation</b>	<b>Simple</b> – Requires relatively minor changes to grouper software. No impact on the Administrator’s reconciliation process.	<b>Moderate</b> – Requires development of risk adjustment methodology and changes to the Administrator’s reconciliation process.	<b>Moderate</b> – Requires development of risk adjustment methodology but no changes to the Administrator’s reconciliation process.

Since the release of the Consultation Paper in September 2016, IHPA has undertaken a significant program of work to investigate possible variations of Option 3. The NSW proposal includes both negative and positive funding adjustments related to the presence or absence, respectively, of a HAC. IHPA considers that the incorporation of positive funding adjustments is inconsistent with the Pricing Guidelines as this approach would result in episodes without a HAC being priced in excess of their costs.

The second issue is that the NSW model assumes that the adjustment factor would be calculated at the level of individual DRGs. Based on analysis of the incidence of HACs, calculating adjustments at the HAC level is more robust. These adjustments could be applied to individual episodes on the basis of the HAC reported in the episode.

On 30 November 2016 IHPA provided advice to the COAG Health Council regarding a recommended approach to HACs. IHPA recommended a variant of Option 3 (based on a proposal by New South Wales) in which all HACs across every hospital would face a reduced funding level to reflect the extra cost of a hospital admission with a HAC, including an approach to risk adjustment for shadow implementation from 1 July 2017. Under this option, the magnitude of the reduction would vary for each HAC.

### **IHPA's decision**

Consistent with the Ministerial Direction, IHPA will reduce the funding level, in line with the approach proposed in Option 3, for all hospital acquired complications across every hospital to reflect the extra cost of a hospital admission with a complication by 1 July 2018, subject to the results of a shadow year from 1 July 2017.

In implementing this approach, IHPA has been directed to:

- a) further refine the risk adjustment methodology prior to 1 July 2017;
- b) shadow the implementation of the HACs model to assess the impact on funding, data reporting, clinical information systems, and specific population and peer hospital groups;
- c) conduct public consultation on the findings of the shadow implementation and report to the COAG Health Council by 30 November 2017;

### **Next steps and future work**

IHPA will work to refine the risk adjustment methodology and progress shadow implementation of the HACs model from 1 July 2017. During the shadow year, IHPA will work to assess the impact of the HACs model. IHPA will report the findings to COAG Health Council by 30 November 2017.

#### *COF data quality issues and impact of funding options on COF reporting*

Submissions recognised the impact that differences in robust reporting of the COF (both between hospitals and between jurisdictions) had for the successful implementation of the HAC pricing and funding options (Tasmania, New South Wales, Western Australia, Victoria).

There were mixed views on how best to drive improvement in COF reporting. Some organisations favoured providing incentives to hospitals that met and/or exceeded reporting requirements (Queensland HS Chief Executives). Many jurisdictions wanted to ensure that there were no perverse incentives whereby states with the best COF reporting were penalised disproportionately to states with poorer COF reporting (South Australia, Victoria, Western Australia, New South Wales).

In advice to the COAG Health Council regarding the implementation of an approach to HACs, IHPA recommended that states and territories commit to a program of audit of

medical records and ICD-10-AM coding. Three governments (Commonwealth, Queensland, Tasmania) supported this recommendation on the basis that it would improve the reporting of HACs. Victoria noted that it has a comprehensive audit program across its data collection and coding systems and suggested that this be replicated in other states and territories.

### **IHPA's decision**

Consistent with the Ministerial Direction, IHPA will provide direction and monitoring of state and territory programs to audit medical records and coding to support continued improvement in reporting of HACs.

### **Next steps and future work**

IHPA will work with jurisdictions to progress state and territory led programs to audit medical records and coding.

## **11.5 AVOIDABLE HOSPITAL READMISSIONS**

The 2016 Heads of Agreement committed governments to work on reducing avoidable hospital readmissions with the development of a comprehensive and risk-adjusted strategy and funding model.

IHPA identified three options for defining avoidable hospital readmissions comprising:

1. All unplanned readmissions;
2. Unplanned readmission for selected surgical procedures, as defined by the AIHW in relation to a commitment under the National Healthcare Agreement 2012; and
3. Readmissions related to a HAC in the original admission where the readmission is primarily due to the original HAC.

Under the the Ministerial Direction issued on 29 August 2016, IHPA was required to develop a model that focusses on avoidable hospital readmissions within five days of discharge. IHPA also assessed readmissions within 28 days and condition-specific timeframes for readmissions.

### **Feedback received**

There were different views on how best to define avoidable hospital readmissions. Submissions suggested that some readmissions were not due to wholly preventable aspects of care directly arising from previous admissions (Western Australia). Some readmissions are clinically expected and may reflect models of care and networking relationships between specialist hospitals and other health services (Children's Healthcare Australasia). Other factors contributing to readmissions may be patient-related factors (such as age and comorbidities), as well as the adequacy of primary care, hospital in the home and other community-based services (Northern Territory, Victoria, New South Wales, Western Australia, AHHA).

#### *Timeframe for measuring avoidable hospital readmissions*

There was considerable support for the development of condition-specific timeframes that were clinically meaningful (the Commission, Northern Territory, South Australia, Western Australia, the Australian Capital Territory, AHHA, SHPA). The Commission noted that the development of condition-specific readmission timeframes could include an iterative process combining clinical consultation and statistical modelling, an approach also advocated by the Australian Capital Territory.

Three governments (Commonwealth, New South Wales and Queensland) restated their support for the five-day readmission period specified in the Heads of Agreement and Direction. However, New South Wales and Queensland suggested that the five-day readmission period could operate in the short-term, pending the development of clinically appropriate condition-specific timeframes.

Some organisations nominated other fixed timeframes for measuring avoidable hospital readmissions. The Australian Health Service Alliance (AHSA) noted that private health insurance rules specify seven days as the duration for measuring readmissions.

#### *Geographic basis for measuring avoidable hospital readmissions*

There were mixed views about whether avoidable hospital readmissions should be measured within the same LHN or more broadly.

The absence of unique patient identifiers across hospitals resulted in some groups suggesting that the focus should be on readmissions within the same LHN (Women's Healthcare Australasia). In addition, South Australia noted that jurisdictions needed to be able to replicate IHPA's methodology if readmissions were to be measured more broadly than LHNs and this would not be possible without access to Medicare PIN information.

Other groups supported measuring readmissions on a broader geographic basis than LHNs (Austin Health). Some submissions suggested that readmissions should be measured across the public and private sector, rather than being limited to readmissions across public hospitals. IHPA notes that it does not have access to private hospital data and because the Pricing Framework applies only to public hospitals, it does not intend to measure readmissions involving private hospitals.

#### *Implementation timeframes*

Most jurisdictions suggested that significant further developmental work will be required to define avoidable hospital readmissions and, accordingly, implementation should be delayed beyond 2017-18 (South Australia, Australian Capital Territory, Queensland, Tasmania, Western Australia, Victoria, New South Wales). The Commonwealth proposed implementation by 1 July 2018, with a year of shadow pricing in 2017-18.

#### ***IHPA response against the assessment criteria***

The third option for defining avoidable hospital readmissions (as admissions arising directly as a result of a HAC in the original admission) is the best option to meet the preventability and risk adjustment criterion as it results in the narrowest set of avoidable hospital readmissions. IHPA further notes that limiting these avoidable hospital readmissions to those occurring within five days of discharge of the original admission. Accordingly, this is the option assessed by IHPA below.



## IHPA assessment: Funding adjustment for readmissions within five days that are related to a HAC in the original admission

Criteria	Assessment
<b>Preventability</b>	<b>Partially meets this criterion</b> – not all HACs are wholly preventable for all patients with all conditions, so measurement of readmissions depends upon reaching agreement on preventable HACs in the original admission
<b>Equitable risk adjustment</b>	<b>Potential to meet this criterion</b> – risk adjustment will not be required for the readmission if there is agreement on preventable, risk-adjusted HACs in the original admission and clear causality with the readmission
<b>Proportionality</b>	<b>Meets this criterion</b> – the funding adjustment would be equivalent to the cost of the avoidable hospital admission
<b>Transparency</b>	<b>Partially meets this criterion</b> – depends upon ability to communicate the link between the original HAC conditions and the related avoidable hospital readmission
<b>Ease of implementation</b>	<b>Partially meets this criterion</b> – relatively small numbers of avoidable hospital readmissions, pending agreement on HACs in original admission

On the basis of this assessment and stakeholder feedback, IHPA provided advice to the COAG Health Council on 30 November 2016 recommending implementation of a funding adjustment for readmissions within five days that are related to a HAC in the original admission.

IHPA also recommended that COAG Health Council request the Australian Commission on Safety and Quality in Health Care to develop a list of clinical conditions that should be considered to be avoidable readmissions, including an examination of the appropriate timeframes for avoidable readmission for each of the conditions selected.

### IHPA's decision

Consistent with the Ministerial Direction, IHPA will undertake further public consultation to inform a future pricing and funding approach to avoidable hospital readmissions, based on a set of definitions to be developed by the Australian Commission on Safety and Quality in Health Care.

### Next steps and future work

The Australian Health Ministers Advisory Council has requested that the Commission develop a list of clinical conditions that should be considered to be avoidable readmissions, including an examination of the appropriate timeframes for avoidable readmission for each of the conditions selected. No pricing or funding approach to avoidable hospital readmissions will be implemented until after the completion of this program of work. IHPA will work with the Commission to progress this body of work.

## 11.6 IMPLEMENTATION ISSUES

### National Benchmarking Portal

IHPA has launched the National Benchmarking Portal which provides the ability, for the first time, for users to compare differences in activity, costs and efficiency between similar hospitals and benchmark their performance.

Much of the collaborative work between IHPA and the Commission over the last four years has highlighted the value of providing comparative information on safety and quality measures back to clinicians. For this reason, information on HACs for each public hospital will be included in the National Benchmarking Portal.

This will enable comparison of HACs by jurisdiction, LHN and hospital at the DRG, principal diagnosis and procedure level, as well comparisons using Service Related Groups.

### **Audit and publication**

The success of a safety and quality pricing mechanism is dependent on national, state, and local health systems working together to support implementation of the model. This includes putting mechanisms in place locally and nationally to audit the recording of safety and quality issues to build confidence in the national compatibility of the reporting of HACs.

Under Clause B95 of the National Health Reform Agreement, the Commonwealth and the States will take responsibility for the data integrity within their systems and agree to establish appropriate independent oversight mechanisms for data integrity. IHPA expects that this will include the auditing of medical records and ICD-10-AM coding to support continued improvement in HAC reporting.

### **Development of robust risk adjustment approaches**

IHPA has outlined different approaches to risk adjustment which seek to balance the likelihood that some patients will be at higher risk of experiencing an adverse event while recognising that all hospitals have scope to improve safety and quality.

Although these risk adjustment approaches are sufficient for the shadowing of options, IHPA intends that the approach be further refined in consultation with states and territories and that a peer review process be undertaken in 2017 to ensure that it is fit for purpose.

### **Curation of the HAC list**

IHPA understands that the Commission will develop governance arrangements for the curation and implementation of the national list of HACs. The continued refinement and implementation of the HAC list through this group will be an important part of ensuring the list of HACs remains up to date and maintains clinical relevance.

# APPENDIX A: AUGUST 2016 DIRECTION TO IHPA



## **Direction to the Independent Hospital Pricing Authority on the performance of its functions under section 226 of the *National Health Reform Act 2011 - No. 1/2016***

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I, SUSSAN LEY, Minister for Health and Aged Care, acting under subsection 226(1) of the *National Health Reform Act 2011* (the Act), having consulted with the Standing Council on Health, DIRECT that the Independent Hospital Pricing Authority provide the relevant advice set out in Item 1 of the Schedule to this instrument, and have regard to the matters set out in Item 2 of the Schedule to this instrument.

Dated: 29<sup>th</sup> August 2016

A handwritten signature in blue ink, appearing to read 'Susan Ley'.

SUSSAN LEY  
Minister for Health and Aged Care

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## Part 1 Preliminary

### 1. Name of Direction

This Instrument is the *Direction to the Independent Hospital Pricing Authority on the performance of its functions under section 226 of the National Health Reform Act 2011 - No. 1/2016*.

### 2. Commencement

This Direction takes effect on the day after it is registered on the Federal Register of Legislative Instruments.

### 3. Authority

This Direction is made under subsection 226(1) of the *National Health Reform Act 2011*.

### 4. Definition

In this Direction:

*Act* means the *National Health Reform Act 2011*.

*hospital acquired condition* means a hospital acquired patient complication, as defined by the Australian Commission on Safety and Quality in Health Care, for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.

*avoidable hospital readmission* means readmission to hospital within 28 days of discharge, with a particular focus on avoidable readmission within 5 days of discharge, for a condition or conditions arising from complications of the management of the original condition.

*sentinel event* means one of a subset of adverse events that result in death or serious harm to a patient.

### 5. Schedule

The Schedule to this Instrument describes the direction given to the Independent Hospital Pricing Authority on the performance of its functions.

## Schedule

### 1. Functions

- (i) The Independent Hospital Pricing Authority, in relation to its functions under paragraphs 131(1)(a) and (h) of the Act must advise the Commonwealth, the States and the Territories (the Parties) on an option or options for:
  - (a) a comprehensive and risk-adjusted model to determine how funding and pricing can be used to improve patient outcomes and reduce the amount the Commonwealth pays for sentinel events, and a set of preventable hospital acquired conditions, defined by the Australian Commission on Safety and Quality in Health Care and agreed by the Parties, that occur in public hospitals; and
  - (b) a comprehensive and risk-adjusted strategy and funding model to reduce avoidable readmissions to hospital that will adjust the funding to hospitals that exceed a predetermined avoidable readmission rate for an agreed set of conditions and the circumstances in which they occur.
- (ii) In performing the activity referred to in Item 1(i)(a), the Independent Hospital Pricing Authority must have regard to the Parties' intention to:
  - (a) implement a model for sentinel events from 1 July 2017; and
  - (b) implement a model for an agreed set of preventable hospital acquired conditions not before 1 July 2018, with a preceding shadow year.
- (iii) In performing the activity referred to in Item 1(i)(b), the Independent Hospital Pricing Authority must have regard to the Parties' intention to focus on avoidable hospital readmissions within 5 days of discharge for conditions referred to in Item 1(i)(b) arising from complications of the management of the original condition that was the reason for the patient's original hospital stay.
- (iv) In performing the activities referred to in Item 1(i), the Independent Hospital Pricing Authority must ensure that any option developed reflects the Parties' intention to send a signal at the health system level of the need to reduce instances of preventable poor quality patient care, while supporting improvements in data quality and information available to inform clinicians' practice.
- (v) In performing the activities referred to in Item 1(i), the Independent Hospital Pricing Authority, should give consideration to any probable known costs and expected benefits.

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- (vi) The Independent Hospital Pricing Authority must provide the advice referred to in Item 1(i) of this Direction to COAG Health Council by 30 November 2016.

**2. Matters the Independent Hospital Pricing Authority is to have regard to**

- (i) In performing the activity described in Item 1 of this Schedule, the Independent Hospital Pricing Authority must have regard to the matters set out in subsection 131(3) of the Act.
- (ii) In addition, in relation to performing the activity described in Item 1 of this Schedule, the Independent Hospital Pricing Authority must, under section 132 of the Act, have regard to the Heads of Agreement on Public Hospital Funding, signed by the Parties on 1 April 2016.
- (iii) In providing the advice described in Item 1 of this Schedule, the Independent Hospital Pricing Authority is to have regard to the following design principles:
- (a) Options prioritise patient outcomes and are evidence based:
- i. Better patient health outcomes underpin the design and implementation of reform.
  - ii. The design and implementation of pricing and funding models for safety and quality, and reducing avoidable readmissions, are based on robust evidence.
  - iii. Adjustments are based on evidence of a causal link to the condition or complication, and are commensurate with the additional care required as a result of the complication.
  - iv. Adjustments relate to conditions or complications which clinicians and other health professionals are reasonably able to take action to reduce their incidence or impact.
  - v. Any models should add to the evidence base for strategies to address safety and quality, with robust monitoring of the effectiveness of implementation and ultimately, their impact on patient outcomes.
- (b) Options are consistent with whole-of-system efforts to deliver improved patient health outcomes:
- i. Adjustments complement existing national and state measures to improve patient health outcomes and reduce avoidable hospital demand, including but not limited to the Australian Commission on

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Schedule

- Safety and Quality in Health Care's goals, national benchmarking, data reporting, and accreditation.
- ii. The design and implementation of pricing and funding models acknowledges that mechanisms other than pricing and funding have a role in achieving the reform intention and that complementarity of all mechanisms is desirable.
  - iii. The design and implementation of pricing and funding models should not compromise state system financial sustainability and quality and should therefore be focused on system level performance improvement.
- (c) Options are transparent and comparable:
- i. As far as practicable, the financial levers are designed to ensure there is transparency between the approach and the intended outcome
  - ii. The model uses an appropriate risk adjustment methodology to consider different patient complexity levels or specialisation across jurisdictions and hospitals.
- (iv) In addition, in relation to performing the activity described in Item 1 of this Schedule, the Independent Hospital Pricing Authority is to have regard to submissions from the Australian Commission on Safety and Quality in Health Care, the National Health Funding Body, the Commonwealth, states and territories, and other parties deemed relevant by the Independent Hospital Pricing Authority.



EXPLANATORY STATEMENT

*National Health Reform Act 2011*

**Direction to the Independent Hospital Pricing Authority on the performance of its functions under section 226 of the *National Health Reform Act 2011***  
*No. 1/2016*

Authority

This Instrument is made under subsection 226(1) of the *National Health Reform Act 2011* (the Act), which provides that the Minister may give directions to the Independent Hospital Pricing Authority (IHPA) in relation to the performance of its functions and exercise of its powers. Section 131 of the Act sets out the functions of the IHPA, which include determining the national efficient price for health care services provided by public hospitals where the services are funded on an activity basis: paragraph 131(1)(a).

This Instrument operates by directing the IHPA in relation to the performance of its functions and the exercise of its powers. Under subsection 226(4) of the Act, the IHPA must comply with a direction made under subsection 226(1).

Purpose

This Instrument directs the IHPA to provide the Commonwealth and the States and Territories (the Parties) with an option, or options for:

- (a) a comprehensive and risk adjusted model to determine how funding and pricing can be used to improve patient outcomes and reduce the amount the Commonwealth pays for sentinel events, and a set of preventable hospital acquired conditions, defined by the Australian Commission on Safety and Quality in Health Care and agreed by the Parties, that occur in public hospitals; and
- (b) a comprehensive and risk-adjusted strategy and funding model to reduce avoidable readmissions to hospital that will adjust the funding to hospitals that exceed a predetermined avoidable readmission rate for an agreed set of conditions and the circumstances in which they occur.

This work will assist with improving service delivery across the health system to achieve better health outcomes and health system efficiencies.

Background

This Instrument gives effect to the Council of Australian Governments (COAG) Heads of Agreement on Public Hospital Funding signed on 1 April 2016, specifically in relation to reforms to improve the efficiency of public hospitals. The Heads of Agreement includes a commitment for the Parties, in conjunction with the IHPA, to

develop a comprehensive and risk-adjusted model to integrate quality and safety into hospital pricing and funding.

#### Details

Subsection 226(3) of the Act provides that a direction made under subsection 226(1) must:

- (a) be of a general nature only; and
- (b) not be a direction to change:
  - i. a particular national efficient price for health care services provided by public hospitals; or
  - ii. a particular efficient cost for health care services provided by public hospitals.

This Instrument is of a general nature only; it does not direct the IHPA to change a particular national efficient price for health care services provided by public hospitals or a particular efficient cost for health care services provided by public hospitals between hospitals and sponsors.

This Instrument directs the IHPA to, have regard to the Parties intention to:

- (a) implement a model for sentinel events from 1 July 2017; and
- (b) implement a model for an agreed set of preventable hospital acquired conditions not before 1 July 2018, with a preceding shadow year.

#### Consultation

Subsection 226(2) of the Act provides that the Minister must consult with the Standing Council on Health (now known as the COAG Health Council) before giving a direction. Subsection 230(1) specifies the meaning of Standing Council on Health to be as follows:

*“The Standing Council on Health is (subject to subsection (2)) the Ministerial Council by that name, or, if there is no such Ministerial Council, the standing Ministerial Council established or recognised by COAG whose members include all Ministers in Australia having portfolio responsibility for health.”*

The Minister has written to State and Territory health ministers, outlining her intention to issue a direction under subsection 226(1) of the Act.

This Instrument relates solely to the functions and duties of the IHPA. The activity that will be undertaken is not regulatory in nature. As such, a Regulation Impact Statement is not required.

This Instrument commences the day after registration on the Federal Register of Legislation.

This Determination is a legislative instrument for the purposes of the *Legislation Act 2003* and under the provisions of section 44 of the *Legislation Act 2003* the Instrument is not subject to disallowance.

# APPENDIX B: FEBRUARY 2017 DIRECTION TO IHPA



## **Direction to the Independent Hospital Pricing Authority on the performance of its functions under section 226 of the *National Health Reform Act 2011 - No. 2/2016***

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I, GREG HUNT, Minister for Health, acting under subsection 226(1) of the *National Health Reform Act 2011* (the Act), having consulted with the Standing Council on Health, DIRECT that in relation to the performance of its functions and exercise of its powers the Independent Hospital Pricing Authority undertake the functions set out in Item 1 of the Schedule to this instrument and have regard to the matters set out in Item 2 of the Schedule to this instrument.

Dated:

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February 2017

A handwritten signature in black ink, appearing to read "Greg Hunt", written over a horizontal line.

GREG HUNT  
Minister for Health

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## Part 1 Preliminary

### 1. Name of Direction

This Instrument is the *Direction to the Independent Hospital Pricing Authority on the performance of its functions under section 226 of the National Health Reform Act 2011 - No. 2/2016*.

### 2. Commencement

This Direction takes effect on the day after it is registered on the Federal Register of Legislation.

### 3. Authority

This Direction is made under section 226 of the *National Health Reform Act 2011*.

### 4. Definition

In this Direction:

*Act* means the *National Health Reform Act 2011*.

*avoidable hospital readmission* means readmission to hospital for a condition or conditions arising from complications of the management of the condition for which the patient was originally admitted.

*hospital acquired complication* means a hospital acquired patient complication, as defined by the national list developed, and amended from time to time, by the Australian Commission on Safety and Quality in Health Care<sup>1</sup>, for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.

*sentinel event* means one of a subset of adverse events that result in death or serious harm to a patient.

### 5. Schedule

The Schedule to this Instrument describes the direction given to the Independent Hospital Pricing Authority on the performance of its functions and exercise of its powers.

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<sup>1</sup> Indicators of Safety and Quality <https://www.safetyandquality.gov.au/our-work/information-strategy/indicators/>

## Schedule

### 1. Functions

- (i) The Independent Hospital Pricing Authority, in relation to its functions under s. 131(1)(a) and (h) of the Act, is to undertake implementation of agreed recommendations of COAG Health Council (on 20 January 2017) on pricing for safety and quality to give effect to:
- (a) nil funding for a public hospital episode including a sentinel event which occurs on or after 1 July 2017, applying to all relevant episodes of care (being admitted and other episodes) in hospitals where the services are funded on an activity basis and hospitals where services are block funded; and
- Note: For *hospitals where the services are funded on an activity basis* and *hospitals where services are block funded* see Chapter 4 of the Act.
- (b) an appropriate reduced funding level for all hospital acquired complications, in accordance with Option 3 of the draft Pricing Framework for Australian Public Hospital Services 2017-18, as existing on 30 November 2016, to reflect the additional cost of a hospital admission with a hospital acquired complication, to be applied across all public hospitals; and
- (c) undertake further public consultation to inform a future pricing and funding approach in relation to avoidable hospital readmissions, based on a set of definitions to be developed by the Australian Commission on Safety and Quality in Health Care.

### 2. Matters the Independent Hospital Pricing Authority is to have regard to

- (i) In performing the activity referred to in Item 1(i)(a), the Independent Hospital Pricing Authority must have regard to the intention of COAG Health Council to:
- (a) implement an adjusted funding model for sentinel events from 1 July 2017;
- (b) have regard to the Australian Commission on Safety and Quality in Health Care's review of sentinel events; and
- (c) monitor and review the reporting of sentinel events by States and Territories to ensure those events are adequately reported for the purpose of funding adjustments.
- (ii) In performing the activity referred to in Item 1(i)(b), the Independent Hospital Pricing Authority must have regard to the intention of COAG Health Council to:

- (a) further refine the risk adjustment methodology for the COAG Health Council agreed hospital acquired complication model prior to 1 July 2017;
  - (b) shadow the implementation of the hospital acquired complication model to assess impact on funding, data reporting (e.g. condition onset flags), clinical information systems, and specific population and peer hospital groups; and
  - (c) public consultation on the findings of the shadow implementation with a final report submitted to COAG Health Council by 30 November 2017;
  - (d) provide direction and monitoring of State and Territory programs to audit medical records and coding to support continued improvement in reporting of hospital acquired complications; and
  - (e) implementation of reduced funding levels for all hospital acquired complications, subject to the results of the shadow period, from 1 July 2018.
- (iii) In performing the activity referred to in Item 1(i)(c), the Independent Hospital Pricing Authority must have regard the intention of COAG Health Council for:
- (a) the Australian Commission on Safety and Quality in Health Care to develop a list of clinical conditions that can be considered avoidable hospital readmissions, including identifying suitable condition-specific timeframes for each of the identified conditions;
  - (b) the Independent Hospital Pricing Authority to provide additional advice on feasibility and financial implications of potential future pricing or funding adjustments for avoidable readmissions in accordance with the list of clinical conditions; and
  - (c) the development of pricing or funding adjustments to target avoidable hospital readmissions which arise from complications of the management of the original condition that was the reason for the patients original hospital stay.
- (iv) The Independent Hospital Pricing Authority's inclusion of the options referred to in Item 1 of this Direction in The Pricing Framework for Australian Public Hospital Services, in March 2017.
- (v) In undertaking implementation, evaluation and provision of the advice described in Item 1 of this Schedule, the Independent Hospital Pricing Authority is to have regard to the following design principles:
- (a) Reforms prioritise patient outcomes and are evidence based:
    - i. Better patient health outcomes underpin the design and implementation of reform



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Schedule

- ii. The implementation and evaluation of pricing and funding models for safety and quality, and reducing avoidable readmissions, are based on robust evidence
  - iii. Adjustments are based on evidence of a causal link to the condition or complication, and are commensurate with the additional care required as a result of the complication
  - iv. Adjustments relate to conditions or complications which clinicians and other health professionals are reasonably able to take action to reduce their incidence or impact
  - v. Any models should add to the evidence base for strategies to address safety and quality, with robust monitoring of the effectiveness of implementation and ultimately, their impact on patient outcomes.
- (b) Reforms are consistent with whole-of-system efforts to deliver improved patient health outcomes:
- i. Adjustments complement existing national and state measures to improve patient health outcomes and reduce avoidable hospital demand, including but not limited to the Australian Commission on Safety and Quality in Health Care's goals, national benchmarking, data reporting, and accreditation
  - ii. The implementation of pricing and funding models acknowledges that mechanisms other than pricing and funding have a role in achieving the reform intention and that complementarity of all mechanisms is desirable
  - iii. The design and implementation of pricing and funding models should not compromise state system financial sustainability and quality and should therefore be focused on system level performance improvement.
- (c) Reforms provide transparency and comparability:
- i. As far as practicable, implementation of financial levers provide transparency between the approach and the intended outcome
  - ii. Pricing models use an appropriate risk adjustment methodology to consider different patient complexity levels or specialisation across jurisdictions and hospitals.
- (vi) In addition, in relation to undertaking functions as described in Item 1 of this Schedule, the Independent Hospital Pricing Authority is to have regard to

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Direction to the Independent Hospital Pricing Authority on the performance of its functions under section 226 of the *National Health Reform Act 2011*

submissions from the Australian Commission on Safety and Quality in Health Care, the National Health Funding Body, the Commonwealth, States and Territories, and other parties deemed relevant by the Independent Hospital Pricing Authority.

- (vii) The Australian Commission on Safety and Quality in Health Care will curate the Australian Sentinel Events List and the Hospital Acquired Complications List, develop rates of preventability for each hospital acquired complication to inform a risk adjustment methodology and lead development of a national consistent definition of avoidable hospital readmissions.

EXPLANATORY STATEMENT

*National Health Reform Act 2011*

**Direction to the Independent Hospital Pricing Authority on the performance of its functions under section 226 of the *National Health Reform Act 2011***  
*No. 2/2016*

Authority

This Instrument is made under subsection 226(1) of the *National Health Reform Act 2011* (the Act), which provides that the Minister may give directions to the Independent Hospital Pricing Authority (IHPA) in relation to the performance of its functions and exercise of its powers. Section 131 of the Act sets out the functions of the IHPA, which include determining the national efficient price for health care services provided by public hospitals where the services are funded on an activity basis: subsection 131(1)(a).

This Instrument operates by directing the IHPA in relation to the performance of its functions and the exercise of its powers. Under subsection 226(4) of the Act, the IHPA must comply with a direction made under subsection 226(1).

Purpose

This Instrument directs the IHPA to progress implementation of agreed recommendations of the Council of Australian Governments (COAG) Health Council on pricing for safety and quality to give effect to:

- (a) nil funding for public hospital episodes including a sentinel event which occurs on or after 1 July 2017. This applies to all relevant episodes of care (being admitted and other episodes) in activity based funded and block funded hospitals);
- (b) an appropriate reduced funding level for all hospital acquired complications, in accordance with Option 3 of the draft Pricing Framework for Australian Public Hospital Services 2017-18, as existing on 30 November 2016. This Option has regard to a funding adjustment reflecting the additional cost of a hospital admission with a hospital acquired complication and applying across all public hospitals; and
- (c) undertake further public consultation to inform a future pricing and funding approach in relation to avoidable hospital readmissions, based on a set of definitions to be developed by the Australian Commission on Safety and Quality in Health Care.

Implementation of the agreed recommendations of COAG Health Council on pricing and funding for safety and quality will support improved service delivery across the health system to achieve better health outcomes and health system efficiencies.

### Background

This Instrument gives effect to the COAG Heads of Agreement on Public Hospital Funding signed on 1 April 2016 (Heads of Agreement), specifically in relation to reforms to improve health outcomes and efficiency of public hospitals. The Heads of Agreement includes a commitment for the Parties to the Agreement, in conjunction with the IHPA, to develop and implement a comprehensive and risk-adjusted model to integrate quality and safety into hospital pricing and funding.

An Addendum to the National Health Reform Agreement (Schedule I) is being developed to give effect to the Heads of Agreement to be signed by First Ministers by March 2017. This Schedule, once agreed, will provide authority for the implementation of agreed outcomes in the Heads of Agreement from 1 July 2017 to 30 June 2020.

### Details

Subsection 226(3) of the Act provides that a direction made under subsection 226(1) must:

- (a) be of a general nature only; and
- (b) not be a direction to change:
  - i. a particular national efficient price for health care services provided by public hospitals; or
  - ii. a particular efficient cost for health care services provided by public hospitals.

This Instrument is of a general nature only it does not direct the IHPA to change a particular national efficient price for health care services provided by public hospitals or a particular efficient cost for health care services provided by public hospitals between hospitals and sponsors.

This Instrument directs the IHPA to, have regard to the Parties to the Heads of Agreement, intention to:

- (a) implement a funding model for sentinel events from 1 July 2017, to give effect to nil funding for public hospital episodes including a sentinel event; and
- (b) implement a model for an agreed set of preventable hospital acquired conditions not before 1 July 2018, with a preceding shadow year. The model will give effect to a reduced funding amount for hospital acquired complications, with the reduction being reflective the additional cost of a hospital admission with a hospital acquired complication.

### Consultation

Subsection 226(2) of the Act provides that the Minister must consult with the Standing Council on Health (now known as the COAG Health Council) before giving a direction. Subsection 230(1) specifies the meaning of Standing Council on Health to be as follows:

***“The Standing Council on Health is*** (subject to subsection (2)) the Ministerial Council by that name, or, if there is no such Ministerial Council, the standing Ministerial Council established or recognised by COAG whose members include all Ministers in Australia having portfolio responsibility for health.”

The previous Minister for Health, the Hon. Sussan Ley, wrote to State and Territory health ministers, outlining her intention to issue a direction under subsection 226(1) of the Act.

This Instrument relates solely to the functions and duties of the IHPA. The activity that will be undertaken is not regulatory in nature. As such, a Regulation Impact Statement is not required.

This Instrument commences the day after registration on the Federal Register of Legislation.

This Determination is a legislative instrument for the purposes of the *Legislation Act 2003* and under the provisions of section 44 of the *Legislation Act 2003* the Instrument is not subject to disallowance.

**Independent Hospital Pricing Authority**

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**IHPA**