IHPA

Pricing Framework for Australian Public Hospital Services 2020–21

Consultation Report

Independent Hospital Pricing Authority

Pricing Framework for Australian Public Hospitals 2020–21 — Consultation Report – December 2019

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1 Introduction

1 Introduction

The Independent Hospital Pricing Authority (IHPA) conducted a public consultation on key issues to be included in *the Pricing Framework for Australian Public Hospital Services 2020–21* (the Pricing Framework). The consultation ran from 14 June to 15 July 2019, and invited submissions from Commonwealth, state and territory (jurisdictions) health departments, professional health organisations, private industry and any other interested members of the Australian public.

IHPA received 31 submissions from a diverse range of stakeholders. Key themes from the consultation feedback are summarised in this report, corresponding with the chapters in the Pricing Framework. Stakeholder feedback has informed the development of the Pricing Framework, which sets out the policy rationale and decisions regarding IHPA's program of work, including the decisions that underpin the National Efficient Price (NEP) and National Efficient Cost (NEC) Determinations for 2020–21.

IHPA has included some of its own general feedback within this report and will respond to stakeholders directly where specific issues were highlighted relevant to that organisation. The key decisions for the National Efficient Price Determination 2020–21 and the National Efficient Cost Determination 2020–21 are stated in the Pricing Framework.

All submissions are available on IHPA's website, unless they were marked confidential.

2 The Pricing Guidelines

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Consultation questions

- Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?
- Does the proposed addition to the Pricing Guidelines appropriately capture the need for pricing models to support value in hospital and health services?

Feedback received

Stakeholders were generally supportive of the existing Pricing Guidelines as a tool to provide consistency in IHPA's approach to policy decisions, and their inclusion in the Pricing Framework.

New South Wales (NSW), Victoria (VIC), Queensland (QLD), South Australia (SA), Western Australia (WA), Tasmania (TAS), Northern Territory (NT) and the Commonwealth (Cwth) all supported the inclusion of the current Pricing Guidelines in the Pricing Framework.

NSW and WA proposed alterations to the new 'promoting value' Pricing Guideline to ensure a specific focus on patient outcomes, a common theme that was reiterated in a number of submissions. Queensland Nurses and Midwives Union (QNMU) noted that patient experience is an important element of the health care journey.

NSW, QLD, NT and the Australian College of Nurses (ACN) noted that in some circumstances, Activity Based Funding's (ABF) pre-eminence can be restrictive of efforts to implement other Pricing Guidelines such as 'fostering clinical innovation' and 'timely quality care'. Challenges noted include reconciling capitation funding with the overarching Pricing Guideline addressing efficiency, as well as updates to coding, cost studies and price determinations lagging two to three years behind recent innovation.

QLD, NT and the John Walsh Centre had concerns about applicability of the concept of 'fairness', noting that some facilities and patient groups will always be associated with higher costs. IHPA was encouraged to clarify what 'fairness' means in terms of social inclusion and reduction of disadvantage (particularly for Indigenous Australians) and equitable access of services regardless of geographical location.

NSW and QLD noted the impact of technology, with NSW suggesting IHPA should not restrict considerations of the impact of technology to the inpatient setting. It was recommended IHPA further investigate ways of introducing flexibility into the pricing model that support innovation and technology in the outpatient setting.

IHPA's response

IHPA agreed with the feedback received regarding the wording of the Pricing Guideline to support value in hospital and health services. IHPA has strengthened the wording to encompass patient experience and outcomes. The Pricing Guideline now reads:

> *Promoting value: pricing supports innovative and alternative funding solutions that deliver efficient, high quality, patient-centered care.*

IHPA has also amended the 'Fairness' guideline in response to comments from the NT regarding the need to recognise social inclusion and equitable access to services.

IHPA has updated the Pricing Guideline 'Fairness', incorporating stakeholder feedback as follows:

> *Fairness: ABF 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 and recognise the legitimate and unavoidable costs faced by some providers of public hospital services.*

IHPA agrees that the Pricing Guidelines place a pre-eminence on ABF in line with the current National Health Reform Agreement (NHRA).

IHPA will consider the issues raised around the need to 'foster clinical innovation' and 'timely, quality care' as part of an end-to-end review of the acute care classifications (being conducted in the second half of 2019), including how new and costly interventions are incorporated into classifications.

3 Scope of public hospital services

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IHPA did not ask any specific consultation questions on the scope of public hospital services.

IHPA will continue to consider services to be added or removed as part of its annual review of the General List of In-Scope Public Hospital Services process, that provides jurisdictions with the opportunity to nominate services that they consider should be in-scope for Commonwealth funding.

4 Classifications used to describe and price public hospital services

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Admitted acute care

Consultation questions asked

- What should IHPA prioritise when developing Australian Refined Diagnosis Related Groups (AR-DRG) Version 11.0 and International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM), Australian Classification of Health Interventions (ACHI) and Australian Coding Standards (ACS) (ICD-10-AM/ACHI/ACS) Twelfth Edition?
- Are there other priorities that should be included as part of the comprehensive review of the admitted acute care classification development process?

Feedback received

AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition

Suggestions included a review of the hospital acquired complication (HAC) code specifications, in particular the coding rules related to the assigning of the condition onset flag to minimise 'false' HACs being reported. Women's and Children's Healthcare Australasia (WCHA) noted concern that normal, non-harmful, distortions of the fetal head in babies born vaginally were being included in data on neonatal trauma.

Children's Health Queensland Hospital and Health Service (CHQ) recommended a review of the Major Diagnostic Category 'Newborns & Other Neonates' to better identify the underlying casemix/reason for hospital admission, as well as consideration of the classification of a number of specialist paediatric procedures.

NSW and VIC recommended an assessment of the impact of changes to Australian Coding Standard (ACS) 002 *Additional Diagnoses* to ensure it is being consistently applied and is not having adverse consequences with regards to reporting of certain conditions.

A number of stakeholders recommended IHPA consider the capture of patient social and functional determinants, behavioural issues (such as those related to delirium and dementia) and chronic conditions in ICD-10-AM/ACHI/ACS and in explaining complexity in the AR-DRG classification.

NSW and Australian Health Service Alliance (AHSA) suggested a review of codes to identify in-reach services such as mental health consultation-liaison services and assessment of whether mental health intervention codes should be assigned on a mandatory basis for national reporting.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) reiterated its position from the consultation on the 2019–20 Pricing Framework, noting the importance of consultation-liaison psychiatry and that this, along with mother and baby units, is not adequately captured under the current acute care classification system.

End-to end-review of the admitted acute care classification development process

Key feedback on areas to assess as part of the end-to-end review of the acute care classification development process included the development and delivery of clinical coder education, including consideration of national education forums and face-to-face training. Ensuring timely publication of coding advice, response to coding queries and streamlining the process for receiving coding queries and classification change proposals were also listed as priorities.

NSW, VIC and WA suggested consideration be given to whether AR-DRG and ICD-10-AM/ACHI/ACS development should be carried out in parallel, commencing the work plan earlier to ensure jurisdictions have sufficient time to provide informed input and ensuring sufficient time for implementation of new versions by jurisdictions.

NSW suggested consideration of a single classification system rather than a separate classification for acute care, subacute care, mental health care etc., clarifying how classifications can facilitate a move towards value-based healthcare. WA and the Cwth highlighted the potential for unintended consequences resulting from classification changes, requesting that any changes be assessed and addressed in a timely manner.

IHPA's response

IHPA will consider all of the feedback provided as it progresses the work program for the development of AR-DRG Version 11.0 and ICD-10 AM/ACHI/ACS Twelfth Edition. IHPA notes that newborns and other neonates were reviewed for AR-DRG Version 7.0 and Version 9.0, however, IHPA will look at revisiting this as part of the work program for Version 11.0.

IHPA will publish the national advice previously provided by the Australian Consortium for Classification Development on its website and will work with stakeholders to find ways to streamline and improve this process.

IHPA will continue to monitor the impact of classification changes through its quarterly activity data reports, and provide feedback including any potential unintended consequences through its committee process as soon as they are identified.

In addition, IHPA has conducted an end-to-end review of the acute care classifications. This comprehensive review considered the education, resource requirements and cycle times for AR-DRG and ICD development.

ICD-11

IHPA did not ask any specific consultation questions on ICD-11 but received feedback from a small number of stakeholders.

Feedback received

Stakeholders noted that consideration of ICD-11 was required when making decisions on updating ICD-10 AM/ACHI/ACS, including how Australia might transition to ICD-11 in the future. NSW noted that thought should be given to any impact on the coding workforce and information systems as preparations for the introduction of ICD-11 begin.

IHPA's response

IHPA is working closely with the Australian Institute of Health and Welfare on the feasibility and timeframe for implementation of ICD-11 in Australia and anticipates that any decision in this regard will require consideration by health ministers.

Australian National Subacute and Non-Acute Patient Classification (AN-SNAP)

IHPA did not ask any specific consultation questions on the AN-SNAP classification, however, NSW requested further information on any changes to the timeline for AN-SNAP Version 5.0. The Victorian Rehabilitation and Subacute Nurses Special Interest group also recommended a review of the funding for subacute and non-acute care to address the increasing complexity of admitted patient care requirements for subacute patients.

IHPA's response

IHPA is working with its Subacute Care Working Group to continue to progress AN-SNAP Version 5.0. The timelines will be communicated through IHPA's Subacute Care Working Group.

IHPA is reviewing patient complexity as part of its development of AN-SNAP Version 5.0 and will provide feedback through its Subacute Care Working Group.

Non-Admitted care

Although IHPA did not seek specific feedback on non-admitted care classifications, NSW and Exercise and Sports Science Australia (ESSA) offered comment. NSW recommended that the Tier 2 Non-Admitted Services Classification (Tier 2) remain relevant during the development of the Australian Non-Admitted Care Classification (ANACC). ESSA recommended an intervention list specific to the exercise physiology specialty be listed under the scope of Tier 2.

IHPA's response

IHPA notes that it will continue using Tier 2 for pricing non-admitted services for NEP20 while continuing work to develop the ANACC. Tier 2 price weights for each NEP will be informed by up-to-date cost data from states and territories.

Whilst IHPA does not include a list of in-scope professions applicable to each Tier 2 class, exercise physiology has been included on the ANACC intervention short list, which is being tested as part of the non-admitted care costing study.

Emergency care

Consultation questions asked

- Are there any impediments to implementing pricing using the Australian Emergency Care Classification (AECC) Version 1.0 for emergency departments from 1 July 2020?

Feedback received

Some states and territories advised IHPA of their readiness for implementing the AECC for NEP20.

NSW, VIC, QLD, SA, WA, TAS, NT and the Cwth supported shadow pricing the AECC Version 1.0 for NEP20 to mitigate any unintended consequences and enable jurisdictions to review and assess their data and test the AECC Version 1.0 Grouper.

NT acknowledged that AECC Version 1.0 recognises some complexity and cost drivers, however notes that it ignores other cost drivers such as social, location and capacity (including overcrowding and under-utilisation).

IHPA's response

IHPA will use Urgency Related Groups Version 1.4 to classify and price emergency department activities and Urgency Disposition Groups Version 1.3 to classify and price emergency service activities. Following a quality assurance process in 2019 to validate the AECC Version 1.0, for NEP20 IHPA will also include shadow price weights for emergency department activities using AECC Version 1.0. IHPA will work with states and territories to ensure any barriers to pricing emergency department activities using the AECC Version 1.0 are addressed for NEP21.

Teaching, training and research (TTR)

IHPA did not ask any specific consultation questions regarding TTR, but received feedback from a small number of stakeholders.

NSW and QLD supported the continuation of block funding TTR activity through the NEC20 process based on state and territory advice in the absence of robust data and the level of investment needed to develop systems to capture the data.

IHPA's response

TTR is currently covered by block funding with amounts provided by each state and territory as part of the NEC Determination. IHPA remains committed to pricing teaching and training activities using the Australian Teaching and Training Classification (ATTC), and will continue to explore options to accelerate this in the absence of reliable cost data being supplied by states and territories.

IHPA has developed an implementation plan for the ATTC and will continue to work with states and territories on the timeframe for shadow pricing and implementation, including investigating alternative models to block funding until there is sufficient data to enable pricing using the ATTC. States and territories are required under IHPA's Three Year Data Plan to provide ATTC data.

Mental health care

Consultation questions asked

- Are there any impediments to implementing pricing for mental health services using the Australian Mental Health Care Classification (AMHCC) Version 1.0 from 1 July 2020?

Feedback received

SA, WA, TAS, NT and the Cwth supported shadow pricing mental health services using the AMHCC Version 1.0 from 1 July 2020 while noting concerns over the robustness and comparability of the data used for shadow pricing. Conversely, NSW, VIC and QLD did not support pricing or shadow pricing using the AMHCC at this time, notably due to concerns with data robustness.

A common area of discussion was the Mental Health Phase of Care Clinical Refinement Project. NSW, VIC, QLD, WA and TAS noted a range of challenges facing the project and highlighted the need for further testing prior to any implementation of new phase definitions. These concerns were linked to the implications of future pricing of mental health services using the AMHCC following significant changes to the current phase definitions and noted that this may lead to variability and instability.

IHPA's response

IHPA has continued to work with states and territories to understand the mental health specific activity data reported through the quarterly data submissions. IHPA has linked 2017–18 activity data to National Hospital Cost Data Collection (NHCDC) to assess the viability of pricing using the AMHCC Version 1.0. Based on the quality and quantity of data available IHPA anticipates preparing a shadow price for admitted mental health activity using the AMHCC Version 1.0 for 2020–21. The classification provides a clinically meaningful way of classifying mental health care to better predict the actual cost of delivering mental health services than the AR-DRG classification. IHPA will continue to work with states and territories to expand the volume and quality of community data to be used for pricing in future NEP Determinations.

The Mental Health Phase of Care Clinical Refinement Project will continue to be discussed with stakeholders, including the various testing options, before IHPA identifies the best approach to Mental Health Phase of Care.

5 Setting the National Efficient Price

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Technical improvements and adjustments to the National Efficient Price

Consultation questions asked

- Are there adjustments for legitimate and unavoidable cost variations that IHPA should consider for NEP20?

Feedback received

Feedback received from states and territories noted that they were awaiting the outcomes of IHPA's Fundamental Review of the National Pricing Model and would provide comment through relevant committees and working groups.

NSW, WA, NT and ACN expressed concerns about cost disadvantages in rural and remote areas above the level of the NEP, with NT specifically raising the issue of medical evacuations.

NSW and SA recommended IHPA consider adjustments to address the disconnect in costs for smaller jurisdictions and review classes where there is a significant cost differential between jurisdictional cost buckets.

TAS, WCHA and CHQ recommended changes to pricing of intensive care units (ICUs). Changes proposed included:

- Unbundling the ICU component of the diagnosis related group (DRG) price for newborns and other neonates to provide consistency for all patients treated in an ICU; and
- Reviewing ICU components, particularly for invasive, ventilated patients, to develop a weighting if an invasively ventilated patient is managed in a regional centre critical care unit.

RANZCP reiterated the importance of accounting for the additional costs of consultation liaison psychiatry services and mother and baby units.

IHPA's response

IHPA has finalised the Fundamental Review. While the Review did not recommend significant changes to the National Pricing Model, IHPA is considering a number of recommendations made in the Review (which are outlined in the Pricing Framework).

IHPA's analysis and consultation with its Clinical Advisory Committee has found that based on currently available data the cost impacts of mother and baby units and consultant liaison psychiatry do not warrant an adjustment. Results based on currently available data indicated the cost impact of these services have low materiality and that an adjustment would increase model complexity. As such, they will not receive an adjustment for NEP20. This can be investigated further in future years as additional data becomes available.

IHPA has investigated patient travel costs using a proxy identifier and determined that the materiality is low. Implementation of this adjustment would require a robust identifier to be included in the National Minimum Dataset. IHPA will not include a patient travel adjustment in the admitted acute mode for NEP20.

In relation to the ICU episode care types cited by stakeholders, IHPA will consider these comments as part of a review of the ICU criteria for specified ICUs, noting that IHPA currently has limited data on non-invasive ventilation.

Pricing private patients in public hospitals

Feedback received

The Grattan Institute provided a detailed submission to IHPA regarding its analysis that indicates that the NHRA produces the unintended consequence of creating revenue raising opportunities through the provision of private services in public hospitals. The Grattan Institute asserts that while IHPA's Private Patient Adjustments account for the payments hospitals receive when treating private patients, the price discount applied only impacts the 45% of funding that is provided by the Commonwealth.

The NHRA stipulates that the Commonwealth will pay 45% of efficient growth in the cost of delivering hospital services each year, consisting of growth in the NEP, and growth in the volume of services delivered each year.

The full breakdown of the Grattan Institute's analysis can be found in its submission to the Consultation Paper published on the IHPA website.

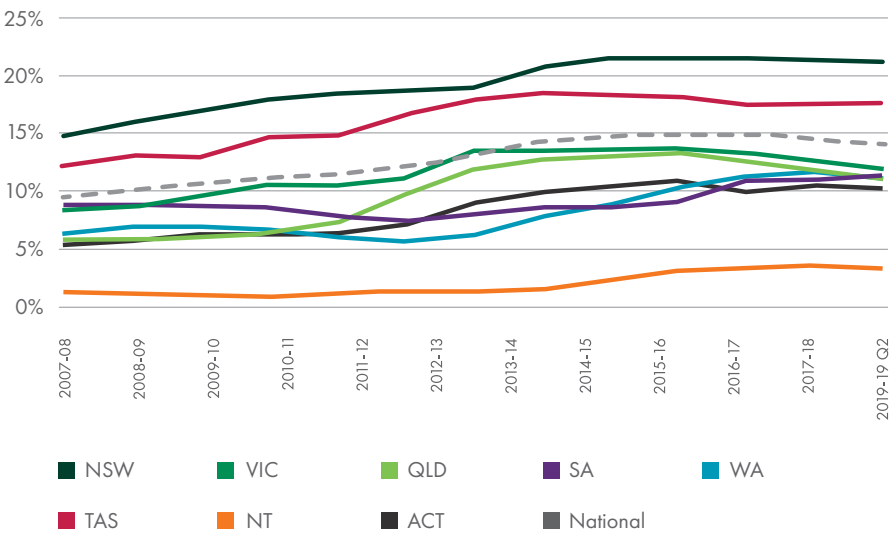
The Cwth submission noted concern around the potential for the National Pricing Model creating incentives for public hospitals to admit private patients, and the possibility this would lead to detrimental impacts on access to public hospital services by public patients. The Cwth recommended IHPA work with jurisdictions, the Administrator of the National Health Funding Pool and other interested parties to ensure funding neutrality between public and private patients, with the removal of any incentives that lead to private patient revenue being targeted.

IHPA's response

Prior to the introduction of the NHRA, privately insured patients in public hospitals were considered to be an additional revenue source for public hospitals, over and above the fixed budgets provided by state and territory governments. Some states and territories set targets for private patient revenue. As a result, when the NHRA commenced in 2012, the rate of private patient utilisation varied around the country.

For example, NSW has historically had the highest rate of private insurance utilisation, whilst the NT has always had a very low rate, reflecting the very low rate of private health insurance coverage in that population as shown in Figure 1.

Figure 1 – Private Patient Utilisation



Since the implementation of the NHRA, there has been rapid growth in the utilisation rate of private health insurance in some states and territories. The national utilisation rate has increased from 11.7% to a peak of 14.6% in 2015–16. More recently, the rate has reduced slightly to 13.7%. The increases in 2012–13 were driven by large increases in VIC and QLD, whilst later increases were driven by SA and WA. This has led some to claim that there is an incentive under the national ABF system for public hospitals to admit private patients.

IHPA has conducted detailed analysis and determined that the incentives in the system with respect to private patients in public hospitals are complex and vary according to a number of factors such as the Medicare Benefits Schedule (MBS) revenue arrangements in place for a hospital or Local Hospital Network (LHN). In addition, many of the targets and behaviours in the system are a result of historical funding arrangements that may pre-date the NHRA arrangements.

As noted in the Pricing Framework, IHPA has accounted for private patients in public hospitals through its Private Patient Adjustments to the National Pricing Model, as required by clause A41 of the NHRA. The reduction in the price weights for private patients is, on average, around 30%, but varies according to the type of DRG — surgical DRGs generally have higher reductions due to the cost of prosthesis.

IHPA has assessed the efficacy of this deduction by comparing the total price reductions in 2016–17 with the actual payments made for private patients in 2016–17, as recorded in the Hospital Casemix Protocol (HCP) collection and confirmed at the national level. The total deductions of $986.6 million is comparable to the total benefits paid of $986.0 million.

However, there is variation at a state and territory level. For example, in NSW, the total benefits paid exceeded the price reduction by $72.1 million. Conversely in QLD, the reduction was more than total benefits paid $41.4 million. However, in line with the Grattan Institute's comments, it does appear that when IHPA's pricing approach is applied in the national funding formula, there is a residual incentive for hospitals to admit private patients.

States and territories are not required to adopt IHPA's pricing approach in their models. Further, many states and territories set private patient revenue targets for public hospitals, providing further incentives for admitting private patients.

As the Grattan Institute notes, IHPA is constrained in its ability to address this issue because of the phrasing of the NHRA. Consistent with Clause B3(l) of the NHRA, IHPA's 'Public-private neutrality' Pricing Guideline states that ABF pricing should not disrupt current incentives (in place prior to the commencement of the NHRA on 1 July 2012) for a person to elect to be treated as a private or a public patient in a public hospital. IHPA is constrained in the actions it can take regarding altering current incentives for public hospitals to treat private patients under the current NHRA and therefore will not undertake further work in this area.

Costing private patients in public hospitals

Consultation questions asked

- Is there any objection to IHPA phasing out the private patient correction factor for NEP20?

Feedback received

Feedback indicated that the private patient correction factor is not well understood and is often confused with the Private Patient Service Adjustment and the Private Patient Accommodation Adjustment, which is explained in more detail in the previous section.

QLD, NT, Cwth, CHQ and ACN were cautiously supportive of phasing out the private patient correction factor for NEP20.

NSW, SA, WA, TAS and Catholic Health Australia (CHA) opposed the phasing out of the private patient correction factor at this stage. Reasons included an inability to identify the true costs of providing treatment to private patients, the lack of consistency between states and territories and the need to undertake a state by state assessment of the differences in treatment for private patients.

IHPA's response

IHPA will retain the Private Patient Correction Factor for NEP20.

6 Data collection

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Phasing out aggregate non-admitted data reporting

Feedback received

IHPA did not seek specific feedback on phasing out aggregate non-admitted data in the Consultation Paper. However, NSW noted it does not support phasing out aggregate non-admitted data reporting and that it expressed concerns through national data committees about privacy considerations for vulnerable services, as well as challenges collecting patient level data through third party providers.

NSW also noted the removal of the option for non-admitted aggregate reporting would increase administrative burden, in contradiction to the Pricing Guideline on 'Administrative ease'.

IHPA's response

IHPA has already commenced phasing out of aggregated non-admitted data reporting. IHPA will continue to work with states and territories to identify specific services that may need further time to transition to non-aggregated data reporting.

Access to public hospital data

Consultation questions asked

- Do you support IHPA making the National Benchmarking Portal (NBP) publicly available, with appropriate safeguards in place to protect patient privacy?

Feedback received

Most states, territories and other stakeholders were supportive of providing broader access to the NBP, providing stringent safeguards are established to protect data. Non-government stakeholders were particularly supportive, noting benefits such as the potential for more effective research capability, improved policy decisions, better benchmarking against similar health services and improved transparency.

However, stakeholders noted a range of issues that needed to be addressed prior to providing greater public access to the NBP, such as comparability, confidentiality and contextualisation to ensure correct interpretation of the data.

NSW and TAS held the view that access to the NBP should continue to be limited to those using health department systems and that the scope should not be expanded.

IHPA's response

IHPA will work with states and territories through its Jurisidictional and Technical Advisory Committees over the coming year to address safeguards and develop educational resources to enable public access to the NBP by the end of 2020.

Individual Healthcare Identifier (IHI)

Consultation questions asked

- What are the estimated costs of collecting the IHI in your state or territory?
- Would you support the introduction of an incentive payment or other mechanisms to assist in covering these costs for a limited time period?

Feedback received

Stakeholders were generally supportive in-principle of the need for the IHI. VIC, QLD, WA, TAS, Australian Healthcare and Hospitals Association (AHHA), the Royal Australasian College of Physicians (RACP) and the Australian Medical Association (AMA) all recognised the need for an IHI. Benefits noted included:

- Linked data;
- Enhanced ability to support innovative, value-based funding models;
- Improved ability to capture Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs); and
- Improved clinician involvement in digital health.

It would seem that the main barrier to collection is based on resourcing and capacity of existing software systems. Stakeholders were largely unable to provide an estimate of costs required to address this.

Other challenges to implementation included data quality concerns, the need for secondary data use approval (and the associated ethical concerns) and privacy and technical concerns. For example, QLD noted that as a health service provider, it cannot update Medicare's system when there is incorrect information in their system. They suggest it is a risk that jurisdictions will have no influence or control to address the other parties' data quality. NSW commented that in order to release the IHI of patients to IHPA, ethics approval would be required. However, NSW also noted that they support exploration of alternative funding models, including bundled payments, while also raising data linkage as a challenge. While NSW is willing to continue discussions around introducing the IHI, they do not support its collection at this stage.

States, territories and other stakeholders generally withheld judgement on IHPA's proposal for an 'incentive' payment for the collection of the IHI. Many supported further discussion to find a payment methodology that would have consensus support. NT opposed an adjustment whereby funding is reduced for episode records without a valid IHI. Macquarie University Centre for the Health Economy (MUCHE) opposed the mechanism as it viewed upfront costs as likely recoverable through the improvements linking datasets would provide.

IHPA's response

IHPA notes that it is unable to substantially progress a number of key work areas — particularly work to provide funding options for avoidable hospital readmissions as well as alternate funding models such as bundled pricing — without the broad adoption of the IHI. IHPA will continue to work with states and territories through the Jurisdictional and Technical Advisory Committees and national data committees to progress the inclusion of the IHI in the national data collections. IHPA will also commence discussions around an incentive payment when the cost of collecting the IHI is better understood.

IHPA will continue to discuss incentive payments to recognise the legitimate additional costs associated with provision of the IHI in national data sets.

Patient reported outcome measures

Consultation questions asked

- What initiatives are currently underway to collect PROMs and how are they being collated?
- Should a national PROMs collection be considered as part of national datasets?

Feedback received

All jurisdictions who provided feedback on PROMs noted that their jurisdiction is collecting or is planning to collect PROMs in some form and were generally supportive of collecting PROMs data to assist in moving to an outcomes-based model of care that is centred around the patient. NSW, SA, WA, Cwth, ACN, Alfred Health, John Walsh Centre, CHA, WCHA, Maternity Consumer Network Inc (MCN), Johnson and Johnson and eHealthier all noted their support for the collection of PROMs as part of national datasets.

States and territories noted that they are at varying stages of PROMs implementation. Notable examples from across Australia include:

- The WA Your Experience of Services (YES) Survey which has been developed to capture PROMs;
- The Tasmanian Health Service currently collects and reports on PROMs for renal, pain, stroke, orthopaedic and cardiac services;
- NT has initiated a project to collect PROMs using an online patient experience survey, which has been translated in to six Indigenous and nine international languages. A trial will begin in 2020–21; and
- CHQ has established a PROM Research Advisory Group to oversee and coordinate all PROM research currently underway at CHQ.

WHA and AHHA each noted that the International Consortium for Health Outcomes Measurement (ICHOM) is a good starting point for implementing PROMs in Australia, while highlighting that PROMs would need to be contextualised to the Australian health system.

There was significant support for PROMs to be incorporated in to the national Clinical Quality Registry (CQR) Framework. CQR's collect data to identify benchmarks and variation in clinical outcomes, and then feed this information back to clinicians to inform clinical practice and decision making. It was noted that the Australian Commission on Safety and Quality in Health Care (the Commission) is leading work on PROMs and PREMs, and manages the CQR Framework.

NSW, SA, TAS and the AMA noted challenges to implementing PROMs, including the additional burden that collection places on clinicians and patients, the subjectivity of the patient experience, and the need for any PROMs collection framework to be well considered if it is to result in improvements in patient outcomes. NSW and the AMA also noted that they are not supportive of using PROMs to drive funding decisions. The AMA specified that research demonstrates learnings from valid clinical indicators and PROM tools is most effective when it is clinician led.

CHQ did not support development of a national PROMs dataset for statistical comparisons as they believe the focus should be on helping patients make informed choices.

IHPA's response

IHPA will continue to work closely with the Commission as well as the Commonwealth on their CQR work regarding the 10 year National Strategy that sets out its commitment to broaden the benefits of CQRs for equitable improvements in patient care. IHPA will also work with stakeholders via its advisory committees and relevant data committees to identify opportunities to incorporate PROMs into national datasets.

7 Treatment of other Commonwealth programs

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Feedback received

IHPA did not seek specific feedback on treatment of other Commonwealth programs in the Consultation Paper. However, IHPA received recommendations from the Society for Hospital Pharmacists of Australia (SHPA) noting that changes to the Pharmaceutical Benefits Scheme (PBS) were being implemented to avoid duplication of payments. As a result, SHPA recommended IHPA assess the impact of this cut to Commonwealth funding of hospital pharmacy remuneration and whether any adjustments were subsequently required.

Similarly, Biotronik recommended developing rules that would apply when government changes to regulatory or policy instruments result in a stakeholder being assigned costs or accountabilities.

The changes referred to are adjustments in the 2019–20 Commonwealth budget to the PBS policy around drugs covered under Section 85 of the *National Health Act 1953* (also known as the 'General Schedule'). The PBS wholesale mark-up for private and public hospitals is being aligned with community pharmacies. The mark-up will move from the existing 11.1% uncapped, to meet the existing mark-up for community pharmacies, which is 7.52% capped at $69.94 (where the ex-manufacturer price is greater than $930.06). This change commenced on 1 October 2019.

IHPA's response

IHPA will assess the impact of any changes to pharmacy dispensing practices and costs as part of its annual NHCDC process and development of the National Pricing Model. IHPA will work with all jurisdictions to understand how the legislated changes to PBS Section 85 reimbursement rules can be accounted for in the development of NEP20.

8 Setting the National Efficient Cost

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Consideration of alternative National Efficient Cost methodologies

Consultation questions asked

- Are there any impediments to shadow pricing the 'fixed plus variable' model for NEC20?

Feedback received

NSW, VIC, QLD, SA, WA and the Cwth supported, in principle, shadow pricing the 'fixed plus variable' model for NEC20. VIC, SA, the Cwth and Biotronik recommended a minimum shadow pricing period of at least a year.

QLD and Biotronik noted specific areas for further consultation, particularly in relation to rural and regional services. For example, QLD noted that treatment of transport related supply costs are not currently reflected in the NEC model remoteness class.

IHPA's response

IHPA notes that it shadowed the 'fixed plus variable' model for 2019–20 based on previously supplied data and will provide feedback through its Small Rural Hospital Working Group. IHPA will use the 'fixed plus variable' model for NEC20. IHPA will continue to work with its Small Rural Hospital Working Group as it implements the 'fixed plus variable' model for NEC20, and provide regular reports through its committee process.

9 Alternative funding models

9 Alternative funding models

Consultation questions asked

- Are there any additional alternative funding models IHPA should explore in the context of Australia's existing NHRA and ABF framework?
- IHPA proposes investigating bundled payments for stroke and joint pain, in particular knee and hip replacements. Should any other conditions be considered?

Feedback received

Alternative funding models

There was strong support among all responding states and territories for IHPA continuing to investigate alternative and specifically value-based funding models.

Some states have active value-based health care programs. For example, NSW has launched a large scale value-based healthcare program. The Leading Better Value Care program aims to change how care is delivered by focusing on the patient's experience through the health system and working collaboratively with the State's health care services. VIC is also investigating options for value-based care for stroke patients across different care settings — acute, rehabilitation and community. The 'improving value in stroke care' project is in its initial stages, consulting with clinicians and other key stakeholders on options for obtaining feedback on patient outcomes and experience and identifying opportunities to make a difference.

NSW, VIC, QLD and TAS noted the benefits of a range of value-based care models, including flexibility, improved outcomes and support for innovation.

Some specific recommendations included:

- NSW: use alternative funding models to strengthen integrated care through the provision of incentive payments for specific patient cohorts as part of hospital avoidance strategies;
- VIC: where supported by evidence, delivery of targeted ABF services using value-based funding as a pragmatic way to incrementally develop new funding models and reporting requirements: and
- WA: consider models that improve coordination and collaboration with primary healthcare networks to promote hospital avoidance and put forward a funding methodology for the Council of Australian Governments Health Council approval, that enables jurisdictional innovation.

QLD noted the next iteration of the NHRA will include a commitment to exploring funding reforms that focus on paying for value and outcomes such as capitation and bundling and that value-based care models should include a focus on patient experience and outcomes.

There was broad support for work in this area from non-government stakeholders. Their recommendations included:

- AHHA: consider a longer-term move towards outcome contingent payment mechanisms where providers are funded on the basis of the pre-defined and agreed outcomes. AHHA also supported the Council of Australian Governments avoidable hospital readmission initiatives;
- MUCHE: ensure models are designed for a specific, identified behavioural change sought by funding bodies and are tailored to the unique circumstances of LHNs; and
- RACP and Johnson and Johnson: review relevant recommendations from the Productivity Commission's 'Shifting the Dial: 5 year productivity review' report. For example, consider a new funding approach such as using a small share of current ABF funds to care for patients with comorbidities or creating a Prevention and Chronic Condition Management Fund in each LHN.

Bundled payments

The majority of stakeholders, including states and territories generally supported the concept of bundling payments for particular patient cohorts and recommended IHPA investigate a range of specific services and procedures including cancer and cardiovascular diseases, delirium and dementia, palliative care, musculoskeletal conditions, chronic and acute paediatric conditions, breast cancer, bariatric surgery and regional/rural models of care across multiple facilities.

NSW, QLD, NT and MCN supported the concept of bundled payments but noted difficulties operationalising them, including data collection, linkage issues and variation in service delivery. They recommended IHPA consider how to appropriately share risk within a bundled payment mechanism.

IHPA's response

IHPA's recently completed Global Horizon Scan explored alternative funding models being developed internationally with a focus on value-based funding options. IHPA will explore a number of options highlighted in this report specifically relating to capitation models and bundled pricing. IHPA will also continue to work with jurisdictions to look at hospital avoidance programs such as the Victorian HealthLinks program, in the context of the Australian ABF framework.

IHPA will review the list of services and procedures proposed by stakeholders and seek clinical advice before developing a roadmap outlining an approach to developing clinical bundles on a trial basis.

IHPA reiterates that the lack of a consistently collected national unique patient identifier such as the IHI presents a challenge to implementation of alternative funding models as patients cannot currently be tracked across different care streams or different health care settings.

10 Pricing and funding for safety and quality

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Sentinel events

No feedback was received in relation to the funding of sentinel events.

Hospital acquired complications

Consultation questions asked

- Is IHPA's funding approach to HACs improving safety and quality, for example through changing clinician behaviour and providing opportunities for effective benchmarking?

Feedback received

Stakeholders were generally supportive of IHPA's funding approach to HACs. However, many agreed that it was too early to identify whether IHPA's funding approach had been effective in changing clinician behaviour.

A number of states, territories and other stakeholders requested further analysis at the national, state and local level to:

- Identify false positives;
- Review of source data to ensure that the data is providing an accurate representation where significant change in the HAC rate has been observed; and
- Investigate whether safety and quality approaches are being implemented as intended.

NSW and ACN noted the importance of benchmarking tools in influencing clinician behaviour.

NSW, QLD, WA, AMA, QNMU and RACP held reservations around the use of funding adjustments to reduce HACs due to impacts on data reporting, the potential for unintended consequences, and the questionable effectiveness of penalties.

WA, the John Walsh Centre and WCHA raised concerns around the use of the Charlson score particularly in paediatric settings and for patients with complex needs such as spinal cord injuries. WCHA recommended replacing the Charlson score with the Rhee score, as Sydney Children's Hospital Network has found it outperforms the Charlson score in predicting the likelihood of HACs in paediatric populations.

IHPA's response

Stakeholder feedback demonstrated a potential lack of understanding in relation to how the funding mechanism works in that an improvement in HAC rates can result in a financial gain.

IHPA will continue to work with its committees to gain a greater understanding of the impacts of the introduction of the HAC funding approach. IHPA will also work with its stakeholders to provide greater education around how the HAC funding adjustments are applied.

IHPA will continue to work with the Commission to ensure that the HAC definitions are still current and meaningful, to understand the true preventability and effectiveness of these measures in driving safety and quality and to consider expanding the conditions included on the HACs list.

IHPA will investigate other options to the Charlson score and their effectiveness, as part of efforts to continually improve the risk adjustment model.

Avoidable hospital readmission funding options

Feedback received

IHPA did not seek feedback on its approach to avoidable hospital readmissions as it commenced analysis of three funding options from 1 July 2019 for a 24–month period, which are outlined in the Pricing Framework 2019–20.

However, some stakeholders provided comment on the ongoing program of work.

IHPA met with NSW to discuss a proposed fourth option. NSW proposed benchmarking the three options against each other so that readmission rates and funding impacts were transparent across each option and that hospitals could access this analysis prior to any decisions being made. It was agreed that this approach is not an alternative funding approach, but an additional mechanism for analysing the three proposed funding options currently being considered. NSW agreed that adding avoidable readmission rates to the National Benchmarking Portal and providing a comparison under each option should address this.

NSW, VIC, QLD and CHQ recommended IHPA consult broadly to establish a definition of potentially avoidable hospital readmissions.

IHPA's response

IHPA will continue to engage with all jurisdictions through its committee process, including exploring the incorporation of NSWs' proposed fourth option into the avoidable readmissions 24–month shadow reporting period.

IHPA is also working with the University of Melbourne to develop an appropriate risk-adjusted model for funding avoidable hospital readmissions.

To avoid perverse or unintended consequences, IHPA is maintaining a cautious approach to implementing funding options to reduce avoidable hospital readmissions. As with HACs, IHPA notes it has not been well communicated that where avoidable hospital readmission rates improve, there is potential for financial incentive.

IHPA notes the Commission is currently working with stakeholders to develop a definition for potentially avoidable hospital readmissions. Once complete this definition will be provided to the Australian Health Ministers Advisory Council for consideration. The Commission is also finalising a second literature review conducted by the Sax Institute that has a focus on the effect that readmission programs that use financial levers have on hospital readmission rates, mortality rates and whether there are any other identifiable consequences.

Commercial readmission software

Consultation questions asked

- What should IHPA consider to configure software for the Australian context that can identify potentially avoidable hospital readmissions?

Feedback received

Stakeholders were generally supportive of IHPA's work to explore the options for configuring commercial software that will determine whether a readmission is clinically related to a prior admission based on the patient's diagnosis, procedures in the index admission and the reason for the readmission.

NSW, QLD, SA, QNMU and ACN noted that software configuration should consider variables other than diagnosis and be specific to the Australian context, and proposed several variables including weather, substance use, breastfeeding rates, social status, health professional's opinions and patient health literacy.

NSW, SA and the John Walsh Centre offered a range of practical input on the functionality of the software tool, for example automatically recognising at-risk patients and assistance recognising potentially avoidable readmissions. VIC noted that access to the software tool would be important, including the capability to provide access to agencies such as Safer Care Victoria.

IHPA's response

IHPA will consider functionality and recommendations when developing the software tool.

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