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17 August 2017

Mr James Downie
CEO
Independent Hospital Pricing Authority
Level 6
1 Oxford Street
Darlinghurst NSW 2010

Dear Mr Downie

Thank you for the opportunity to provide comment on the Independent Hospital Pricing Authority's Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19.

Alfred Health in principal supports the introduction of funding reform for public hospital services to support the improvement of safety and quality in healthcare.

We encourage the Independent Hospital Pricing Authority to continue to work with stakeholders to understand if the current National Cost Data Collection is appropriate for building funding models for safety and quality.

We are in agreement that the Independent Hospital Pricing Authority should consider the value of the patient outcome as opposed to the throughput model inherent in Activity Based Funding models. However, we recommend caution as there is an underlying assumption that coding and costing data is mature enough across all jurisdictions to draw valid conclusions to incorporate safety and quality into the pricing and funding of public hospital services in Australia.

Furthermore, the model is based on a punitive approach whereas funding would be better utilised to reward public health service providers for better and safer patient outcomes. Funding models should encourage innovation, and patient centred models of care that support the introduction of coordinated care reforms for patients with chronic and complex disease allowing hospitals the financial flexibility to invest.

Please find enclosed Alfred Health's response to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19.

Yours sincerely

Andrew Way
Chief Executive

AlfredHealth

Summary of Responses

Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19

The following information is provided on behalf of Alfred Health in response to Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19 released in July 2017.

1 What additional areas should IHPA consider in developing Version 10 of the Australian Refined Diagnosis Related Groups classification system?

The IHPA may wish to consider in its development of Version 10 of the Refined Diagnosis Related Groups:

- Review classification and grouping for low volume, high cost DRGs, in particular transplant services where there is significant variability in the patient's length of stay, costs, co-morbidities, and pathways (e.g. ECMO, Single/Dual VADs, Lung vs Heart/Lung).
- Incorporating Social Complexity into classification system - anyone who is from a vulnerable group (intellectual or complex disability, family violence, alcohol and drugs, homeless, CALD, ATSI background).

We encourage the continued review of Cardiovascular Interventional DRGs and specifically consider electrophysiology studies and associated procedures.

4 Do you support the proposal to shadow price non-admitted multidisciplinary case conferences where the patient is not present for NEP18?

We agree with the proposal to shadow price non-admitted multidisciplinary case conferences where the patient is not present for NEP18, although sufficient lead time would be required for providers to ensure that the data is captured and is accurate.

5 Do you support investigation of the creation of multiple classes in the classification for home ventilation?

Yes, there is support for investigating and developing multiple classes in the classification of home ventilation.

8 What are the priority areas for IHPA to consider when evaluating adjustments to NEP18?

We encourage the IHPA to consider in its evaluation of adjusts to NEP18:

- Stabilisation adjustments should extend to low volume, high cost DRGs. The current National Pricing Model Stability Policy looks at these DRGs over a two-year period to increase the sample size but in some cases this can still result in low volumes.
- Costs for these low volume DRGs can be highly volatile on an annual basis so implementing a lower than 20% threshold cap for price weight changes should be considered.

15 Do you support investigation of whether the Individual Healthcare Identifier or another unique patient identifier could be included in IHPA's national data sets?

There is in principal agreement that Individual Healthcare Identifier could be included in national data sets however please note this poses significant challenges in terms of ensuring accurate data capture and ability to extract and send.

16 What issues should IHPA consider when examining innovative funding model proposals from jurisdictions?

There is agreement that IHPA should consider the value of the patient outcome as opposed to the throughput model inherit in ABF models. In particular, it should take into account models that provide alternatives to hospitalisation as well as models that support integrated care across service delivery areas.

17 Should IHPA consider new models of value-based care, and what foundations are needed to facilitate this?

We agree that IHPA should consider new models of value based care, although this would require significant work in terms of ensuring systems and processes are sufficiently robust to capture and utilise any of the data required to support it.

Providing care to complex groups (incorporating social complexity) will be costlier and the current funding may not encourage clinicians to spend more time with patients to ensure they get the high quality of care and best outcomes. There is a need to add a quality outcome that will provide incentive to improve.

18 Do you support the proposed risk adjustment model for HACs? Are there other factors that IHPA should assess for inclusion in the model?

We do not provide support for the proposed risk adjustment model for HACs as:

- the model is complex and implementation at the hospital level would require significant amounts of time in both technical work and in terms of operationalizing the information.
- There is an underlying assumption that coding and costing data is mature enough across all jurisdictions to draw valid conclusions from any algorithm development.
- The model is based on a punitive approach whereas funding would be better utilised to reward providers for better and safer patient outcomes.

20 What pricing and funding models should be considered by IHPA for avoidable hospital readmissions?

Adjusting price and funding at the patient level is both complicated and difficult to operationalize at the health service level. The extent to which hospitals can manage the risk of patient readmission also needs to be well developed and take into account non clinical factors that can influence the likelihood of patients coming back (e.g. Socio-economic factors, living arrangements, substance dependency).

Funding policy would be better done at the health service level by monitoring rates of avoidable readmissions and rewarding those who display evidence of reducing these rates.

21 Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing and funding adjustments for avoidable hospital readmissions? Are there any other criteria that should be considered?

The assessment criteria proposed appear reasonable with suggest IHPA considers emphasis on Criteria 5 – ease of implementation, ensure implementation of pricing and funding policy does not result in administrative burden to the health service.

In addition, Alfred Health requests IHPA considers the pricing and funding for Advance Practice Allied Health to Tier 2 consults,

- It is our understanding in that there will be one price for all allied health regardless of whether it is a substitute for medical or not.
- It is understood that Nurse Practitioners will be funded at a higher rate because they have a different registration on AHPRA which is not the case for Allied Health Professionals despite their role in medical substitution.