AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

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

The AMA is pleased to have an opportunity to comment on the draft Pricing Framework for Australian Public Hospital Services 2018-19. The AMA has a significant interest in the pricing framework given its direct impact on public hospitals and AMA members who work there. Our submission mainly focuses on the proposed implementation of safety and quality penalties.

General Comments

The AMA has long championed the need for safe, quality hospital services. We believe the medical professionals working within our public hospital systems are some of the best in the world, who deal with incredibly challenging cases and conditions. We want to see less hospital acquired conditions (HACs) and avoidable readmissions but we do not endorse the use of Commonwealth financial penalties as an effective way to achieve this. Adverse or avoidable outcomes are so often the direct consequence of hospitals being overstretched and under-resourced which unavoidably compromises their capacity to do their jobs. Further decreases in funding to hospitals that do not meet the quality and safety targets will not assist these hospital to lift performance. It will instead entrench a spiralling decline in the hospital's capacity to undertake the internal changes needed to stabilise and meet such targets in the future. Medical professionals strive to give the best possible care to their patients – they do not require financial disincentives to prompt them to improve their care.

The AMA has consistently pointed out overall funding for public hospitals has been and continues to be inadequate. The baseline funding that underpins current year on year ABF and NEP adjustments is the historic cost of an underfunded and under-performing system. The consequence of underfunding is demonstrated by the record of hospital performance against government targets documented in the annual AMA *Public Hospital Report Card*. In this context, it is curious why the Commonwealth has chosen fiscal punishment instead of fiscal reward to incentivise public hospitals to increase safety and quality performance.

The HAC list

The AMA notes a hospital acquired condition (HAC) is defined as "a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring [during an admitted episode of care for a condition treatment other

than the HAC][1]. Under the proposed model, if one of the HACs occurs during and admitted episode, ABF funding for the principal diagnosis will be reduced. The magnitude of the financial penalty will be risk adjusted to take account of patient factors that make them more or less likely to develop the HAC.

It is positive that the following HACs will be excluded from the 2018-19 costing framework[2]:

i. third and fourth degree perineal lacerations during delivery;
ii. neonatal birth trauma;
iii. unplanned intensive care unit admission

However, AMA members question the validity of some of the other conditions listed as preventable hospital acquired complications as they could have attributable causes outside of the hospital's control.

Examples include:

i. Renal failure. One of our members recently treated a patient admitted with a severe systemic drug hypersensitivity who had normal renal and hepatic function on admission and then subsequently progressed to failure of both as a consequence of the inflammation. He required haemoperfusion for a period before renal and hepatic function recovered. This was not preventable. The responsible medication was prescribed outside the hospital.
ii. Malnutrition - Patients have been admitted to hospital with skin eruptions that have, with exclusion of other causes, been diagnosed as nutrition related. Definitely pre-existing and yet requiring diagnosis by exclusion so usually not identified at admission.
iii. Respiratory complications – aspiration pneumonia is listed as a respiratory complication. Seemingly a reasonable HAC inclusion except it may occur through no negligence as a non-preventable consequence of grand mal fit.
iv. Gastrointestinal bleeding – A patient with a gastric melanoma metastasis which bled after Bx causing melaena necessary to diagnosis. An identifiable risk but definitely not preventable.
v. Delirium is another example of a poorly defined HAC and it should also be excluded.

Each patient is unique and responds differently to treatment. The AMA opposes the use of financial penalties on an already under-resources public hospital system as a productive way to lift safety and quality. If HAC penalties are maintained, they should not be imposed without first undertaking a case by case root cause analysis to establish causality and confirm the event is justifiably attributable to 'poor or mismanaged public hospital care'.

HAC Implementation timeframe

The AMA is very concerned about the rushed timeframe before HAC penalties take effect from 1 July 2018. The 2018-19 Pricing Framework indicates the original commitment to a 12 month HAC shadow data collection that will now be reduced to just three to four months (1 July 2017-September or October 2017) to allow IHPA time to consult on the shadow results and report to

[1] IHPA 2018-19 Pricing Framework, p38-39
[2] IHPA 2018-19 Pricing Framework, p38-39

health ministers prior to their next COAG meeting on 30 November 2017. A three month shadow period is too short to reliably indicate the likely financial impact HAC penalties will have at the jurisdiction/local health network level. We are also concerned such a short shadow period may not reliably identify all unintended negative consequences for patients as hospitals adapt and respond to the risk of HAC related financial penalties.

The timing is also not right to use Condition Onset Flags (COFs) documented in the patient's medical record to distinguish HACs acquired during an admission from those that pre-existed before the admission. Without patient identifiers and interoperable patient data across the primary and tertiary sectors, how are hospitals expected to establish and document the full set of *known* pre-existing patient conditions/co-morbidities at the point of admission? If this is not possible, then under the proposed HAC model, a hospital could unreasonably be financially penalised if one of these pre-existing but unrecorded conditions emerges during an admitted episode of care.

HAC Risk adjustment methodology

In cases where a patient is deemed to have more than one HAC it seems unnecessarily harsh to apply the highest of the HAC risk adjusted financial penalties to all the other HACs in the same episode.

Avoidable readmissions

The AMA understands an avoidable readmission is one that

> *'… arise[s] from complications of the management of the original condition that was the reason for the patient's original hospital stay (Pricing Framework p43).*

The AMA notes IHPA is developing the methodology that will underpin risk adjusted deductions in ABF funding for avoidable readmissions. The list of avoidable readmissions will not be finalised until late 2017 at which time stakeholders will be consulted.

As a preliminary comment, the AMA considers the assessment of whether a readmission was avoidable must be based on an independent clinical review of *each* case. Patients are not homogenous, each patient responds differently to treatment and each patient will have a unique experience post discharge which the hospital cannot control.

Readmissions that arise because of patient factors post discharge should be excluded. Examples include: patient failure to follow the discharge plan or follow up with their GP; failure to take the medicines prescribed, or polypharmacy complications that arise but are unrelated to drugs prescribed by the hospital on discharge; and elderly patients who are readmitted because they don't receive adequate follow-up care in the primary health care setting or aged care facility. Patients with physical or mental health conditions with a history of frequent admission should also be excluded.

The AMA is concerned there will be too little time after the avoidable readmissions list and methodology is released in late 2017 to consult with stakeholders and address concerns before implementation from 1 July 2018.

The avoidable readmissions list and methodology should instead be refined and tested over a longer period of time to ensure unexpected or perverse outcomes are identified and addressed. It is also reasonable to collect shadow data over at least a 12 month period before implementation to show the likely impact on hospital funding and patient outcomes.

Australian Mental Health Care Classification

The AMA notes more work needs to be done before pricing can be finalised for mental health phase of care pricing so this will be delayed until beyond 2018-19. Mental health phase of care is described as:

> *A prospective assessment of a patient's needs defined by patient characteristics and the associated goals of care (Pricing Framework p17).*

In the meantime the existing National Pricing Model for mental health will be used for 2018-19. It is critical that refinement to the current pricing model is informed by consultation with the medical profession, and that this consultation specifically include psychiatrary and well as those working in the forensic mental health sector. The AMA supports continued block funding for residential mental health care into the future.

Value based healthcare

The AMA notes IHPA is developing a proposed model to migrate health care funding away from payments based on the type and volume of services delivered toward payments that are based on the value of care actually provided to patients. The AMA looks forward to receiving more details on this and participating in the future consultation.

At a conceptual level, a proposed transition to value based care must be adequately funded and should not be rushed. The Health Care Homes Trial will pilot a new funding model aimed to support improved patient outcomes in the community, leading to fewer potentially avoidable hospital admissions and readmissions. We remain concerned with aspects of the proposed trial, including the adequacy of funding and the inadequate time frame for its evaluation. A value based care model should not be contemplated until the Health Care Homes Trial is finalised and outcomes known. Nor could a value based care model work unless the Commonwealth is prepared to commit long term funding to boost the capacity and co-ordination of care in the primary sector.

Innovative funding models

The AMA welcomes the discussion around innovative funding models. In pursuing this issue, IHPA must ensure that any proposed arrangements:

- Do not dilute available funding for public hospitals services;
- Measures are not seen as cost cutting exercise, noting the evidence showing that shifting more care into primary care settings inevitably requires additional investment in return for a 'longer term' savings;

- Are supported by a strong evidence base;
- Support high quality models of care, coordinated by a GP;
- To the extent that they involve outcomes measurement, these are designed in a way that avoids unintended consequences, such as unnecessary testing, inappropriate prescribing, or the "cherry-picking" of patients

Bundled Maternity Payments

The AMA is reticent about the development of bundled pricing for maternity services. We note this reform will not apply in 2018-19 but is under development.

Bundled pricing has the potential to undermine the standard of maternity services in public hospitals because in pursuit of savings - maternity patients could be shifted to lower cost care setting that puts them and their baby at risk. Funding for maternity services must be evidence based and must incorporate the costs of the full range of health care professionals involved in the provision of maternity services. Medical practitioners involved in 21st century best practice maternity care include specialist Obstetricians, General Practitioners, Anaesthetists, Psychiatrists, Obstetric Physicians, Pathologists and Haematologists.

Of course it is important that services are women centred, recognise cultural differences and are equally accessible by all women. However, we should also recognise and be guided by the evidence and a much greater requirement to focus on the safety and needs of the other half of the equation in this care - the baby.

The fact is that obstetrician-led maternity services provide the best outcomes for mothers and babies. There is compelling recent Australian evidence that women accessing 'low risk' models of care delivered by midwife teams and birth centres in large public hospital units have a significantly higher perinatal mortality rate (2.3/1000) when compared to that of women accessing obstetrician-led care (1.2/1000) (Permezel & Milne, *Pregnancy outcome at term in low risk population: study at a tertiary obstetric hospital*, J Obstet Gynaecol, Res. 2015 Aug; 41(8):1171-7). The practice of obstetrician-led care ensures risk is managed appropriately and any co-morbidity or extra precautions to improve patient safety are properly considered.
It is devastating for our obstetrician members to see mothers and babies suffer needlessly. All too often an obstetrician is only made aware of a labour problem once it has become acute or serious, sometimes many hours after it began to develop. The obstetrician is then expected to assume all responsibility for the care and outcome of the mother and baby.
The popular public hospital maternity services model tends to be midwife-led with obstetrician rescue. But sometimes it is too late for rescue.

An obstetrician has broad medical education in addition to their speciality training spanning 15 years, giving them the clinical and surgical skills to assist mothers and babies in all scenarios. Midwifery training is narrower in scope and much shorter, however midwives are often put in the position of managing a patient's entire pregnancy and labour. This is despite the AIHW 2016 report on National Core Maternity Indicators stage 3 and 4 results from 2010-13 showing that critical obstetrician assistance is required in almost half of all births amongst mothers from a 'low-risk' group.

The latest concerning trends in public hospital maternity outcomes is a very good example of how 'funding incentives' can go terribly wrong and actually diminish safety and quality standards rather than improve them.

The AMA looks forward to being directly involved in the further development of the proposed bundled pricing of maternity services – much earlier than when the details are summarised in the next IHPA pricing framework consultation paper.

Private patients/public hospitals

The option to elect private patient treatment in a public hospital is a long standing feature of our healthcare system. The AMA notes the correction factor used by IHPA to take account of the private patient cost data missing in the National Hospital Cost Data Collection will be maintained in 2018-19. IHPA will continue to work with jurisdictions to address any missing data.

The AMA supports transparency of hospital data collections. It is important, however, that the adjustments that account for private patient revenue do not discourage private patient treatment in public hospitals in circumstances where the patient elects to do so.

Multidisciplinary case conferences where the patient is not present

The AMA supports the proposal to fund non-admitted multidisciplinary case conferences that occur without the presence of the patient. As acknowledged in your paper, case conferences are increasingly important aspect of clinical care given the extent and benefit of multidisciplinary collaboration.

However, it is not clear if IHPA intends to start funding this important activity from 1 July 2018 or instead collect activity data for these services during 2018-19 with a view to funding them in the 2019-20 year? Adequately funded multidisciplinary case conferences are integral to support admitted patients transition to a non-admitted setting for part of their episode of care. AMA suggests hospitals could be retrospectively funded in 2019 for the multidisciplinary case conferences that occurred during the 2018-19 year once the 2018-19 activity data has been collected.

Conclusion

The AMA remains opposed to Commonwealth funding cuts as the mechanism to increase public hospital standards on safety and quality.

The AMA considers the implementation of HACs from 1 July 2018 is too rushed. Our members also question the validity of some of the conditions listed as 'hospital acquired'. Many of them could have attributable causes outside of the hospital's control. This list needs more work prior to implementation including additional consultation with clinicians. At a minimum the 12 month shadow data collection period should be maintained prior to implementation.

The AMA also has substantial concerns about the plan to start penalizing public hospitals for avoidable readmissions from 1 July 2018. The methodology to underpin risk adjusted deductions in the ABF funding has not yet been released. The planned consultation on this

detail late this year raises questions about how genuine this consultation will be, since this work needs to be finalised before health ministers meet on 30 November 2017. It also appears there is no intention to collect avoidable readmission impact data over a defined shadow period prior to implementation.

A rushed implementation of an under-developed avoidable readmissions model that inadequately accounts for human and other post discharge factors outside of the hospital's control, risks creating perverse incentives that may make hospitals reluctant to use step down arrangements and other lower cost settings for part of the patient's admission. The exact opposite of hospital efficiency and quality of care.

The AMA wants to see less HACs and avoidable readmissions but we do not endorse the use of Commonwealth funding penalties to achieve this when public hospitals are already under-resourced and under-funded. However, if the HAC and avoidable readmissions penalties are to proceed, they should to be refined and tested over a longer period with the aim of implementing a fully developed approach from 2020 as part of the proposed longer term hospital funding agreement to operate from that date.

August 2017