Commonwealth Submission for IHPA 2016-17 Pricing Framework Discussion Paper

Should posthumous organ procurement activities be in-scope for pricing under the National Health Reform Agreement?
Is posthumous organ procurement adequately accounted for in activity and cost data collections and, if not, how could it be improved?

The Commonwealth supports posthumous organ procurement activities being in-scope for pricing under the National Health Reform Agreement (NHRA) to the extent that they are not covered by funding in other Commonwealth programmes. It recommends that the IHPA further investigate how these activities are currently included in activity and cost data collections, and how the acute admitted classification can be appropriately applied to these activities.

Should IHPA consider any further technical improvements to the NEP pricing model for 2016-17?

The Commonwealth considers that the existing NEP model is adequate and fit for purpose for setting pricing in 2016-17. Any further technical improvements should only be considered if it can be demonstrated that they would materially affect the distribution of hospital funding, and that the benefits of the improved distribution would outweigh the costs involved in implementation.

While there are no proposed changes for 2016-17 the Commonwealth notes the continuation of IHPAs work to develop a new Australian non-admitted patient care classification which is considered a higher priority at this time than Multidisciplinary Case Conferences (MDCCs).

What are the advantages and disadvantages of changing the geographical classification system used by IHPA?

The Commonwealth supports IHPA investigating the Modified Monash Model as an alternative to the Australian Statistical Geography Standard (ASGS) for determining patient and hospital remoteness. If the Modified Monash Model significantly improves the NEP or NEC pricing models performance in comparison to ASGS then it could be considered for incorporation into the 2016 NEP and NEC.

What are the priority areas for IHPA to consider when evaluating adjustments to NEP16?

The Commonwealth does not support IHPA making any additional adjustments to NEP16. Any additional adjustments to NEP16 should only be considered if it can be demonstrated that they would materially affect the distribution of hospital funding, and that the benefits of the improved distribution would outweigh the costs involved in implementation and significantly improve the performance of the NEP model.

Do you support IHPA's expanded policy intention for bundled pricing in future years?
What services or patient episodes of care would most benefit from this expanded bundled pricing approach?
What issues should IHPA consider prior to implementing a bundled price and how can these issues best be resolved?

The Commonwealth considers that IHPA should expand its policy intent for bundled pricing with caution. Only clinical services that have well-established and defined pathways should be bundled, and there should be evidence that the majority of services are provided following these pathways. In the case of maternity services, the Commonwealth notes that there are significant differences between states in the provision of antenatal care. Setting a bundled price based on the number of antenatal visits recommended in guidelines rather than the number actually provided is arguably contrary to the IHPA's statutory duty under paragraph 131(3)(d) of the National Health Reform Act to have regard to "the range of public hospitals and the variables affecting the actual cost of providing health care services in each of those hospitals".

The Commonwealth notes that bundling will not be successful if there is unpredictability in the course of a condition and consequential variations in patients' clinical pathway.

A potential risk of a bundled approach is reduced ability to audit and monitor the activity and costing of these services as bundling would rely on sophisticated hospital systems to be able to link episodes across admitted, non-admitted and subacute care.

Priority should be placed on improving the counting and collection of non-admitted patient care data. This work needs to be completed before the Commonwealth could be assured that the risk of paying twice for any bundled service has been effectively mitigated.

If feasible, would you support a best-practice pricing approach for hip fracture care in future years?
What implementation issues should IHPA consider when further investigating the feasibility of applying a best-practice pricing approach in future years?

The Commonwealth considers there is merit in the Australian Commission on Safety and Quality in Health Care and the IHPA continuing work to develop a best practice pricing scheme for hip fracture care for possible implementation in future years. In principle, the Commonwealth would support the implementation of such a scheme provided that there is sufficient evidence to demonstrate it will deliver improvements in patient outcomes.

The introduction of a best-practice pricing approach for hip fracture care will require the development and collection of new data elements. It is important to ensure that the overall benefits of such an approach (i.e. improvement in patient care) more than offset any additional system costs associated with the collection of new data elements.

When should IHPA undertake 'Phase two' of the evaluation of the impact of the implementation of national Activity Based Funding for public hospital services?

This work should not commence until Activity Based Funding has operated for a minimum of two full years. As such, the Commonwealth would not support the inclusion of this activity in the IHPA work plan until at least 2016-17.