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

Queensland submission to the Independent Hospital Pricing Authority

Background

The Independent Hospital Pricing Authority (IHPA) is seeking feedback from stakeholders on the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19*, released on 17 July for public feedback.

This year, the Consultation Paper contains an update on the work relating to sentinel events and avoidable hospital readmissions as well as a summary of the final risk adjustment model for Hospital Acquired Complications as approved by the Pricing Authority. The risk adjustment methodology for Hospital Acquired Complications is outlined in a separate report, *Risk adjustment model for Hospital Acquired Complications – Technical Specifications.*

Feedback gathered from the public consultation process will inform IHPA's development of the *Pricing Framework for Australian Public Hospital Services 2018-19* which sets out the policy rationale and decisions regarding their program of work and the decisions in the National Efficient Price (NEP) and National Efficient Cost (NEC) Determinations for 2018-19 (also known as the NEP18 and NEC18).

Directorate Position

Note that this feedback is from the Queensland Department of Health, unless identified as being from a specific Queensland stakeholder.

4 Classifications used by IHPA to describe public hospital services

4.1 Australian Refined Diagnosis Related Groups (AR-DRG) classification

Consultation Questions:
What additional areas should IHPA consider in developing Version 10 of the Australian Refined Diagnosis Related Groups classification system?
Do you support the phasing out of older versions of the Australian Refined Diagnosis Related Groups classification system?
What time frame would be sufficient for the health care sector to transition to the more recent versions of the classification?

Queensland recommends that IHPA consider an AR-DRG for Acute Rheumatic Fever (ARF). Australia has among the highest recorded rates of ARF and Rheumatic Heart Disease (RHD) in the world, and it's a significant cause of disease among Aboriginal and Torres Strait Islander children. Aboriginal and Torres Strait Islander people living in rural or remote settings are known to be at high risk. It is important for

statistical analysis, appropriate pricing and funding, and service planning that this cohort of patients have a separate AR-DRG classification.

Queensland updates to the revised DRG version each two years in line with the national classification version. Queensland has found that in some instances this rapid change has not been helpful when viewing healthcare services longitudinally, and as such maintains grouping to prior versions -1 (i.e. currently data for 5+ years can be reported centrally in versions 8.0 and 7.0, with 6.x reporting phased out when version 8.0 bedded down). It is noted that a longer window would allow more time for the education and training of clinicians and coders and update in systems, i.e. grouper changes with each AR-DRG version, in both public and private health sector.

Queensland recommends that IHPA summarise the changes between versions in a summary document as a communication tool.

Queensland supports the phasing out of older versions of the AR-DRG classification system but recommends that IHPA consider the impact on Private Hospitals and subscription organisations (i.e. health roundtable).

Recommendations for development of Version 10 of the Australian Refined Diagnosis Related Groups classification system:

- a DRG for Acute Rhematic Fever.
- that IHPA consider the impact of frequent changes to DRG models on Public Hospitals, Private Hospitals and subscription organisations.
- a period of two years for the health care sector to transition to each new version of the AR-DRG.

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

Sunshine Coast HHS have provided the following in relation to the challenges of the AN-SNAP classification:

- AN-SNAP requires the use of the Functional Independence Measure (FIM) assessment tool for all patients in the SNAP type of Geriatric Evaluation and Management (GEM) and Rehabilitation.
- The FIM tool is, however, resource intensive and for a large cohort of patients it has not been found to improve care or outcomes. The clinical resources required to undertake the FIM assessment could be better utilised providing care to other patients.
- It is recommend IHPA undertake a cost benefit analysis of the FIM tool and where patients do not benefit from the FIM assessment tool, a tool similar to the Resource Utilisation Group (RUG) assessment tool could be developed and used. The RUG tool requires less training and the assessment can be undertaken by many staff, including staff who provide regular care to the patient and are familiar with the patients level of function.

4.5 Tier 2 Non-Admitted Services classification

4.5.1 Multidisciplinary case conferences (MDCC) where the patient is not present

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

Queensland supports IHPA's assessment that MDCC are an important and rapidly developing feature of evidence-based care and treatment. *MDCC where the patient is not present* are an integral part of clinical therapy and Queensland encourages Hospital and Health Services (HHS) to develop this model of care within facilities, noting that this model provide staff the opportunity to collaborate and design a treatment plan that ensures the best outcome for the patient.

Queensland participated in the IHPA MDCC study conducted by KPMG in May 2016. Jurisdictional staff and staff from Princess Alexandra Hospital and The Prince Charles Hospital were involved in the consultations. The prospect of a classification to recognise *MDCCs where the patient is not present* was received favourably by clinical staff; however, jurisdictional staff raised concerns regarding consistent application of a standard definition and the additional workload for clinical and administrative staff to collection the information.

Due to the focussed nature of the IHPA commissioned KPMG study, HHS services that already have processes established to conduct and record *MDCC where the patient is not present*, were identified and targeted for the consultation. Considering that a comprehensive activity data collection currently does not exist, the jurisdictional funding impact cannot be estimated and Queensland supports the proposal that funding for *MDCC where the patient is not present* be shadowed for at least two years to ensure implementation does not cause an adverse effect, when supported by complete agreed data collection methods.

For the majority of non-admitted services, *MDCC where the patient is not present* are part of the inherent cost of service delivery and do not therefore necessitate a separate classification. As any classification changes will likely not increase the available funding pool, the eligibility scope of MDCCs where the patient is not present will need to be clearly defined; otherwise, it may lead to over-reporting which potentially dilutes the current non-admitted Tier 2 prices / National Efficient Price (NEP). Queensland also recommends that IHPA retain the current definition for MDCC rather than broadening the scope of the definition to increase reportable activity.

In particular, the Cancer Clinical Stream, Metro North Hospital and Health Service (MNHHS) Services, notes that:

- MDCCs are an essential component of quality cancer care. A significant share of all cancer patients have their treatment in MNHHS planned or reviewed by a MDCC.
- Specific pricing and funding will further buttress the role of MDCCs as crucial to the provision of quality cancer care, by ensuring the significant clinical and administrative effort associated with their conduct is remunerated.
- Shadow costing and funding MDCCs for NEP18 will ensure the Department and HHSs can prepare for and respond sensibly to any consequential impacts that arise.
- There are variations in the ability of existing systems used across MNHHS cancer services to record the conduct of, and relevant attributes of, a MDCC in relation to a specific patient.
- Significant changes to MNHHS existing MDCC processes and composition would be required in order to meet the proposed definition.
- Consideration should be given to aligning the definition and funding eligibility for MDCCs in the Medicare Benefits Schedule (MBS) systems to reflect the proposed Activity Based Funding (ABF) definition.
- A detailed costing study is essential to properly inform the pricing and costing of MDCC activity. The Victorian sites in the KPMG study do not reflect as strongly the multidisciplinary model that is expected

in cancer care in Queensland; presumably, a broader study would be more likely to reveal a more representative MDCC composition and cost profile.

- Specific issues that will need consideration in shadow pricing and funding of MDCC include:
  - determining the location at which the MDCC activity is counted when health professionals from multiple sites participate in the MDCC.
  - the process by which a MDCC team would become aware that a patient, scheduled in advance for discussion, had become an inpatient, at the time of the discussion. There is an inherent tension in requiring both advance scheduling and continuing non-admitted status as part of the MDCC definition. Additionally, the approach in situations in which the patient were admitted for a purpose unrelated to the MDCC would benefit from clarification.
  - the approach to be applied when it is not known whether a MDCC participant has "…direct care responsibilities for the patient discussed" until after the patient is discussed in the MDCC. For example, it may not be known whether a radiation or medical oncologist has a direct care responsibility until consensus about the optimal care plan is reached during the meeting. There could be adverse incentives for Multidisciplinary Team (MDT) participation if, in situations where the MDCC concludes that fewer than three participants in the MDCC will have direct care responsibilities, that patient's discussion is not considered remunerable.
- Queensland has raised concerns regarding the counting, reporting and pricing of *MDCC where the patient is not present* through the IHPA Jurisdictional Advisory Committee (JAC) and Technical Advisory Committee (TAC) representatives.
- Primarily the 'core concepts' of what defines a non-admitted patient service event as well as the counting rules would have to be addressed in terms of the national standards process before this could be considered for support first
- Queensland welcomes a discussion on any data collection and classification developments that will support greater understanding of service delivery and equitable distribution of available funding. Queensland has refined the National non-admitted funding model for the state application and incorporated differential pricing for new, repeat and telephone service events; this enhancement has improved the explanatory power of the existing non-admitted classification. With the transition to a patient level non-admitted data collection, it is an ideal opportunity to consider integrating pricing distinctions, which are shown to have a positive influence and cost benefit, into the National model. Queensland recommends that reporting and funding of *MDCC where the patient is not present* be considered for implementation in line with the move to patient level reporting rather than changing the current Tier 2 classification.

Darling Downs Hospital and Health Service (DDHHS) does not support the proposal to shadow price non-admitted *MDCC where the patient is not present* for NEP18 and has provided the following summary of concerns with expanding the Tier 2 classification to include this activity:

- MDCC occur frequently for the purpose of reviewing current treatment plans and coordinating patient care. Many of these are concerned with treatment of currently admitted patients. They may include specialists, junior medical staff, nursing staff and allied health professionals; as such, they meet the criteria of having three or more clinical specialties involved. However, these often include a number of patients, are not booked or planned in advance of the day they occur, with outcomes not noted in patient medical charts. While important for achieving patient care outcomes, these form part of usual clinical treatment and care planning for patients, rather than stand-alone treatment events.
- Furthermore, the patient is not present. This breaks the basic principle of ABF, that direct patient care is funded. Instead, this reimburses the cost of administrative reviews and may lead to other clinical

activities not associated with direct care to a patient to be nominated for funding / pricing consideration in future.

- To quote from the other consultation paper: "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." At Toowoomba Hospital, there are currently no pre-booked clinics, which meet the current criteria for recording multidisciplinary (MDC) involvement. Many have two clinical specialties, but few or none have three. Given the very low volume of expected MDC clinics, a "drop-in" MDC clinic template can be established on the appointment scheduling system to either prospectively or retrospectively record attendances. DDHHS would consider that recording routine case management meetings, where multiple patients were discussed, would not meet either "Clinical content" or "outcomes documented in the patient's chart".
- Feedback in relation to the specific recommendations are as follows:
  - Recommendation 1: Redefine the current MDCC definition – Not Supported, as Patient is not present, so no direct treatment is being provided.
  - Recommendation 2: Revise the existing counting rules – Not supported for the same reasons as recommendation 1
  - Recommendation 3: Conduct a study to directly cost MDCC activities – Not supported for the same reasons as recommendation 1

Recommendations for the proposal to shadow price non-admitted multidisciplinary case conferences where the patient is not present for NEP18:

Queensland requires that the data collection and definitions are resolved prior to supporting the proposal to shadow price non-admitted *multidisciplinary case conferences where the patient is not present* for NEP18. Any changes to improve service transparency and ensure more equitable access to available funding are welcomed; however, Queensland notes the following concerns:

- A robust and clear definition will need to be established to ensure accurate, consistent and appropriate services are reported under this classification.
- As the cost of *MDCC where the patient is not present* are currently embedded in and across the Tier 2 prices, the alternate service delivery models will need to be identified to determine differential pricing. It is unlikely that this can achieved through current National Hospital Cost Data Collection (NHCDC) data at this time and based on current implementation to NHCDC collection timeframes, will not be available for pricing for at least two to three years.

As previously mentioned, gathering data for MDCCs where the patient is not present will create an additional workload for administrative and clinical staff if the data not already collected. Significant changes may also be required to jurisdictional information technology (IT) systems to collect the required data. Any IT developments that are not directly related to patient care provision will be assessed against other clinical priorities; this is especially relevant for Queensland facilities with the implementation of digital hospitals (ieMR).

4.5.2 Home ventilation

Consultation Question: *Do you support investigation of the creation of multiple classes in the classification for home ventilation?*

Queensland supports the investigation of the creation of multiple classes in the classification for home ventilation. Queensland had requested in late 2016 IHPA to conduct a costing study into the pricing

approach for the Tier 2 non-admitted procedure clinic 10.19 Ventilation – Home Delivered to establish if differential pricing is warranted between services provided for paediatric and adult patient, particularly noting the high cost of delivering paediatric home ventilation. Supported by Metro South, Sunshine Coast and Townsville Hospital and Health Services, an investigation and cost benefit analysis into the creation of multiple classes in the classification for home ventilation should provide greater granularity and transparency in this category. From a data collection perspective, the current reporting infrastructure could be enhanced to accommodate this change similar to when there are other additions and/or end dated Tier 2 classification changes.

The Queensland Health Sleep Disorders Program (QHSDP), MNHHS, is in support of the investigation of the creation of multiple classes for the classification for home ventilation.

- The QHSDP is a statewide clinical program comprising medical directors, senior sleep scientists and nursing representatives from the 8 Queensland Health Sleep Disorders Prescriber Centres including The Prince Charles Hospital, Princess Alexandra Hospital, Lady Cilento Children's Hospital, Royal Brisbane and Women's Hospital, Sunshine Coast University Hospital, Gold Coast University Hospital, Townsville Hospital, Cairns Hospital and Mater Health Services.
- Home delivered ventilation encompasses many forms of ventilation for which the complexity and cost of care and medical equipment such as ventilators and associated consumables vary significantly. The QHSDP recommends that the definition of ventilator dependent patient classes be clearly defined with reference to medical condition, type of ventilation and hours of ventilation.
- Examples of Ventilator Dependent Classes that illustrate significant differences in requirements:
  - Tracheostomy ventilation for a minimum of 8 hours per day – these patients require high cost life-support ventilators, associated equipment and continuous care.
  - Non-invasive ventilation (all clinical indications) usage 16-24 hours per day or >12 hours per day for geographically isolated patients where a replacement ventilator cannot be provided within four hours (excludes Continuous Positive Airway pressure (CPAP)) – these patients require high cost life support capable ventilators and ongoing frequent support from medical, nursing and scientific staff.
  - Non-invasive ventilation 12-16 hours per day for chest wall deformity related or neuromuscular disease related chronic respiratory failure (excludes CPAP) – ventilator requirements significant (but can vary between patients) and level of care significant but generally less than above.
  - Non-invasive ventilation 8-12 hours for chest wall deformity related or neuromuscular disease related chronic respiratory failure (excludes CPAP) – ventilator requirements vary between patients; requires significant ongoing level of care.
  - CPAP ventilation >8 hours for chest wall deformity related or neuromuscular related chronic respiratory failure – CPAP is not commonly used for ventilator dependent patients as it is of lower cost. Generally, patients on CPAP would require less care than those requiring more complex or frequent ventilatory support.
  - Diaphragm pacing.
  - Central Hypoventilation Syndrome.
  - Non-invasive ventilation for obstructive lung disease such as Chronic Obstructive Pulmonary Disease (COPD), bronchiectasis and Obesity Hypoventilation Syndrome – a small number of these patients are ventilator dependent and were not included in the current 10.19 classification of the Tier 2 Non-admitted services definitions manual 2015-16.

Recommendations for the investigation of the creation of multiple classes in the classification for home ventilation:

- Queensland supports the investigation into the pricing approach for the Tier 2 non-admitted procedure clinic 10.19 Ventilation – Home Delivered and recommends that IHPA broaden the scope of the conduct a costing study to establish if differential pricing is warranted between services provided for paediatric and adult patients.

4.6 Emergency Classification

Queensland notes the work commenced by IHPA on the new emergency care classification systems and costing study completed in 2016, which captured clinician time per patient to allow for more accurate cost allocation. The Department of Health is actively involved in testing the new classification tool and has recently received the updated grouper; feedback is being provided directly to IHPA in relation to this.

4.7 Teaching, training and research (TTR)

Queensland notes that IHPA has commenced public consultation on the draft Australian Teaching and Training Classification (ATTC). Queensland has provided feedback regarding the structure, content and language of the public consultation paper and the Hospital Teaching, Training and Research Activities National Best Endeavours Data Set (HTTRA NBEDS); Queensland is currently engaging with appropriate stakeholders to prepare a response to the ATTC through the public consultation process.

Queensland has established a jurisdictional working group to gather feedback on the ATTC, consider the impact of the new classification, coordinate recommendations to positively influence development of the ATTC and work towards establishing a jurisdictional data collection to support the classification. The jurisdictional working group members have raised concerns regarding the impact and benefits of the collection; Queensland has proposed that further investment is required to elaborate the benefits of the collection. Some benefits are listed in the public consultation document, however there is no evidence supporting these statements. Queensland has suggested that IHPA expand the list of benefits to mitigate concerns that are likely to be raised by HHS and jurisdictions. The following concerns have been raised by Queensland working group members:

- Some thought / question should be included regarding how jurisdictions and facilities would implement an output-based approach as it acknowledged that managing an activity based system is more expensive than a grant-based approach. Has there been any consideration in relation to where the funding is to come from in order to monitor and manage this?
- Activity based models are designed to promote efficiency and provide the opportunity for hospitals / HHSs to monitor utilisation. It is unclear how an activity based model for TTR can achieve this. The number of participants, duration of education sessions and expertise of training staff cannot be altered; any reduction of training / education may compromise patient safety and quality. The appropriateness of any activity based model is questionable if facilities / jurisdictions cannot increase efficiency of services delivered.
- It has been suggested that there is little benefit in the collection for jurisdictions. The data collection process may be a significant cost impost for states and facilities and can only lead to increased complexity with little likelihood of additional funding. If no additional funding is available, there can be no expansion in TTR and with the additional cost of gathering, collating and reporting the data; it is more likely that funds will need to be redirected from core TTR activities to support the collection at the expense of patient care.
- The ATTC must demonstrate clear benefits for teaching and training activities to justify focussing on a relatively small portion of the funding.

Another factor that is likely to influence public acceptance of the classification, is the noted limitation whereby no hospitals from New South Wales or Victoria participated in the costing study. The benefits listed must be robust and specific to encourage jurisdictional confidence in the classification and any subsequent pricing derived from the classification. The “Pricing teaching and training activities using the ATTC” section of the document provides details of the future direction and states that IHPA will continue to block fund TTR as the classification system evolves however it may also be worthwhile to note 'jurisdictional funding risks will be assessed and strategies implemented to mitigate as part of the development process, to give funding assurance'.

4.8 Australian Mental Health Care Classification

Consultation Question:
What other issues should be considered in the development of Version 2 of the Australian Mental Health Care Classification?

With the move to a revised Australian Mental Health Care Classification, the review and analysis of patient costing against the classification would be required to be tested in order for any future price setting for under this classification.

The Division of Mental Health, Alcohol and Other Drugs Service (MHAODS), DDHHS, noted their support of a revised costing model if there was sufficient accounting for the associated medical costs related to the complex comorbid physical health and related case complexities.

Queensland notes IHPA’s commitment to a comprehensive training program and a number of modifications to improve the clarity and decrease the ambiguity of the ‘mental health phase of care’ instrument. Further refinement of the mental health phase of care type and improved supporting documentation is needed to address clinicians’ concerns and improve the data collection.

The Queensland 2018-19 annual determination of the General List of In-Scope Public Hospital Services and Legitimate and Unavoidable Cost Variations submission also recommended that IHPA:

- reconsider the current exclusion of child and youth community mental health services from the General List of In-Scope Public Hospital Services. The submission included data demonstrating a direct relationship between child and youth mental health services, inpatient admissions and Emergency Department attendances at public hospitals. Some jurisdictions’ HHS/LHNs are already recognised for Commonwealth funding under the A17 List.
- consider new models of care such a ‘residential care’ and ‘step-up / step down’ type.

Queensland supports IHPA in their proposal to not price mental health services using the new classification for NEP18 given the absence of ‘phase of care’ data at this time.

Recommendations for development of the Australian Mental Health Care Classification:

- reconsider the current exclusion of child and youth community mental health services from the General List of In-Scope Public Hospital Services. The submission included data demonstrating a direct relationship between child and youth mental health services, inpatient admissions and Emergency Department attendances at public hospitals. Some jurisdictions’ HHS are already recognised for Commonwealth funding under the A17 List.
- consider new models of care such a ‘residential care’ and ‘step-up / step down’ type NOT ADMITTED bed based care activity.
- further refinement of the mental health phase of care type and improved supporting documentation to address clinicians’ concerns and improve the data collection.

5 Data collection

Queensland notes that IHPA uses the National Public Hospital Establishment database (NPHED) to calculate the National Efficient Cost, not the National Hospital Cost Data Collection (NHCDC) and should note this in this section. Refer National Efficient Cost Determination 2017-18 that '*the NEC was determined using the average in-scope expenditure data for 2014-15 reported in the NPHED of $4.710 million indexed at 4.7 per cent per annum to account for price and activity growth over the three years*. Queensland analysis has shown that there are fundamental differences between the two data collections and recommends that IHPA conduct a variance review of the two collections to quantify and examine the variances.

6 Setting the National Efficient Price for activity based funding public hospitals

6.1 Technical improvements

Consultation Question:
Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2018-19?

DDS HHS has identified three ABF components, which would be appropriate for review as pricing is not aligned to the cost of treatment. These are:

- Emergency Department (ED) presentations. It is hoped that the ED funding will improve following the costing study performed last financial year.
- Tier 2 non-admitted classification. It is acknowledged that this is a focus area of IHPA and the Australian Non-Admitted Care Classification (ANACC) Stakeholder Consultation Paper is currently being finalised and is to be presented to the Pricing Authority on 4 October 2017. HHSs welcome the planned classification review, however it is recommended that a much larger and more comprehensive costing study be performed when the classification is reviewed than that the study used many years ago to establish the clinic classes.
- The Australian National Subacute and Non-Acute Patient (AN-SNAP) version 4 classification is vastly more complicated than is needed, and adds little in explanatory power when compared with the far simpler combination of Care Type and Overnight Flag Stay per diem payment system. There is poor compliance in using the scoring systems, and duplicated reporting requirements to the University of Wollongong data collection.

Recommendations for further technical improvements to the pricing model used to determine the National Efficient Price for 2018-19:

- ED pricing be reviewed based on the results of the ED costing study performed last financial year.
- continue with the ANACC review noting that a larger and more comprehensive study should be conducted than the study used to determine the original clinic classes.
- review the AN-SNAP classification through a cost benefit analysis to determine whether a more simplified pricing model should be adopted.

6.3 Stability of the national pricing model

Consultation Questions:
What are the priority areas for IHPA to consider when evaluating adjustments to NEP18?
What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.

The Queensland 2018-19 annual determination of the General List of In-Scope Public Hospital Services and Legitimate and Unavoidable Cost Variations submission requested that IHPA consider commissioning a study into pricing for patient travel.

Due to the geographical diversity of Queensland hospitals, patients from non-metropolitan areas will frequently require treatment in a tertiary facility if the clinical specialty or case complexity cannot be managed in their local hospital.

Queensland acknowledges that patient travel costs are directly attributable to geographical population patterns, which are beyond the remit of an activity, based pricing framework. However, patient travel accumulates a significant portion of jurisdictional cost and commissioning a study to examine these costs could offer the opportunity to create a pricing framework that ensures appropriate levels of funding to support equitable access for patients to necessary treatment.

In the submission, it was suggested that the NHCDC should be expanded to include a separate cost bucket for patient travel as patient travel is currently included in to the Goods and Services NHCDC cost bucket. Of the Queensland NHCDC R20 submission, 6.7% of reported costs were attributable to the Goods and Services category, of this cost category 8.6% related to patient travel. The significant variance in travel costs incurred by Hospital and Health Services and jurisdictions with a high volume of remote patients cannot be examined using the current NHCDC cost bucket classifications.

It is important to better understand this critical cost component of healthcare. A study into pricing for patient travel and a separate NHCDC cost bucket will enable the IHPA to develop a pricing framework that recognises the variation in this area, therefore improving equitable pricing for patients.

Feedback received from DDHHS also reiterated that patient transport should be priority for review. HHS staff noted that in Queensland, ambulance road and air transport costs at a patient level are passed on directly to the Health Service. Through clinical costing processes these costs are attached to ED, inpatient or outpatient episodes and included within treatment costs. This provides a point of validation to assess the appropriateness for a loading based cost variations in the National model, and demonstrate actual treatment costs for patients transported to regional and metropolitan hospitals.

North West Hospital and Health Service (NWHHS) also cited travel costs associated with transferring patients to tertiary hospitals from rural and remote areas as a priority area for consideration.

Metro South Hospital and Health Service (MSHHS) raised concerns that pricing model is becoming progressively more complex and expensive to implement. A number of the changes discussed in the consultation paper will further add to the complexity. For example, the proposal to package maternity care looks good at first – but there will need to be so many exceptions, which will either add or deduct from the package it would probably be less administratively demanding if the present system is maintained. Also, there is no evidence given to support that packaging would be more patient centred. MSHHS recommended that efforts be directed at reducing complexity of the entire NEP model.

Recommendations for priority areas for IHPA to consider when evaluating adjustments to NEP18:

- as included in the Queensland 2018-19 annual determination of the General List of In-Scope Public Hospital Services and Legitimate and Unavoidable Cost Variations submission, the jurisdictions recommends that IHPA consider commissioning a study into pricing for patient travel. A study into pricing for patient travel and a separate NHCDC cost bucket will enable the IHPA to develop a pricing framework that recognises the variation in this area.

Recommendations regarding availability of patient-based factors to provide the basis for these or other adjustments:

Patient transport is available in Queensland NHCDC data thus providing a point of validation to assess the appropriateness for a loading based cost variations in the National model, and demonstrate actual treatment costs for patients transported to regional and metropolitan hospitals.

9 Setting the National Efficient Cost

9.1.1 Transferring services from ABF hospitals to block funded hospitals

Consultation Questions:
Should IHPA ensure that there is no financial penalty due to the transfer of public hospital services from ABF hospitals to block funded hospitals?
If so, how should this be carried out?
Do you support investigation of whether the Individual Healthcare Identifier or another unique patient identifier could be included in IHPA's national data sets?

Block funded facilities represent a significant proportion of hospitals within Queensland and provide healthcare to a clinically and geographically diverse population. The financial impact of falling below a lower banding threshold, or achieving beyond a high threshold are large and present a funding risk as each years models are applied for the calculation of growth funding for the State and to the HHS should the models be flowed to the HHSs with larger numbers of rural block funded facilities. It is worth noting that an activity based (or partly activity based) model for smaller 24/7/365 rural facilities is workable, but there need to be more bands with smoother funding transitions when moving between them.

- Funding needs to be responsive to changes in activity rather than using a rolling three-year average. For example the loss of activity following the decline of the mining boom has had a delayed but significant impact on the banding of our western and south western Queensland hospitals.
- Transferring services from hub (ABF) to spoke (non-ABF) facilities should not incur a financial penalty. The most direct impact is in commonwealth growth funding adjustments, where ABF public activity drops.
- Transitioning services from an ABF facility to a NEC facility is a complex process. Packaging bundles of activity and ABF funding for services transferred back would be overly complex and messy. Adopting a full variable funding ABF model for all facilities, or a variant with fixed and variable components for currently block funded facilities would be the most transparent.

A review into the NEC methodology is welcomed.

Recommendations for whether IHPA should ensure that there is no financial penalty due to the transfer of public hospital services from ABF hospitals to block funded hospitals:

- to ensure effective and efficient models of care that promote clinically-appropriate treatment closer to home, Queensland recommends that no financial penalty be applied when public hospital services transfer from ABF hospitals to block funded hospitals.

Recommendations regarding how this should be carried out:

- investigate a variant to an ABF model with fixed and variable components; investigate jurisdictional models to assess the practicality of incorporating elements into the National model.

Recommendations regarding whether the Individual Healthcare Identifier or another unique patient identifier could be included in IHPA's national data sets:

- a unique identifier would enable jurisdictions to measure hospital readmissions across states. With data currently available this is not possible which subsequentially limits jurisdictions to validate or monitor IHPA compiled datasets. Queensland considers a unique patient identifier crucial to progress value based healthcare initiatives.

9.3 Non-admitted mental health services

Consultation question:
Do you support IHPA's proposal to continue to block fund residential mental health care in future years?

Recommendations for IHPA's proposal to continue to block fund residential mental health care in future years:

- until a robust classification system is established for this patient cohort, Queensland considers block funding through the NEC determination as the most appropriate funding for residential mental health.

10 Bundled pricing for maternity care

10.7 Next steps

Consultation questions:
Do you support the proposed bundled pricing model for maternity care?
Do you agree with IHPA's assessment of the preconditions to bundled pricing?
Do you support investigation of whether the Individual Healthcare Identifier or another unique patient identifier could be included in IHPA's national data sets?

Queensland supports innovative funding models that enable HHSs provide contemporary treatment options, however the jurisdiction cannot currently support implementation of bundled pricing for maternity care. It is acknowledged that the higher number of antenatal visits are linked with better maternity outcomes, and therefore any pricing policy should not potentially place downward pressure on the number of antenatal visits either being offered by hospitals or the number of visits mothers are attending.

Before a bundled pricing model is established, a thorough impact assessment must be conducted. The current financial impact assessment has no data from Victoria or South Australia (SA) and significant issues with linkage and incomplete cost data has reduced the sample to be around 27% of the data, without Victoria and SA. Jurisdictional assessment of the information concluded that larger hospitals with lower non-admitted costs are over-represented in the sample.

Queensland is also concerned that the bundle is based on average resource utilisation and this may not align with good practice. Any bundled pathways need to be assessed against the price of the good

practice pathway (i.e. antenatal care provision as per national guidelines). Queensland acknowledges that it is not IHPA's role to influence clinical practice; the principle should be that funding is not a disincentive to providing good quality care.

Any bundled payments must also be linked to outcome measures to ensure there has not been an increase to adverse events.

Queensland considers bundled pricing worthwhile to consider for future funding models however outstanding issues including the absence of a unique patient identifier across all healthcare settings must be resolved before bundled pricing can be implemented.

The SPPD-DDG Aboriginal and Torres Strait Islander Health Branch had the following feedback:

- While the proposal for bundled maternity payments are supported in theory, the proposed model does not adequately consider the additional needs of Aboriginal and Torres Strait Islander women or the role that maternal care plays in preventing infant mortality, and therefore the role in supporting the Council of Australian Government (COAG) target of halving the child mortality gap by 2018.
- It is recommended that the proposed bundled pricing model for maternity care the higher complexity of Aboriginal and Torres Strait Islander child and maternal health be explicitly considered in the formulation of any bundled pricing for maternity care.
- Detailed statistical information contextualising the additional resources required to support Aboriginal and Torres Strait Island women was provided in the branch's feedback and has been included as attachment one.

Feedback received from HHSs is included below for IHPA's reference:

DDHS

- Bundled pricing for maternity care is not supported. As well as the issues identified, many women also have additional pre-delivery admissions (for false labour etc.) which incur costs. Maintaining separate pricing for admitted and non-admitted services is more robust. However some bundling is already imposed by the Commonwealth, where multiple clinic services provided on the same day within the same specialty (i.e. Maternity) are not funded, even though this is an efficient and effective way of delivering care.
- In response to question: Do you agree with IHPA's assessment of the preconditions to bundled pricing, the preconditions identified are important but do not include discussion of price sharing between different providers.
- We agree that adoption of a universal patient identifier is required to effectively and efficiently manage health care resourcing in Australia. By itself, this will not make bundling of maternity services better. However, it will support better analysis where care is shared between the public and private sectors, or between facilities.

Gold Coast Hospital and Health Service (GCHHS)

- GCHHS note the significant challenges in implementing bundled pricing for maternity patients. In addition to those identified in the consultation paper:
  - Equity – how will the model manage patients moving across facilities / jurisdictions? How will the model manage patients in different models of care (i.e. Obstetrics, Midwifery, GP shared care)?
  - Ease of implementation - must be as simple as possible with the bundled model to represent the vast majority of the maternity patients if implemented.

- GCHHS also note the importance of strong clinical and stakeholder support identified in the preconditions to bundled pricing in the consultation paper. This is essential to the success of the model.

MNHHS

- This is a very complex area, likely more so than other areas that have been bundled in the past. Bundling may therefore be very difficult to analyse and implement.
- Surgical bundling is much simpler in terms of agreed standard practice of care with preadmission, post-surgical follow-up that is hard wired into the process. This is not the case in maternity services. Clinical complexity – needs to consider more than obstetric complexity such as low socioeconomic grouping, poor diet, lifestyle, alcohol and drug use.

MSHHS

- It is unclear what the resulting pricing would be for the high risk patients and how the time and effort to care for the high risk women will be assessed.

NWHHS supported the concept of bundled pricing for maternity care.

SCHHS

- SCHHS supports the concept of bundled pricing for maternity care assuming the preconditions to bundling can be met, and only when these can be met.
- SCHHS supports IHPA's assessment of the preconditions to bundled pricing.
- SCHHS supports that the Individual Healthcare Identifier or another unique patient identifier be included in IHPA's national data sets.

THHS

- THHS supports the delayed implementation of this proposal until the barriers such as availability of patient level outpatient data, and integrated systems, which span various settings, are addressed.

Recommendations for proposed bundled pricing model for maternity care:

- any bundled pathways need to be assessed against the price of the good practice pathway to ensure that funding is not a disincentive to providing good quality care.
- issues including the absence of a unique patient identifier across all healthcare settings must be resolved before bundled pricing can be implemented.
- support deferring a bundled pricing model until appropriate clinical pathways can be established with lead clinician input and data linkages can be resolved.

11 Innovative funding models

11.4 Value-based healthcare

Consultation Question:
What issues should IHPA consider when examining innovative funding model proposals from jurisdictions?
Should IHPA consider new models of value-based care, and what foundations are needed to facilitate this?

Queensland supports further work by IHPA to support new models of value-based care. This is, however, a complex and long term objective. In particular, key considerations are the ability to define high value in terms of outcomes that matter to patients. This requires a far more sophisticated approach than the current approach, which is focused on adverse clinical outcomes, such as hospital acquired complications. The approach needs to be balanced and reward effective appropriate care, not just penalise poor care.

The collection of outcome data is also very undeveloped and will require new data collections. This needs to be integrated into usual business so as not to be burdensome. The ability to understand the cost of care across the entire patient pathway and across funders is also essential. Cost data also needs to relate meaningfully to the interventions undertaken so that it can be understood what interventions were provided and whether or not these interventions affected the patients' outcomes. Work such as that to develop the non-admitted patient classification system is therefore a key element.

With the increased focus by jurisdictions to identify patient cohort(s) for a change in models of care (e.g. chronic disease patients from ABF to block for flexible service delivery), IHPA could support this in a systematic way through a classification/patient characteristic profiling for each of these programs and reflect these against ABF reported activity in other States where the funding model has not been applied as a shadow model for analysis and review.

Feedback received from HHSs is included below for IHPA's reference:

DDHHS

- Block funding hospital avoidance initiatives, such as chronic disease management programs, presents a viable alternative to the current model, which only funds on hospital based treatment. Currently there is little incentive for acute care budgets to be redirected to hospital avoidance programs. This is particularly true in an environment of increasing demand, where there are no savings made as a result of patient A not being admitted if patient B is immediately available to fill the vacant bed.
- There is growing demand for admitted inpatient services from the aging population. The proportion of elderly emergency medical admissions with multiple complicating co-morbidities is increasing. These patients are also more difficult to discharge, particularly if they proceed to a Sub and Non Admitted Patient phase of care. Access to Residential Aged Care Facility (RACF) beds is not increasing in DDHHS, and patients with dementia or delirium are difficult to place.
- Access to step-down facilities where Maintenance patients can be accommodated with a higher level of nursing care than is available in RACFs would alleviate much of the acute bed pressure currently being experienced.
- In response to question, *Should IHPA consider new models of value-based care, and what foundations are needed to facilitate this*, poor care and unnecessary or inappropriate care should not be encouraged or funded. Reduced payment rates for hospital acquired complications should be adopted, but not severe financial penalties for adverse events. Penalties encourage non-reporting and non-compliance.
- Adjusting individual episode payments by the additional costs resulting from Hospital Acquired Complications (HAC) is supported, provided the calculations are robust.

MNHHS

- Any changes must be based upon valid clinical evidence and patient outcomes in the Australian healthcare setting. There also must be risk adjustment so that public health facilities do not become financially disadvantaged for looking after complex patients with high care needs.

- MNHHS noted that it is difficult for the hospitals to fully analyse these changes due to limited access to Pharmaceutical Benefits Scheme (PBS) and Medicare data in order to assess systemic health system costs.

SCHHS

- SCHHS supported the proposal that IHPA consider new models of value-based care, and in relation to what foundations are needed to facilitate this, the HHS noted that significant investment is required in information and communications technology (ICT) to collect better and more integrated data, including unique patient identifiers.

Recommendations for issues IHPA should consider when examining innovative funding model proposals from jurisdictions:

- key considerations are the ability to define high value in terms of outcomes that matter to patients. This requires a far more sophisticated approach than the current approach, which is focused on adverse clinical outcomes, such as hospital acquired complications. The approach needs to be balanced and reward effective appropriate care, not just penalise poor care.
- the collection of outcome data should be a priority. This needs to be integrated into usual business so as not to be burdensome or discourage reporting.

Recommendations regarding whether IHPA should consider new models of value-based care, and what foundations are needed to facilitate this:

- new models of value-based care are an important part of the evolution of the funding model to incentivise best-practice clinical care. An essential foundation to deliver this will be investment in ICT to improve data integration and enable analysis across healthcare providers.

12 Pricing and funding for safety and quality

12.5.1 Risk adjustment model

Consultation Question:
Do you support the proposed risk adjustment model for HACs? Are there other factors that IHPA should assess for inclusion in the model?
Do you agree that HACs third and fourth degree perineal lacerations during delivery and neonatal birth trauma be excluded from any funding adjustment?

Queensland is concerned that, as stated in section 2.3 of supporting document: *Risk adjustment model for hospital acquired complications – technical specifications*, a number of hospitals are being excluded due to poor quality condition onset flag (COF) reporting, i.e. hospitals with less than 1% of episodes containing conditions ‘arising in hospital’ and hospitals where greater than 10% of episodes had no reported COF. Poor quality COF reporting could be penalised. COF of ‘not reported’ should be assumed as COF – present.

The definition of a HAC is poorly defined. There is little information in relation to patients who are very likely to develop a HAC and may have that complication on presentation. Furthermore, several of the HACs may occur as part of natural foreseeable disease progression rather than be related to hospital care. The binary application of present/not present on admission combined with the complexity of HACs that may subsequently develop, but were entirely clinically predictable and not preventable is problematic.

We challenge the presumption that anything that was not present at admission and develops whilst in hospital should, by default, be a HAC.

The following issues are recommended for consideration in regards to the list of national agreed HACs (Table 1):

- HAC04 Surgical complications requiring unplanned return to theatre - Queensland has chosen to not report this HAC as it is not currently possible to identify *unplanned return to theatre*. A similar issue was noted by IHPA regarding identifying HAC05 '*unplanned admissions to intensive care*' in the national datasets and there is no funding adjustment proposed for that HAC).
- HAC10 Medication factors - has polypharmacy been considered as a factor in determining this HAC? The number of medications, which a patient is taking, is known as a risk factor for medication misadventure.
- HAC08 Renal failure, HAC09 Gastrointestinal bleeds and HAC14 Cardiac complications are, in the majority of cases in Specialist Paediatric Hospitals, events closely associated with the underlying admission condition and are, in most cases, an expected complication that is not present on admission. As the risk adjustment model does not adjust to 'zero', coding standards may need to be adjusted to reflect complications and or comorbidities that are not present on admission but are an expected part of the disease process, i.e. Renal failure following admission for septic shock.
- HAC16 Neonatal birth trauma - In response to question, *Do you agree that HACs third and fourth degree perineal lacerations during delivery and neonatal birth trauma be excluded from any funding adjustment,* it is difficult to prevent these given childbirth is inherently traumatic. We agree that imposing a penalty for a health outcome outside the control of the clinicians makes little sense. The sample size is not large enough for statistically significant results, this is due to the small cohort of patients to whom the HACs apply and IHPA being unable to develop a risk adjustment model with sufficient explanatory power to produce robust and reliable adjustments for their use. The data is also not available in the NHCDC.

In regards to the Final risk factors adopted for each HAC group (Table 3, page 41):

- Patient age - the proposed Age groups including banding 0 – 4 years (and in particular the first few days of life) excludes the impact of the comorbidity (including congenital factors) and complexity of babies and children under one year where the model of care is 'treat at all costs'. For example, the model could include age in days under one year, neonatal care type or birth weight as risk factors.
- Gender - the nationally collected data element is Sex. Gender is not typically collected nor is it reported nationally.
- Diagnosis related group type (medical, surgical, other).
- Major diagnostic category.
- Charlson score – There is minimal information about this score included in the specifications. Derived from the Charlson Co-morbidity Index, it uses comorbidities to provide an index on mortality and includes conditions such as Dementia, Renal disease, Mild liver disease. The concern with the use of this tool and the reference periods used (2014-15 and 2015-16) is that International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) / Australian Classification of Health Interventions (ACHI) / Australian Coding Standards (ACS) Ninth Edition was implemented in 2015-16. Ninth Edition included the implementation of Supplementary codes for chronic conditions (U codes) – conditions such as Dementia, Renal disease, Mild liver disease. There were also code process changes (code also instructions removed) that would see comorbidities move from Chapter to U codes. This will have impacted the data (unless included in

the Charlson score). These codes are also assigned when not being actively treated. Either way, they have the potential to skew the data. The vignettes do not provide detail on if the comorbidities met ACS 0002 or 0003.

The Charlson score also does not adequately reflect paediatric patient acuity and it is recommended that an expanded/ separate risk-adjusted comorbidity model for children should be considered to include conditions such as congenital disorders. For example the Derek Tai et al paper Arch Pediatr Adolesc Med. 2006;160(3):293-299. doi:10.1001/archpedi.160.3.293 describes the approach undertaken to develop a Paediatric Comorbidity model in Ontario, Canada.

Mobility is not listed as a factor, which is a consideration for HAC07 Venous thromboembolism. However, it is noted that the Charlson score is included and this includes 'Stroke with immobility' so it has been deduced that mobility had been considered in that context.

- Admission status (whether admission occurred on an emergency basis).
- Transfer status (whether the patient was transferred from another hospital) - the specifications are not clear if this is only transfer of an admitted patient from another hospital or if it also included a non-admitted patient.

The Aboriginal and Torres Strait Islander Health branch notes that patient's indigenous status was excluded from the risk adjustment model for hospital acquired complications. Although in agreement with the methodological approach taken, the branch wishes to flag that it may be necessary to make an additional risk adjustment for Indigenous status to ensure Aboriginal and Torres Strait Islander people are not unfairly disadvantaged from any funding changes that may arise. NWHHS also supports this request.

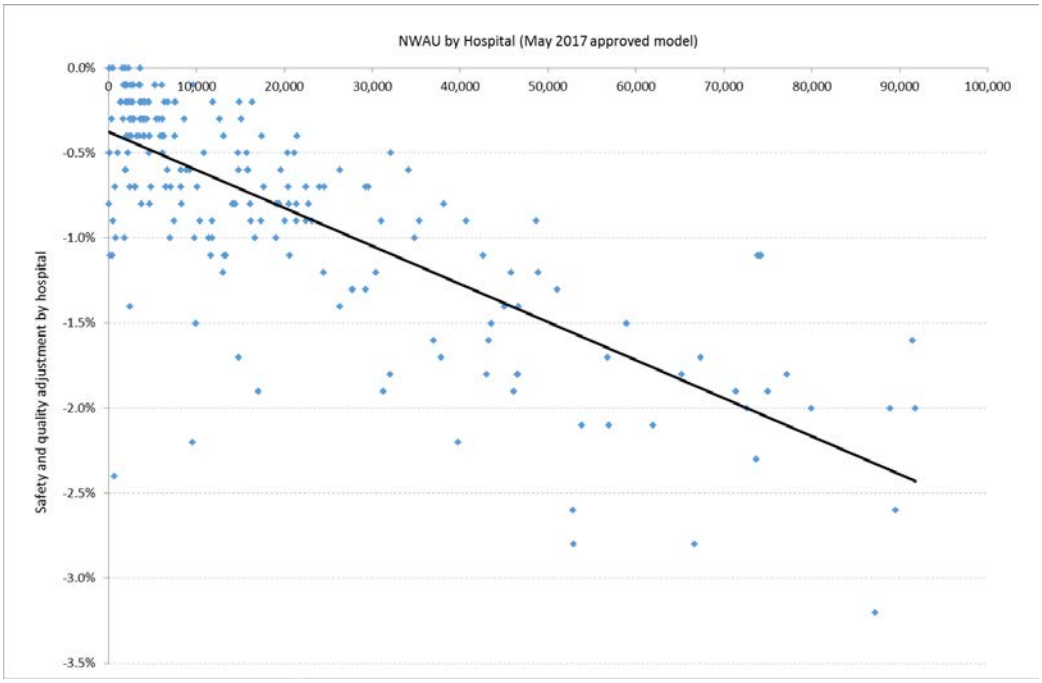
MNHHS recommends that consideration should be given to using a frailty score in addition to, or in replacement of, age. There should be consideration of inclusion of the following as risk factors: Obesity/ Body Mass index (BMI), Smoking status, unit/service specific risk scores, such as the Acute Physiology and Chronic Health Evaluation (APACHE) score for intensive care unit (ICU).

There is no description provided for the rationale for summing the risk factors for HACs in determining a risk score. The summing of risk factors may oversimplify the analysis of the risks. Whilst it is possible that risks are mutually exclusive, however it should be examined to determine if there is any additional interdependency worsening the effect of multiple risks.

Application of funding adjustment

Queensland further notes that estimates of the impact of the funding adjustment at a hospital level provided by IHPA show a disproportional amount of the funding impact rests with large tertiary hospitals. In fact, there appears to be a strong relationship between the size of the hospital (measured by annual National Weighted Activity Units (NWAU) delivered) and the relative funding impact as per the chart below. It is not clear, from the information provided to jurisdictions, whether this is because there is a disproportionately higher rate of HACs for larger hospitals. Alternatively, the apparent bias against larger hospitals may be the result of the risk adjustment process not appropriately adjusting the funding impact for higher risk episodes of care – which presumably are more prevalent in larger hospitals.

CHART 1: Funding impact by hospital, Australia



Source: IHPA

The proposed proportional adjustment based on each individual patient's NWAU value and therefore associated AR-DRG assumes the HAC cost is dependent on the DRG, not the complication that has occurred. Children's Health Queensland (CHQ) do not support this proposal and believe this is inequitable and penalises Hospitals providing Tertiary / Quaternary services.

For example, it would be difficult to explain to clinicians and hospital staff the apparent pressure injury cost difference in the example below:

1. Pressure injury

	DRG	NWAU1718	High Adjustment (1.0%)	Adjustment at NEP	Moderate Adjustment (6.9%)	Adjustment at NEP	Low Adjustment (13.8%)	Adjustment at NEP
Patient 1	A06B TRACHEOSTMY/VENT>=96HRS, INTC	337.19	(3.37)	($16,556)	(23.27)	($114,238)	(46.53)	($228,476)
Patient 2	D03Z SURGICAL REPR CLEFT LIP/PALATE	2.43	(0.02)	($119)	(0.17)	($823)	(0.34)	($1,645)

Queensland recommends that a 'fixed' risk adjusted HAC adjustment is a fairer and more transparent means of reflecting the actual HAC Cost as currently adopted by Queensland Health for adverse events.

Risk adjustment model for hospital acquired complications – technical specifications

The technical specifications paper is difficult to fully understand and does not allow readers to fully reconcile the model (CHQ requested on 9 August that IHPA provide further clarification and paediatric examples).

Regarding the episodes that have been trimmed from the data (such as deaths and those >95 years old) will these be exempt from penalty since they were not included in the analysis? Would this not create inaccuracy and bias in the data set?

Roughly 25% of the patients outlined in table 5, page p 13 (of the technical specifications document) are cardiac complications. There should be further investigation as to whether these cardiac complications may be natural disease progression rather than HACs. In light of this, there should be a mechanism by which clinician notation or review can declare that a complication was expected/predicted/natural progression of disease and therefore is not a HAC, even if not present on admission.

Further information should be provided in relation to clinician input provided in the development of this document, particularly in relation to the risk factors assessed. It would be interesting to understand which specialities and jurisdictions have been involved as the information provided does not provide this clarity and implies only minor clinical input.

The technical specifications document does not provide clarity as to the number of HACs, which occurred in trimmed patients. This information would allow the assessment as to whether a significant volume of HACs has not been included in determining risk and dampening effect.

There needs to an assessment of how medical documentation can identify a HAC over a fluctuating condition that may or may not have been recorded on admission (e.g. atrial fibrillation) and for which a penalty should not be levied.

12.6.1 Policy context of pricing and funding models to reduce avoidable hospital readmissions

Consultation Question:
What pricing and funding models should be considered by IHPA for avoidable hospital readmissions?

Queensland notes that an adjusted model, similar to that which has been used in the HAC document, would be appropriate. The Patient Safety Queensland notes that there are currently no clinically robust readmissions indicators that have been developed for the intention of funding or pricing approaches. However, it is noted that the Australian Commission on Safety and Quality in Health Care (the Commission) is finalising an agreed list of clinical conditions that can be considered avoidable hospital readmissions. Queensland recommends that the Commission and IHPA undertake a rigorous process implemented to define clinically and statistically reliable indicators, and these indicators are pilot tested for at least a year.

Feedback received from HHSs is included below for IHPA's reference:

DDHHS

- Assessment of whether an individual hospital admission was avoidable is at heart a clinical judgement. Previous attempts to penalised based on readmissions have failed due to the need for chart review by a clinician in order to validate the assessment of "avoidable". We do not consider development of robust decision making tools based on the patient information currently captured electronically is probable.

GCHHS

- GCHHS suggests that analysis of funding models to reduce avoidable hospital readmissions should follow a similar pathway to the HAC analysis, which included consultation on funding models after an analysis of HAC definitions and trends across jurisdictions.
- Similarly, readmission definitions will vary between jurisdictions and hospitals and the definition of "avoidable" will be subject to interpretation. Presumably, this would also be dependent on an Individual Healthcare Identifier to be properly analysed and interpreted, similar to the bundling of maternity services.

MNHHS

- Investigation should include other international models such as Canada and New Zealand.
- A risk adjustment model should only apply a penalty above an agreed clinically appropriate level (which may be different from the national mean).

NWHHS

- It would be appropriate to consider payment for the readmission and original episode combined; the exception being where the original episode discharge disposition is “Discharged against medical advice”.

SCHHS

- Data definitions need to be agreed and defined initially and data availability determined.

Recommendations for pricing and funding models to be considered by IHPA for avoidable hospital readmissions:

- that the Commission and IHPA undertake a rigorous process implemented to define clinically and statistically reliable indicators, and these indicators are pilot tested for at least a year.

12.6.3 Criteria for assessing pricing and funding options

Consultation Question:
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?

Queensland supports the assessment criteria to evaluate the relative merit of the different approaches to pricing and funding adjustments for avoidable hospital readmissions. The Department of Health with support of DDHHS and GCHHS recommends:

- that the transparency criteria, as part of encouraging action at relevant levels of the health system, include identification of clear clinical actions to prevent the outcome occurring.
- including only emergency readmissions or using the ED Triage Priority as a filter to identify severe exacerbations prior to admission.
- consideration of the impact of readmissions across jurisdictions and facilities from an equity perspective, i.e. where a patient was discharged from one jurisdiction and then presents with an avoidable readmission to another jurisdiction. In that scenario, any negative funding adjustment should only apply to the first jurisdiction, not the second.

Response to Pricing Framework for Australian Public Hospital Services 2018-19 consultation

Strategy, Policy and Planning Division

DATE: 4 August 2017

RE: Response to *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19: Section 10 Bundled pricing for maternity care*

Summary of Advice

- The Statistical Services Branch has reviewed the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19 and wishes to provide comments on Item 4.5.1, Item 4.5.2, Item 4.8 and Item 10.7.

Item 4.5.1 – Multidisciplinary case conferences where the patient is NOT present

- Statistics Services Branch has previous advised to JAC & TAC representative that it not support the counting of this activity. We understand that this is also aligned to the position of Qld's JAC & TAC representatives.
- Primarily the 'core concepts' of what defines a non-admitted patient service event as well as the counting rules would have to be addressed in terms of the national standards process before this could be considered for support first.

Item 4.5.2 – Home Ventilation – Creation of multiple classes in Home Ventilation in the Tier 2 Classification

- From a data collection perspective the current reporting infrastructure could be enhanced to accommodate this change similar to when there are other additions and/or end dated Tie2 classification changes.

Item 4.8 – Australian Mental Health Classification – What other Issues should be considered in the development of Version 2 of the Australian Mental Health Classification

- The classification refers to activity in both admitted and non-admitted settings. However, the Classification should recognise / accommodate new models of care such a 'residential care' and 'step-up / step down' type NOT ADMITTED bed based care activity.

Item 10.7 – Next Steps

- Given that higher number of antenatal visits are linked with better maternity outcomes, I would not support any pricing policy that could potentially place downward pressure on the number of antenatal visits either being offered by hospitals or the number of visits mothers are attending.

Summary of Advice

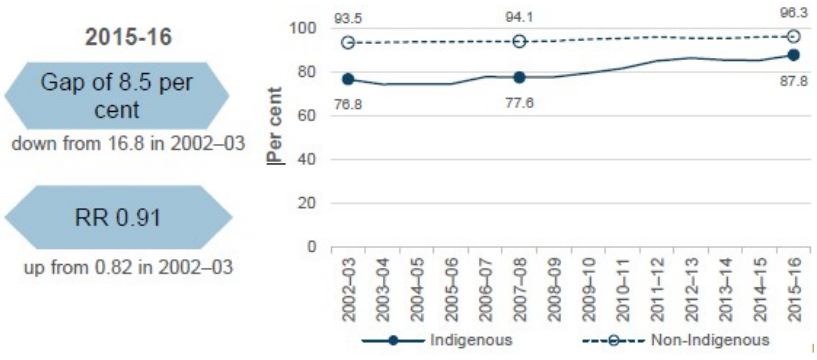
- The Aboriginal and Torres Strait Islander Health Branch has reviewed the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018–19 and wishes to provide comment on Section 10 Bundled pricing for maternity care.
- While the proposal for bundled maternity payments are supported in theory, the proposed model does not adequately consider the additional needs of Aboriginal and Torres Strait Islander women or the role that maternal care plays in preventing infant mortality, and therefore the role in supporting the Council of Australian Government (COAG) target of halving the child mortality gap by 2018.
- It is recommended that the proposed bundled pricing model for maternity care the higher complexity of Aboriginal and Torres Strait Islander child and maternal health be explicitly considered in the formulation of any bundled pricing for maternity care.

Background

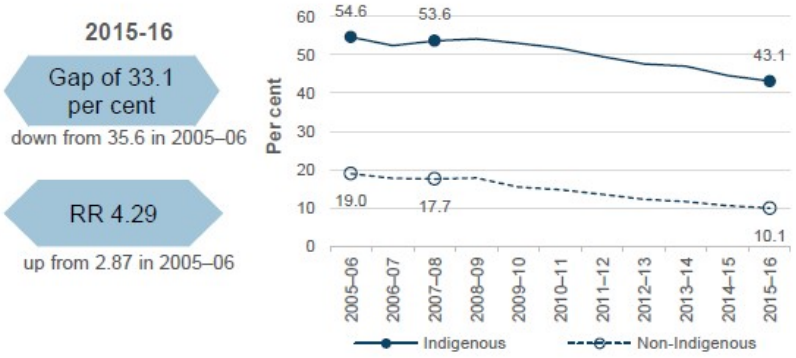
Maternal health

- Aboriginal and Torres Strait Islander mothers have both higher rates and complexity of pre-existing conditions (such as anxiety and depression, diabetes and other chronic disease) and greater complications during pregnancy.
- Aboriginal and Torres Strait Islander mothers experience greater exposure to risk factors such as anaemia, poor nutrition, hypertension, diabetes, genital and urinary tract infections, and smoking during gestation, compared to non-Indigenous mothers.
    - Antenatal attendance is generally lower among Aboriginal and Torres Strait Islander mothers, with 87.8 per cent of Aboriginal and Torres Strait Islander women who gave birth in 2015–16 attending 5 or more antenatal visits compared to 96.3 per cent of non-Indigenous women.
    - In 2015-16, 43.1 per cent of Queensland Aboriginal and Torres Strait Islander mothers who gave birth reported smoking at some stage during pregnancy, a rate more than four times that of non-Indigenous women. Smoking increases the risk of complications during pregnancy, low birth weight, pre term birth, and perinatal death.

Attended 5 or more antenatal visits



Smoked at all during pregnancy

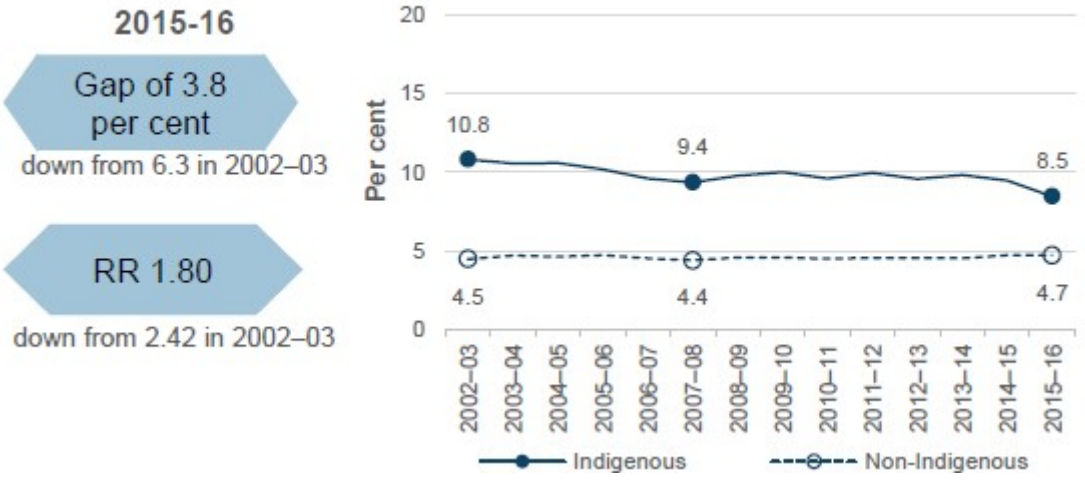


Source: Queensland Health (2017). *Closing the gap performance report 2016*. Brisbane: Queensland Health

Infant and child health

- Addressing poorer maternal health outcomes is paramount to supporting the national Closing the Gap agenda, in particular the COAG health target to halve the child mortality gap between Aboriginal and Torres Strait Islander and non-Indigenous children aged 0–4 years by 2018.
    - Aboriginal and Torres Strait Islander child mortality rates are 1.7 times that of non-Indigenous children aged 0–4 years. Almost 85 per cent of child deaths occur in the first year of life, in particular the first 28 days of life.
    - Currently in Queensland, low birth weight babies accounted for 8.5 per cent of births to Aboriginal and Torres Strait Islander women in 2015-16, which is 1.8 times the proportion of non-Indigenous babies born with low birth weight.
    - Low birth weight babies are at greater risk of mortality in their first year of life, experiencing ill health during childhood, and developing chronic disease in adulthood. There are a number of maternal risk factors that influence the birth weight of the baby, including smoking during pregnancy, high body mass, socio-economic disadvantage, poor nutrition and inadequate antenatal care.

Babies born low birth weight (less than 2500 grams)



Child, infant and perinatal mortality indicators by Indigenous status

	Indigenous deaths	Indigenous rate	Non-Indigenous deaths	Non-Indigenous rate	Rate ratio
Child 0-4 mortality (2011 – 2015)	207 (41/year)	162.7 per 100,000 population	1395 (279/year)	96.8 per 100,000 population	1.7
Child 1-4 mortality (2011-2015)	32 (6.4/year)	31.6 per 100,000 population	212 (42/year)	18.4 per 100,000 population	1.7
Infant <1 mortality (2011 – 2015)	175 (35/year)	6.6 per 1,000 live births	1183 (237/year)	4.1 per 1,000 live births	1.6
Perinatal deaths (2011-2015)	259	9.7 per 1,000 live births	2711	9.4 per 1,000 live births	1.0
Fetal deaths (2011-2015)	147	5.5 per 1,000 total births	1880	6.5 per 1,000 total births	0.8
Neonatal deaths (2011-2015)	112	4.2 per 1,000 live births	831	2.9 per 1,000 live births	1.5

Sources: Perinatal, foetal and neonatal deaths from ABS, 2015, Cat No. 3303.0; Infant and child mortality rates from ABS, 2015, Cat No. 3302.0

Source: Queensland Health (2017). *Closing the gap performance report 2016*. Brisbane: Queensland Health

The importance of maternal care

- The link between pre-natal and antenatal behaviours and complexity of pregnancy and perinatal health suggests there should be a greater focus on non-admitted antenatal maternity services for Aboriginal and Torres Strait Islander women.
- Improved access to culturally appropriate, quality antenatal care for Aboriginal and Torres Strait Islander mothers can assist in identifying and managing issues that may affect adverse birth outcomes.
- Through the *Making Tracks towards Closing the Gap in health outcomes for Indigenous Queenslanders by 2033, Investment Strategy 2015–2018*, Queensland is investing in supporting better antenatal care for Aboriginal and Torres Strait Islander mothers and making progress in the rates for smoking, antenatal care and low birth weights. This success is being achieved through investment in initiatives like:
    - Ngarrama in Metro North Hospital and Health Service is an antenatal, birthing and postnatal service for Aboriginal and Torres Strait Islander families who choose to birth at the Royal Brisbane and Women's Hospital, Caboolture and Redcliffe hospitals: Metro North has seen an increase in the percentage of Aboriginal and Torres Strait Islander women attending five or more antenatal visits to 90.8 per cent, and a decrease in the number of women who smoked at any stage during pregnancy from 47.0 per cent in 2010–11 to 39.8 per cent in 2015–16, which is lower than the Queensland Aboriginal and Torres Strait Islander average (43.1 per cent).

- The Birthing in Our Communities (BiOC) program on Brisbane's South: since opening, of the women BIOC has supported to birth at the Mater Mothers Hospital, 97.8% have had five or more antenatal visits and only 4.4 per cent have birthed a low birthweight baby (weighing less than 2500gms).
- Given that smoking is a major risk factor for chronic disease, Queensland Health actively engages with Aboriginal and Torres Strait Islander communities to support individuals looking to quit smoking through multiple state based programs. The Quit for You…Quit for Baby provides tailored quit smoking support through Quitline, for pregnant women. Recruitment is through Queensland public hospital antenatal services. During 2015-16, around 10 per cent of participants identified as Aboriginal and Torres Strait Islander.

- The proposed payment bundling does not appear to consider the possibility of higher costs associated with providing Aboriginal and Torres Strait Islander women with additional support based on their higher needs nor the provision of culturally appropriate antenatal care, an additional input independent of DRG.

- It is recommended that the greater input required to address the higher complexity of Aboriginal and Torres Strait Islander child and maternal health be explicitly considered in the formulation of any bundled pricing for maternity care in order to more accurately reflect the differential of maternity care requirements with non-Indigenous people and to better support the national Closing the Gap agenda.

Comments from DDG, SPP
