

Submission by Marlene Eggert RN PhD to the Independent Hospital Pricing Authority's Consultation paper on the pricing framework for Australian public hospital services 2017-18, September 2016 (the Pricing Framework Consultation Paper)

Thank you for granting me an extension to 7 November 2016 giving me the opportunity to respond to this consultation. I am writing this submission as a private citizen. I am currently not in paid employment as I care for my husband full-time.

General comments

IHPA was directed by the honourable Minister Ley to 'send a signal at the health system level of the need to reduce instances of preventable poor quality patient care, while supporting improvements in data quality and information available to inform clinicians' practice.' (Page 53 of the Pricing Framework Consultation Paper). I note that this direction requests IHPA to design two types of incentives (1) financial incentives delivered through a funding response to variations in care quality and (2) incentives through feedback on care performance via comparative quality of care data. The consultation paper states that, according to the Direction, the incentives should 'reach the health system level'.

I note that this Direction does not clearly identify which level of hospital management and/or employees the incentives target. I assume that financial incentives that impact hospital budgets in response to quality of care performance target the different levels of executive and management staff responsible for budget allocations, such as CEOs, General Managers, Clinical Directors, Directors of Nursing etc. IHPA does not present any evidence as to the motivational mix of these executive and management staff. I assume that executives and managers at these levels are likely to be motivated if budget allocations are affected by quality of care performance. Thus a financial incentive may elicit the desired response.

Relative to executive and management staff most clinicians are likely to have a fairly different motivational mix driving their work performance. For example, Australian data indicate that clinical nurses are highly motivated by a desire to make a difference to the people they care for¹. This indicates that clinical nurses' perception that the quality of the care they deliver meets their professional standards would be an important driver of their care performance. This observation aligns with the strong evidence presented in the literature review (appended to the Pricing Framework Consultation Paper) that information on quality of care performance improves clinicians' care performance.

The incentives' broad targeting at the 'health system level' makes it somewhat difficult to consider how effective the proposed incentives may be in driving quality of care performance. Ideally, robust evidence as to the motivational mix of the various levels of employees should be used to inform the incentives' design. This information would enable a better assessment to be made as to whether the incentives target an important job motivator, making their effectiveness more likely.

¹ Nowak, M. 2005, 'Choosing to be a nurse, remaining a nurse and leaving nursing in Western Australia: nursing workforce issues in the twenty-first century', *Australian Bulletin of Labour*, vol.31,no4,pp304-20.

Response to consultation questions

In the remaining section I respond to select questions posed by the Pricing Framework Consultation Paper.

p. 18 *What patient-based factors would provide the basis for these and other adjustments? Please provide supporting evidence.*

New models of care can be highly effective relative to usual treatments and models of care. For example, the *Eat, Walk, Engage* model of care² responds therapeutically to the physical and cognitive characteristics commonly observed in older people experiencing delirium. *Eat, Walk, Engage* has been shown to be highly effective in settling this cognitive disorder, so much so that older peoples' length of stay reduced by 3 days. This model of care may require a different mix of labour inputs or a higher level of labour input and its wider implementation may require an adjustments to the NEP. The article cited below plus a conference abstract are attached to this submission.

p. 28 *Is there support for pricing and funding models for safety and quality to be applied broadly across all types of public hospitals, all services, all patients and all care settings?*

I agree that pricing and funding models for safety and quality are (1) applied to all care settings and (2) that they align to non-financial incentives and other measures put in place to secure care quality. Currently, subacute episodes of care result in a higher rate of Hospital Acquired Conditions (HACs) relative to acute episodes. While subacute episodes of care may involve delivering care and treatment to populations with a higher risk, these risks should be mitigated as far as possible. With appropriate treatment environments in place there should be little or no difference in the rate of HACs between the acute and subacute episodes of care. Applying pricing and funding models for safety and quality to all public health services may contribute to alleviating any differences in care quality that arise from the type of clinical setting.

p.30 *What factors should be considered in risk adjustment for safety and quality in pricing and funding models for hospital care?*

Some hospitals may service many patients who do not reside in the Local Hospital Network (LHN) to which the hospital belongs. If a hospital's catchment includes a LHN in a different state and this LHN provides little community based support for patients who require it post discharge, then this fact needs to be considered in risk adjustments. Unscheduled re-admissions are a good example for a particular risk that may arise from such a situation. For example, The Canberra Hospital services many patients from NSW. In Queanbeyan, NSW, which is part of The Canberra Hospital's catchment, a community based service such as *Hospital in the Home* is unavailable, yet it may reduce hospital re-admissions (and shorten length of stay). Risk adjustments need to take account of factors in hospitals' environment over which hospitals' executives have little or no influence.

²Mudge, A. McRae, P. & Cruickshank, M. 2015, *Eat, walk, engage: An interdisciplinary collaborative model to improve care of hospitalized elders*, *American Journal of Medical Quality*, vol. 30, no 1, pp.5-13.

On the other hand, the introduction of financial adjustments in response to care quality may instigate negotiations between adjacent jurisdictions on how to deliver community based health care and related supports that meet population requirements.

p.31 Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing and funding for safety and quality? Are there other criteria that should be considered?

As an additional assessment criterion IHPA may consider the issue whether agents have decisive control over some factors influencing quality of care outcomes. The example above of The Canberra Hospital demonstrates that some hospitals may lack the ability to influence particular aspects in their internal or external operating environment. Rewarding or sanctioning a performance over which agents do not have decisive control introduces an element of randomness into the application of the incentive. If sanctioned for a performance agents perceive they lacked control to decisively influence, they may respond with demoralization and disengagement from the work effort.

p.31 Do you support the proposal to not fund episodes that include a sentinel event? If not, what are the alternatives and how could they be applied consistently?

p. 34 Do you support the proposal to include a sentinel events flag to improve the timeliness and consistency of data that is used for funding purposes?

The Pricing Framework Consultation Paper observes the very low prevalence rate of sentinel events. This low rate means that withholding payment for a sentinel event results in a negligible impact on the hospital budget and thus may not be perceived by the executive/management as a financial penalty. However, there is some considerable symbolic value expressing an element of justice in not paying for a service which was delivered without due care. Sentinel events may be more effectively responded to with sanctions targeting the professional reputations of the persons responsible.

The timeliness of a sanction/reward is eminently important to its effectiveness in changing behaviour. Any measure that improves the timeliness and consistency of data that is used for funding purposes is to be welcomed.

Response to questions about a pricing/funding response to HACs

Clinicians are the people directly involved in the production of quality care. Two factors are essential to clinicians' quality performance: (1) access to the materials required (technology etc) and (2) high professional morale. A high professional morale constitutes an intrinsic job motivator which drives health care professionals to do their best by the patient. A high professional morale is an important production factor as clinicians' work is difficult and costly to monitor. Any pricing/funding responses to HACs must encourage hospital executive/management to support clinician's professional morale which is an important resource and provide clinicians with the materials they require.

p.44 *What are the advantages and disadvantages of Option 1 which reduces funding for some acute admitted episodes with a HAC?*

Advantages: It is hard to see advantages in this arrangement. I do not agree with IHPA's assessment that this arrangement is transparent as most admissions with a HAC do not change DRG.

Disadvantages: As most admissions with a HAC do not involve a change in DRG, the funding impact is likely to be too small to make an impact on executive/management.

Executive/management may not be motivated to put in the effort to investigate the reason (lack of materials required, poor staff morale) for the HAC rates experienced by the hospital's patients.

p. 46 *What are the advantages and disadvantages of Option 2 that adjusts funding to hospitals on the basis of differences in their HAC rates?*

Advantages: Identifications of HAC rates in the top quartile of all hospitals with 10% of the NWAU of all admission associated with a HAC would target the executive/management through reduced funding and clinicians through a reputational threat. It might bring forth the collaboration required between executive/management and clinicians to investigate causes and seek solutions to improve care outcomes. Properly supported and managed quality improvement activities that result in reductions in HAC rates would build morale.

The implementation of this approach should be phased in over 2 to 3 years to give hospitals time to muster a response.

p. 46 *What are the advantages/disadvantages of the approaches to risk management?*

Any comparisons of HAC rates between hospitals is likely to result in bickering and fights that the comparison is somehow unfair. One way of alleviating this scenario somewhat is to require hospitals to demonstrate year on year improvement on their own performance. In the US governments and regulatory bodies instituted requirements for health care providers, including nurses, to monitor indicators of quality of care relative to peers and to track individual improvements³.

State based comparisons between hospitals' HAC performance should be avoided because (1) small sample sizes will skew comparisons and (2) Australia needs to move to a health care system with the same attributes across jurisdictions, not just in GP based care but also in hospital based care. This way all Australians have access to the same level of health care provision regardless of the state they live in.

p. 47 *What are the advantages/disadvantages of Option 3 that combines funding incentives and penalties?*

Disadvantage: This option will be negatively experienced by all hospitals. As all hospitals experience an unavoidable rate of HACS, even well performing hospitals are likely to lose some

³Gajewski, BJ &Dunton, N 2012 'Identifying individual changes in performance with composite quality indicators while accounting for regression to the mean'. *Medical Decision Making*
<http://mdm.sagepub.com/content/early/2012/10/02/0272989X12461855>.

funding. These reductions would partially neutralize any positive funding adjustments paid out as financial reward.

Returning initially reduced funding to the states dilutes for the people involved in the production of care the immediacy of the reward. Hospital based workers are likely to view this move with cynicism because the reward they contributed to with their effort does not necessarily flow to their employing hospital. Because the jurisdictions are partial funders and the total operators of public hospitals they should be responsible to fund any quality improvement programs.
