Queensland Government

Health Services Chief Executives' Forum

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Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
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Dear Mr Downie,

I am writing on behalf of the Health Services Chief Executive (HSCE) Forum in response to the Independent Hospital Pricing Authority (IHPA) Consultation paper on the pricing framework for Australian hospital services 2017-18.

The HSCE Forum (collaboration of the 16 Queensland public Hospital and Health Services chief executives) collectively supports this submission which specifically addresses seven sections of the consultation paper.

HSCEs also recognise that individual Queensland Hospital and Health Services and the Department of Health may also submit separate responses to the consultation paper.

Furthermore Children's Health Queensland Hospital and Health Service will provide the Queensland submission to IHPA on the pricing framework specific for children's or paediatric hospital services.

Section	Consultation question and HSCE Forum response
Box 2	**Scope of Public Hospital Services and General List of Eligible Services** **Home ventilation** *Yes, it is supported that home ventilation programs be reviewed in the future once the full scope of the National Disability Insurance Scheme is known. Although low in volume the cost is higher than funding*
6.2.2	**Patient Remoteness Area Adjustment** *Yes, for NEP17 the proposal that all high cost outliers are included in the calculation of the Patients Remoteness Area adjustment is supported.* *Yes, it is supported that IHPA use SA2 (rather than postcode) as an initial indicator of patient remoteness. This will provide improve the accuracy of determining the remoteness measure.*
6.3	**Should IHPA further restrict year-on-year changes in price weights?** *No, adjustments should not be applied to any areas or any patient-based factors. When new technologies and drugs are introduced, there can be significant impacts on costs in some services. The pricing model should support innovation and improvement rather than act as a disincentive.*

9.4	**Do you support IHPA's intention to introduce a bundled price for maternity care in future years?** *No, this is not supported as it does not address the high caesarean section rates across Australia. These rates are being addressed in hospitals in particularly in hospitals that provide care to mothers with the highest risk or complications in pregnancy. However bundling prices for maternity care will defeat these efforts possibly leading to further increases in the rate of caesarean sections.*
11.4	**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?** *No, there are concerns that issues as complex as patient safety and quality care can be addressed by crude methods like pricing triggers. The idea of linking quality and safety outcomes to funding is flawed. System or health service safety and quality needs to be achieved through a system wide clinical governance approach. This includes targeted clinical governance processes and a deep understanding of the variations in casemix, levels of clinical risk and management across services.*
11.5	**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?** *Yes, although small in numbers it is essential to recognise the seriousness of these errors.* **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?** *Yes* **Do you agree with IPHAs assessment of the option (not funding episodes with a sentinel event)?** *Yes. It is proposed that in addition to health services not receiving funding for these events, that the funding be directed towards insurance or compensation payments to the patients for the harm caused.*
11.6	**What are the advantages and disadvantages of Option 1 which reduces funding for some acute admitted episodes with a HAC?** **Do you agree with IHPA's assessment of this option?** *No, this option does not address the fact that the largest principle referral hospitals, more often than not, receive and provide care to patients with the most complex diagnoses and needs (as identified in Figure 3 page 42). These patients by the nature of their chronic diseases, co-morbidities and complex needs are more likely to experience a complication (as identified in Table2) that may not be a consequence of or associated with the recent hospitalisation. Hospitals providing care to these types of patients would be penalised for their performance under this model.* *The list of hospital acquired complications at table 2 cannot consistently (and with confidence) be characterised as always resulting from a hospitalisation.* **What are the advantages and disadvantages of Option 2 that adjusts funding to hospitals on the basis of differences in their HAC rates?** **Do you agree with IHPA's assessment of this option?** *No, similarly to option 1, hospital level funding changes fail to address the differences in patient complexity and the sequelae of chronic and/or complex conditions.*

11.6 cont.	**What are the advantages and disadvantages of Option 3 that combines funding incentives and penalties?** **Do you agree with IHPA's assessment of this option?** *No, concerns remain with this methodology again due to the differences in patient complexity; however of the three options proposed option 3 presents the least number of issue/concerns.* **How should IPHA treat hospitals with poor quality COF reporting?** *A national standard for the reporting of COF should be maintained. This should be achieved through the creation of incentives for meeting/exceeding reporting requirements rather than funding reductions for those hospitals with under reporting.*
11.7	**Is there support for pricing and funding models to be based on avoidable hospital readmissions within the same LHN?** *No, similarly to items in 11.6, this proposal fails to appreciate the variable complexity of patients accessing the health and hospital system. Readmissions that are causally related to a prior admission may be an acceptable starting point; however it still doesn't address the issue of patients with chronic and complex needs.*

Thank you for your consideration of these important matters.

Please do not hesitate to contact me on 0448 147 617 as required.

Yours sincerely

Heather Edwards
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on behalf of the HSCE Forum
17 October 2016

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