Government of **Western Australia**
Department of **Health**
Office of the Director General

Contact: Andrew Joseph (08 9222 2259)

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Dear Mr ~~Downie~~ James

CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR PUBLIC HOSPITAL SERVICES 2017-18

Thank you for the opportunity to provide a submission to the *Consultation Paper on the Pricing Framework for Public Hospital Services* released on 30 September 2016.

A detailed feedback to the consultation questions is provided in the attachment. WA Health intends to provide a separate submission through the IHPA's *Legitimate and Unavoidable Cost Variations Framework* by May 2017, which will include findings from a consultancy-led State Price Analysis work to assess location based costs in rural and remote locations. WA Health supports the IHPA's current work program on classification system development, funding model enhancements including technical improvements and adjustments to the National Efficient Price and National Efficient Cost Determinations and Pricing for Safety and Quality.

WA Health will take the opportunity to further provide further comments during the statutory 45-day Ministerial consultation period when the Draft Pricing Framework 2017-18 is released.

Should you require any further information, please contact Andrew Joseph, Group Director Resources on (08) 9222 2256 or Andrew.Joseph@health.wa.gov.au.

Yours sincerely

Dr D J Russell-Weisz
DIRECTOR GENERAL

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Government of **Western Australia**
Department of **Health**

ATTACHMENT

WA HEALTH SUBMISSION TO THE CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2017-18

The Western Australian Department of Health (WA Health) welcomes the opportunity to provide feedback to the Independent Hospital Pricing Authority (IHPA) on the *Consultation Paper for the Pricing Framework for Australian Public Hospital Services 2017-18.*

2. PRICING GUIDELINES

WA Health is generally supportive of the Pricing Guidelines outlined in the Consultation Paper and notes that no changes have been proposed for the *Pricing Framework 2017-18*.

While it is acknowledged that the IHPA's fundamental principles for ABF adjustments are focussed on 'patient-centric' characteristics, WA Health maintains that many remote and very remote cost pressures are not sufficiently recognised within the Pricing Framework, as they pertain to the structural costs associated with staffing hospitals in remote and very remote locations.

WA Health will continue to work with the IHPA to further explore these types of cost variations with the intention to make a submission through the IHPA *Legitimate and Unavoidable Cost Variations Framework* in 2017.

3. SCOPE OF PUBLIC HOSPITAL SERVICES

WA Health acknowledges that IHPA is not proposing any changes to the scope of public hospital services. The approval of the Pricing Authority to include home ventilation on the *General List of In-Scope Public Hospital Services* in recognition that it meets the criteria for inclusion is welcomed.

4. CLASSIFICATIONS USED BY IHPA TO DESCRIBE PUBLIC HOSPITAL SERVICES

WA Health supports in principle, ongoing classification refinement and development for activity based funding purposes and will continue to participate in this work through its representation on the IHPA working groups and advisory committees. The IHPA should ensure that jurisdictions are provided with adequate time to implement any new classifications before introducing pricing based on that new classification.

Australian-Refined Diagnosis Related Groups classification

WA Health acknowledges that IHPA will use AR-DRG Version 8 in NEP17 underpinned by the ICD-10-AM and ACHI 10th edition diagnosis and procedure codes. **WA Heath is generally supportive of the continuing development of AR-DRG Version 9 and looks forward to its release in early 2017 for use for pricing from 1 July 2018.**

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

WA Health acknowledges that IHPA will use AN-SNAP Version 4 to price subacute services in NEP17 and notes that the IHPA is considering whether there is sufficient data to price subacute paediatric services.

Consultation Question 1

- ***What additional areas should IHPA consider in developing Version 5 of the Australian National Subacute and Non-Acute Patient classification?***

Response

WA Health appreciates IHPA endeavours to further develop AN-SNAP Version 5 and the supports the review of all areas of the classification as outlined in the Consultation Paper. However, it is noted that there are still challenges around the collection of admitted subacute and non-acute data, due mainly to the complexity of the data to be collected and the variety of data capture systems in use. These challenges are likely to be compounded for non-admitted data.

Additional areas IHPA might consider when developing AN-SNAP Version 5 are:

- the inconsistent definitions and business rules surrounding non-admitted care;
- the disconnect between counts used for admitted (episode) and non-admitted (service event) patients;
- the diversity of admitted and non-admitted patient requirements and the differing models of subacute and non-acute care in use;
- the use of other cost drivers as potential data variables, e.g. medical complications, availability of social support;
- identifying and recommending appropriate clinical tools for incorporation into AN-SNAP;
- improving the counting and classification of consultation and liaison services;
- greater use of standard coding frameworks and international standards to allow for national and international comparisons; and
- the administrative and operational feasibility, and potential burden, of collecting additional data.

Tier 2 Non-Admitted Patient Services

WA Health acknowledges that the IHPA will continue to use the Tier 2 Non-Admitted Services classification for pricing non-admitted services for NEP17, and that non-admitted multidisciplinary case conferences where the patient will not be separately priced.

The development of the Australian Non-Admitted Care Classification is supported as it is expected to be better able to describe patient complexity and more accurately reflect the costs of non-admitted public hospital services.

Australian Mental Health Care Classification

WA Health acknowledges the considerable work by the IHPA to develop the Australian Mental Health Care Classification (AMHCC) V1.0, introduced as the new classification for mental health services.

WA Health notes that the IHPA will develop a work program for further refinements to the classification which will examine areas such as refinement of classes, incorporating clinical complexity and comorbidities, recommendations from the child and adolescent mental health Clinical Reference Group and options for the refinement of the older persons' mental health branch.

In the *Pricing Framework 2016-17*, the IHPA foreshadowed its intentions to price mental health services for NEP17. As outlined in the Consultation Paper, pricing of mental health services in dependent of the outcome of exploratory work being undertaken by the IHPA to determine a suitable proxy for 'mental health phase of care' as phase level data was not collected in the 2014-15 National Hospital Cost Data Collection, which forms the basis of the NEP17 Determination.

WA Health has considerable concerns with the feasibility of identifying a proxy for 'mental health phase of care' that would provide sufficient accuracy to determine an end class for pricing adult admitted mental health services for NEP17.

Emergency Care Classification

WA Health acknowledges that for NEP17, the IHPA will price emergency activity using the URG Version 1.4 and UDG Version 1.3 classifications. WA Health has been actively involved with the Emergency Care Costing Study and will continue to work with the IHPA in the development of the new classification for emergency care services.

WA Health notes that the implementation of the Emergency Department Principal Diagnosis Short List in the national data collection has been deferred to 2018-19.

Teaching, Training and Research

WA Health acknowledges that IHPA will continue to block fund teaching, training and research activity in activity based funding hospitals including in NEC17.

WA Heath is generally supportive of the current work program towards developing the Australian Teaching and Training Classification, expected to be completed in 2017-18. However, it is noted that there were some limitations to the Teaching, Training and Research Costing Study that will inform the classification, as there was representation from only three jurisdictions and the small sample sizes for embedded teaching and training.

The IHPA should ensure that jurisdictions are provided with adequate time to implement the new classification before pricing based on the new classification for teaching and training is implemented.

5. DATA COLLECTION

WA Health acknowledges that IHPA will be releasing version 4 of the Australian Hospital Patient Costing Standards in 2017 for use in future rounds of the National Hospital Cost Data Collection (NHCDC).

6. THE NATIONAL EFFICIENT PRICE FOR ACTIVITY BASED FUNDED PUBLIC HOSPITAL SERVICES

Consultation Question 2

- ***Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2017-18?***

Response

As noted in our previous years' Pricing Framework submissions, WA Health would be strongly opposed to any change in the calculation of the NEP that has the potential to reduce the Commonwealth contribution to jurisdictions under ABF going forward.

Furthermore, WA Health does not support a move away from the current process of setting a NEP based on the weighted mean cost of admitted services. This is particularly important issue as it would result in more funding being subject to funding guarantee considerations.

WA Health maintains many rural and remote cost pressures are not sufficiently recognised within the Pricing Framework, and would like to continue to work with IHPA to ensure that WA is not disadvantaged in national pricing.

Consultation Question 3

- ***Should IHPA further restrict year-on-year changes in price weights?***

Response

WA Health considers that the IHPA's approach for NEP14, NEP15 and NEP16 using a rolling three year average should adequately moderate any issues with national

cost volatility. Further restrictions to year-on-year price adjustments may not reflect the actual cost of service delivery.

The IHPA should carefully consider any potential changes to price weights for mental health services should the Australian Mental Health Care Classification (AMHCC) be introduced for pricing in NEP17. Should the new classification result in changes to mental health funding IHPA should allow adequate lead in time in order for services to adjust to the new funding model.

As an example in the National Efficient Pricing Determination 2015-16, the IHPA altered the Specialist Psychiatric Age Adjustment for an admitted acute patient who has one or more psychiatric care days during their admission. A key change was for patients aged 17 or less with a mental health related primary diagnosis (MDC 19 or 20) and who were admitted to a Specialised Children's Hospital. While the loading amount to be applied in 2013-14 and 2014-15 in these circumstances was 30%, this was reduced to 9%. **Given this experience, pricing should be phased-in during a transition period as changes can distort prices and makes local implementation of the national ABF model difficult, noting that WA Health applies the ABF model locally.**

In 2014-15 over 90% of Child and Adolescent Mental Health Service patients were diagnosed with a mental health-related primary diagnosis. There was a 21% reduction in adjustments for over 90% of its patients, which is both unstable and unpredictable. The IHPA should carefully review any changes to the pricing of mental health services, to ensure minimal variation in funding during the transition to the AMHCC.

Further to this, analysis could be conducted to further explore reasons why year-on-year price weights vary for material/significant variations. There could be benefits in understanding drivers of DRG cost reductions which could be utilised to assist jurisdictions achieve efficient service delivery without compromising patient safety.

Consultation Question 4

- ***What are the priority areas for IHPA to consider when evaluating adjustments to NEP17?***

Response

WA Health appreciates the visit by IHPA earlier this year to see and experience first-hand the degree of remoteness and costs associated with health service delivery across the North West of WA. While there are positive signals in IHPA's approach for improved recognition of these costs, WA Health maintains that many remote and very remote cost pressures are not sufficiently recognised within the Pricing Framework, as they pertain to the structural costs associated with staffing hospitals in remote and very remote locations.

WA Health welcomes the introduction of a geographical classification system that would better account for the costs of providing public hospital services in remote locations, and supports the inclusion of all high cost outlier episodes in the calculation of the Patient Remoteness Area Adjustment.

Location-based costs

Costing and price studies performed within WA Health and through the State Department of Regional Development (DRD) have identified a range of key categories which are inherently more expensive (cost) or occur more often (volume) when provided as part of a remote service, such as:

- Food supplies (up to 15% more expensive)
- Freight (up to 22% more expensive)
- Utilities: Water and Energy (up to 70% and 80% more expensive respectively)
- Motor vehicles - Fuel (up to 33% more expensive)
- Patient transport (ambulance and patient assisted travel scheme)
- Agency staff cost including medical locums (up to 40% more expensive)
- Cost of award: District Allowance, North West allowances (up to 20% more expensive)
- Staff travel (including for service provision) due to distance
- Staff accommodation (cost pressure not incurred in a metro setting)

Location based costs in rural and remote areas such as those identified above is material and not funded as part of patient based loadings. In 2016-17, WA estimated location-based cost pressures in WA remote and regional ABF hospitals to be $97 million. The most significant locality costs include district allowances ($15.4m), staff housing/accommodation ($13.5m), and additional costs of locum services in comparison with salaried staff ($14.9m).

It is the intention of WA Health to make an application for assessment of these types of cost variations (and volume/scale of service issues) which are not adequately recognised in the National Pricing model through the IHPA's *Legitimate and Unavoidable Cost Variations Framework* in 2017.

Remoteness

WA Health acknowledges the efforts of the IHPA to improve the recognition of costs to inform the Patient Remoteness Area Adjustment via the inclusion of high cost outlier episodes in the calculation.

WA regional and remote hospitals continue to experience a level of cost disability relating to extreme remoteness unlike that experienced in other jurisdictions. Adjustments that relate to remoteness factors should be continually re-examined and demonstrated as they relate to remoteness-based differences in cost variability across jurisdictions.

Many remote areas of Western Australia, particularly the Pilbara are impacted as a result of the resources sector. In Regional Development Australia's (RDA) 2013 report titled The Cost of Doing Business in the Pilbara, RDA highlighted several key findings:

- The price indices for the Pilbara are the highest of any region in WA and impact negatively on employment costs to business and NGOs.

- The major cost drivers in the Pilbara are the resource sector, growth in demand outstripping supply and constraints to economic development and infrastructure provision.
- Over the 5 year period from 2007 to 2011 the gap between the Regional Price Index for the Pilbara and Perth had widened by 26 points which equates to an average increase in costs of nearly 5% per year.

In 2012, data showed that in the Pilbara the level of remuneration for employees would need to be 37% higher than that in Perth and there is often a need to provide subsidised or free accommodation to attract or retain employees.

Consultation Question 5

- ***What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.***

Response

In consideration of the significant factors raised in response to question 4, a funding framework that provides adjustment based on patient-based factors does not adequately address the cost issues that arise from providing health services in rural and remote locations, particularly when a proportion of treated patients have metropolitan-based postcodes and attract no adjustment to the NEP.

Across Pilbara-based NEP funded public hospitals, this can comprise between 10 and 30% of the patients treated in a given year, without any adjustment to NEP in recognition of those factors stated above.

For the Kimberley, where there are only 5 postcodes for over 423,000 square kilometres of land, it is difficult to capture the extreme remoteness and distance experienced in treating patients from very remote communities.

WA Health considers that remoteness is no different to the adjustment made for specialist paediatric services, which is not addressed at a patient level but a site level.

WA Health is supportive, in principle, of changes in the remoteness classification and investigation of the application of the ABS Statistical Area 2 to allow greater recognition of the very remote cost impacts. However, it is requested that IHPA provide appropriate analysis to enable WA Health to assess the impact of any proposed changes in the adjustment from the model's current position.

7. SETTING THE NATIONAL EFFICIENT PRICE FOR PRIVATE PATIENTS IN PUBLIC HOSPITALS

WA Health recognises that the collection of private patient medical expenses is problematic in the National Hospital Cost Data Collection (NHCDC) and appreciates the work of the IHPA to address issues with the costing private patients in public hospitals.

Consultation Question 6

- ***Should IHPA phase out the private patient correction factor in 2018-19 if it feasible to do so?***

Response

The IHPA release of Version 3.1 of the Australian Hospital Patient Costing Standards allows for a significant improvement in the way private patient costs are captured. The private patient correction factor is an estimation of the private patient medical costs and it would be more useful to use actual data captured in the system. **WA Health would support the phasing out of the private patient correction factor in 2018-19 if analysis can show that the full costs of treating private patients is reflected within the NHCDC**.

8. TREATMENT OF OTHER COMMONWEALTH PROGRAMS

WA Health acknowledges that IHPA is not proposing any changes to the treatment of Commonwealth funded programs for NEP17. WA Health welcomes the opportunity to continue to work with IHPA to continue to investigate how blood costs can more accurately be captured in the NHCDC.

9. BUNDLED PRICING FOR MATERNITY CARE

In the Pricing Framework 2016-17, IHPA advised that it would investigate bundled pricing as an alternative approach for pricing public hospital services. WA Health has been involved with this work through representation on the IHPA Bundled Pricing Advisory Group. **WA Health considers there is still considerable work required on the development of a bundled pricing approach for maternity services before it can be implemented for pricing**. **For these reasons, any application of bundled pricing for maternity care should be either trialled or shadowed first prior to implementation**.

Consultation Question 7

- ***Do you support IHPA's intention to introduce a bundled price for maternity care in future years?***

Response:

WA Health notes that the IHPA is proposing to continue work on the development of a bundled pricing approach for maternity services during the 2016-17, with a view to implementation in NEP18.

WA Health continues to have concerns with the introduction of bundled pricing for maternity care services. While recognising that bundled pricing supports a holistic continuum of care approach to funding and encourages innovative models of care, the current bundling options do not present sufficient risk adjustment to account for complexity or significant and costly maternal complications. **Bundled pricing will present a number of implementation challenges as the technical complexity required to produce bundled maternity data will be difficult for WA to achieve. Bundled pricing**

loses transparency and visibility of cost per episode of care and service utilisation which will create difficulties in allocating budgets to health services.

The Consultation Paper excludes maternity care from GPs, private obstetricians and privately practising midwives, however there are models of care which allow for these to occur in public hospitals. There is also a risk that bundled pricing may lead to underservicing of maternity patients relative to the standards agreed by Australian governments or that the wrong type of services are provided to patients.

The quality and consistency of data across jurisdictions will also need to be at a level that would support the implementation of this approach.

Should IHPA continue to progress with bundled pricing, factors that should be considered are the weighting applied for complexity and gestation on entering care. This complexity needs to include such things as maternal disease (including raised BMI), fetal conditions, psycho-social conditions, model of care, and any escalation of care.

Consultation Question 8

- ***What stages of maternity care and patient groups should be included in the bundled price?***

Response:

In general, a continuum of care approach for funding bundled maternity care should consider the inclusion of all phases of care and levels of patient complexity. This would include antenatal care and education, labour and birth care (in hospital and out of hospital) as well as postnatal care. Pathology and ultrasound costs should also be included.

However, the bundling approach would need to include weightings for maternal and neonatal complexity to recognise the higher costs of services in treating patients that would attract a higher complexity DRG. Without a complexity adjustment, bundling should be limited to low-risk mothers.

A non-risk weighted bundle inclusive of all phases of care and patient complexity represents financial risks to hospitals for cases above the bundled price. Tertiary hospitals and birthing centres which accommodate higher risk maternity care may be placed at financial disadvantage from maternity bundles that are not risk adjusted.

WA Health has identified substantial technical complexity required to accurately link admitted and non-admitted episodes, which may impact upon the ability to bundle episodes of care.

Consultation Question 9

- ***Should IHPA include postnatal care provided to the newborn in the bundled price?***

Response:

WA Health considers that postnatal care provided to the newborn should be included in the bundled price. However, this should be dependent on the level and type of

neonatal care provided and exclude admission to a neonatal unit of greater than six hours.

In practice, staff are caring for babies with complex neonatal care needs including neonates requiring intravenous antibiotics, phototherapy and those born of diabetic mothers requiring regular blood glucose testing. Infants admitted with mothers being treated for serious mental health issues often require additional nursing support for physical and developmental conditions, thus requiring additional resources.

These costs need to be taken into consideration in developing a bundled pricing approach.

Consultation Question 10

- ***What other issues should IHPA consider in developing the bundled price?***

Response:

The bundled maternity pricing model should reflect; clear guidelines or protocols; clinical consensus on the characteristics of best practice; consistent opportunities to intervene; and include incentives for quality performance. The effect of adjustments for Hospital Acquired Complications, whether maternal, neonatal or otherwise upon the bundled pricing model requires further consideration by the IHPA. Bundled payments for a clinically defined episode of care should also include quality performance and incentives and not only financial elements.

In addition, factors such as the mental health of the mother and the additional costs of mental health treatment should also be considered. Suicide is the leading cause of maternal mortality in Australia and particularly in the 45 days following birth. Women are more vulnerable to serious relapse and development of psychotic disorders in the postpartum period than any other period in life.

The length of the postnatal care period should also be considered. The National Maternity Services Plan recommends care for up to six weeks following the birth. Two weeks may be a starting point for consideration in the bundled pricing.

The IHPA should also consider how patients moving between jurisdictions during their pregnancy will be addressed in the pricing model, for example whether these patients would be funded under the current AR-DRG or Tier 2 model, or considered out of scope. Consideration should also be given to care provided in tertiary hospitals and rural settings.

The impact on jurisdictions in implementing a bundle pricing approach would need to be considered, including the administrative burden that would be imposed upon jurisdictions through changes in the way that services need to be recorded in order to accommodate changes in pricing arrangements. Bundled pricing for maternity services may also have an impact on the way National bodies report maternal activity, whether by bundled episodes or activity counts.

10. SETTING THE NATIONAL EFFICIENT COST

WA Health recognises the complexity of the work that underpins the development of the NEC Framework. It is important that the IHPA in coordination with jurisdictions

continues to refine the model and address factors that may be contributing to the variability in NEC funding allocation.

WA supports IHPA's continued efforts to ensure that no hospital is materially worse off under a NEC framework than under the NEP framework and that further modifications to the NEC model toward stability are invited.

While WA Health is generally supportive of the NEC model principles, in its current form the model will not deliver appropriate or adequate funding at an individual hospital level in many instances.

At an individual hospital level there are instances of significant variation between NEC funding and the current operating expense / funding allocation. The NEC model, similar to the NEP framework, struggles to deal with the extreme cost pressures experienced in the North West of WA.

Many of the facilities that fall within the NEC framework are characterised by high fixed costs, which are inflexible to any change in funding levels. Funding stability is paramount for facilities that are typically funded from within the NEC framework.

11. PRICING AND FUNDING FOR SAFETY AND QUALITY

WA Health recognises the commitment by governments to integrate safety and quality into hospital pricing and funding and the work undertaken by the IHPA in conjunction with the Australian Commission on Safety and Quality in Health (the ACSQHC) to review possible pricing approaches to improve the safety and quality of hospital care. WA Health welcomes ongoing engagement and collaboration with the IHPA to progress the implementation of pricing for quality and safety.

Scott, I. (2008), *Pay for performance programs in Australia: a need for guiding principles (*Australian Health Review, Vol. 32, No. 8, pp. 740-749) proposed guiding principles for pay for health care performance programs in Australia. These principles included the importance of:

- Application to key areas where improvement can occur;
- Measures should be evidence based and rigorously tested; and
- Data should be collected in a way that is scientifically valid and subject to periodic external audit.

While Safety and Quality data is being collected, there is limited evidence that this is currently comparable nationally. Time will be required to rigorously test and improve this data to the point where it can be fairly used to implement a national Safety & Quality Pricing Framework.

Consultation Question 11

- ***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?***

Response

In principle, WA Health is supportive of pricing for safety and quality provided the process for determining adjustments is transparent and the application is patient based and supported by evidence based measures. However, WA Health does not support 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.

Each pricing and funding option must be considered comprehensively and independently to ensure identification and mitigation of all unintended consequences of the option. Consideration would also need to be given to how pricing for safety and quality will be addressed for services funded on a block-funded basis.

The proposed measures for sentinel events, preventable hospital acquired conditions (HACs) and avoidable hospital admissions outlined in the Consultation Paper are inpatient oriented. The options presented would not allow for all health care services to be included, therefore further work would be needed to incorporate non inpatient service measures if these approaches were to apply to all settings.

Implementation of an approach will need to ensure that it does not negatively impact patients and the development of novel services/treatments are is discouraged.

Consultation Question 12

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

Response

The risk adjustment model would need to be based on patient related factors, not be provider related and reflect the patient journey, so that it captures non hospital service provision. Factors will need to be taken into consideration for complex cases, as risk management processes do not necessarily reduce incidents, but may impact on the level of harm.

For example, a rehabilitation centre would have a high patient cohort with cognitive or complex health conditions that put them at high risk of falls; however assessment and interventions may not reduce the fall from occurring. It is important that hospitals are not penalised for treating high risk patients.

In some service areas, there has been a history of diverting high-risk patients to hospitals that have specialised facilities. Risk-adjustment pricing and funding models would need to take this into consideration to ensure that receiving hospitals are not disadvantaged due to their patient cohort.

The costs to mitigate service risk need to be taken into consideration in a risk adjusted model, as reducing the risk could potentially end up being more costly than treating the incident.

In addition to the usual patient and hospital factors such as age, exclusions such as high risk, low volume procedures should be considered. Specific risk adjustment and exclusions, such as measures of innate anaesthetic/surgical risk (e.g. ASA status) will also need to be considered on a case by case basis by pricing and funding option, and specific HHEC, sentinel event or readmission type.

Other factors such as care type, remoteness, chronic disease, cultural and socio-economic background, patient's distance to home in treating hospital, co-morbidities, and patient experience ratings could also be considered.

Consultation Question 13

- ***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?***

Response

In general, WA Health accepts the use of assessment criteria as they provide a useful mechanism to assess suitable alternatives and the proposed assessment criteria.

WA notes that the IHPA has outlined a set of criteria that it will use to assess the relative merits of proposals for incorporating safety and quality into the pricing and funding of public hospital services.

Comments in relation to these are outlined below.

1. Preventability. It is unclear what evidence will be used to determine preventability. WA Health is unable to agree without further clarification of how this criterion will be assessed.
2. Equitable risk adjustment. Agree with the criteria.
3. Proportionality. Agree in principle.
4. Transparency. Agree with the criteria. This links with good business processes.
5. Ease of implementation. Agree with this criteria.

WA Health suggests "consideration of availability of data" be considered for inclusion under the Ease of implementation criteria. In addition, the frequency/regularity of the issue at a particular health service and/or whether a service appropriately investigates and responds to an incident could also be considered.

Sentinel Events

In Western Australia sentinel events are notified and investigated as part of a broader Clinical Incident Management (CIM) program, the requirements of which are specified in WA Health's CIM Policy. This includes the notification and investigation of all Severity Assessment Code 1 (SAC 1) clinical incidents, which in WA includes the existing sentinel event categories. The purpose of CIM is to prevent or reduce future harm to patients/consumers by:

- Identifying and treating hazards before they cause harm;
- Identifying when patients/consumers are harmed and intervening promptly to minimise the harm; and
- Taking preventive actions and sharing lessons learned.

In WA the notification and investigation of 'near miss' clinical incidents (those that could have, but did not result in harm to the patient/consumer) is encouraged in order to maximise the opportunities for improvements to be made in the health system. As such the WA CIM Policy permits the notification of 'near miss' sentinel events.

While WA Health agrees that pricing and funding approaches to drive improvement in the safety and quality of health care services are a worthwhile initiative, care must be taken that these approaches do not adversely impact quality improvement processes such as CIM that have been established to deliver improvements in the health system in response to sentinel events.

WA Health supports the approach that funding penalties should only be applied to specific events that are considered to be wholly preventable, and notes that the ACSQHC is currently facilitating a review of the existing Australian list of sentinel events which has already identified that some of the existing events in the list may not be wholly preventable.

Under the WA Health CIM Policy it is the investigation process that determines whether clinical incidents (including sentinel events) are preventable or not, and where the investigation identifies that health care related factors did not contribute to the patient outcome (and that the event was not preventable) hospitals and health services are able to request that the event be declassified. Declassified events are no longer considered to be clinical incidents.

WA Health's position is that the implementation of any pricing or funding model relating to sentinel events should be deferred until such time as the ACSQHC's review of the sentinel event list is completed, and jurisdictions have been given sufficient time to make any changes needed to policies and systems to implement the revised sentinel event list and the pricing/funding model.

Consultation Question 14

- ***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?***

Response:

WA Health does not support the IHPA proposal to not fund episodes of care that include a sentinel event in their entirety or sentinel events that are not wholly preventable. However, WA Health agrees with not funding a nationally agreed set of wholly preventable events.

Investigations for maternal deaths and inpatient suicides have shown it is frequently quite difficult to establish whether an alternative clinical decision or preventative action would have affected the outcome nor are these events entirely preventable.

While there may be validity in penalising funding relating to the specific component of the episode of care that included the wholly preventable sentinel event, or the subsequent/additional care required as a result of it, the proposal to not fund the entire episode of care appears inequitable.

The size of the penalty for individual incident would become in part proportional to the duration and complexity of the preceding (and possibly unrelated) care, meaning that otherwise safe and high quality preceding care may be penalised.

WA Health agrees with the IHPA position that there is no justification to risk-adjust for sentinel events that are wholly preventable, however cannot then support a financial penalty model that determines the size of the penalty by zero-weighting preceding care that is related to patient factors and not the sentinel event.

WA Health would support a model where funding related to the specific component of the episode of care that included the wholly preventable sentinel event and the subsequent care required as a result of the event is penalised. This model accounts for routinely safe, high-quality care related to patient factors, duration and clinical complexity preceding the sentinel event, which is otherwise discredited by a policy of zero-funding the episode in its entirety. In order to apply this model a methodology would need to be developed that ensures the point in the episode of care where the wholly preventable sentinel event occurred can clearly be identified, as well as the subsequent care required as a result of it.

Consultation Question 15

- ***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?***

Response:

WA Health **agrees in principle** to the inclusion of a sentinel event flag to improve timeliness and consistency of data. However, it is noted that there may still be variation in how sentinel events are recorded and reported between jurisdictions. The technical capacity for jurisdictions to implement the flag into data collection system also needs to be considered.

Consideration also needs to be given to the timing of the application of the 'sentinel event flag'. In some circumstances (e.g. retained surgical instruments and material) a sentinel event may not be identified until months or years after the actual episode of care where it occurred, and potentially by a different hospital or health service provider.

WA Health notes the sentinel events list is currently under review, which suggests some events currently included on the list are not wholly preventable. It would be premature to begin developing ICD-10-AM code ranges relating to sentinel events before this review is completed.

Consultation Question 16

- ***Do you agree with IHPA's assessment of this option (not funding episodes with a sentinel event)?***

Response:

WA Health agrees in principle with the IHPA's assessment of this option as outlined below:

- Preventability. Agree that the model should be limited to wholly preventable sentinel events, noting that not all events in the current sentinel event list are considered wholly preventable
- Equitable risk adjustment. Agree that risk adjustment is not required in respect of wholly preventable sentinel events, noting that not all events in the current sentinel event list are considered wholly preventable
- Proportionality. Agree that the proposed funding model is only partially proportional. WA Health does not support a model that encompasses both the cost of preceding care and the additional costs incurred as a result of diminished safety and quality.
- Transparency. WA Health has some concerns over the transparency of the model put forward in that penalising the entire episode of care where a wholly preventable sentinel event occurs may create disincentives to, and delays in, the notification of all sentinel events. This has the potential to impair effective investigation and thereby limit system improvement opportunities in response to instances preventable harm
- Ease of implementation. Agree that the funding model put forward involves initial work to flag and agree episodes with a sentinel event. Partial agreement with IHPA's assessment.

WA Health acknowledges that its preferred approach of not funding components of the episode of care specifically related to the sentinel event and the subsequent/additional care as a result of it may introduce additional complexity to implementation.

Hospital Acquired Complications

Patient safety is an integral component of health care delivery, the goal of which is to improve the safety of patients as they progress along their health care journey by learning from our errors. The reporting of clinical incidents is undertaken in a culture that does not apportion blame but supports and encourages the notification and investigation of clinical incidents so that lessons can be learnt and to prevent future incidents from occurring.

The adoption of financial penalties assigned to the presence of a HAC may compromise the patient safety culture. Specifically, if hospital services who report clinical incidents are financially penalised this will impact on their service delivery and therefore impact on their patients' care. The patient safety literature clearly highlights that approximately only 10% of clinical incidents are reported, with mature health care systems supporting and encouraging higher clinical incident reporting rates.

The introduction of financial penalties for patients experiencing HAC could compromise health care delivery by limiting services/resources and therefore has the potential for clinical incidents to increase but not to be reported. The use of the HAC list is concerning as the Consultation Paper (p35) clearly states that "Hospital acquired complications (HACs) are complications which occur during a hospital stay and for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring".

Working from this premise means that reduced funding based on HAC rates that are not necessarily preventable is a severe penalty. The HAC list is questionable and really warrants definitive AR-DRG coding to support and capture only those conditions that are clearly and wholly preventable (e.g. retained instrument/swab etc).

Adoption of financial penalties may potentially have a negative impact on clinical incident reporting which WA Health has invested considerable initiatives and resources to improving patient safety to enhance health care delivery. Specifically, while HAC will be captured in hospital administrative datasets, clinical incidents require clinicians to enter additional data into a separate clinical incident management system. If clinicians perceive that reporting will result in financial penalties, then clinical incidents might not be reported into a clinical incident management system. This means that clinical incidents will not be investigated and improvements to health care delivery will not be identified.

It would be a perverse outcome if jurisdictions were incentivised to game the pricing and funding arrangements by under-reporting HACs, and jurisdictions that comprehensively reported HACs were financially penalised for doing so.

It is acknowledged that health service delivery is costly and that areas for potential saving need to be identified and strategies implemented to provide efficient and affordable health care. Identified cost saving strategies must be evidence based, not only to ensure sound practice, but also to ensure that these strategies are credible and therefore adopted. Having a revised HAC list that consistently captures only preventable complications is the first step to adopting a cost saving strategy for the prevention of HAC. Once these HAC are embedded then further areas of improvement could then be incorporated. This staged approach would allow hospitals to acclimatise to these financial changes and limit the negative impact to clinical incident management.

Option 1: Remove the HAC so that it does not contribute to DRG assignment

Consultation Question 17

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

Response

Option 1 removes HAC related diagnoses which can lead to an increase in DRG complexity due to the additional care required to treat the HAC.

As outlined in the Consultation Paper, it is estimated that only 15% of acute admitted episodes would result in reduced funding due to reassignment of a AR-DRG to exclude a HAC diagnosis (p44). Further data analysis on this group of acute admitted episodes needs to be presented so a better understanding can be gained of the type of HACs that are proposed to not be funded.

The advantages of option 1 are that services are not seen to be reimbursed for the change in care through an acquired condition. The hospital will still receive payment

for the original admission purpose and only the additional work associated with the HAC is not recognised or funded. This option poses an incentive for services to avoid HACs and does not unduly penalise the hospital by removing all funding for the episode, as is the case for option 3 in particular.

Option 1 is likely to have the smallest funding impact ongoing as there is no requirement under any of the options presented to redistribute funding saved back to the jurisdictions. WA Health understands that option 1 could be incorporated into the DRG grouper, reducing the complexity of implementing this change

Furthermore Option 1 does not impact the NEP or calculation of the admitted cost weights as the DRG is only altered for funding purposes, this is not case for option 3. Community acquired complications would need to be developed if the option was to apply outside the inpatient setting.

Clinically informed refinement of the HAC list which represents only those conditions that are clearly and wholly preventable would be supported.

Prima facie, WA Health sees some merit in Option 1, with the results of the application of the model to be reported with patient level transparency. However, further information is required before each option can be fully assessed.

Consultation Question 18

- ***Do you agree with IHPA's assessment of this option?***

Response

WA Health requires further information before it is able to provide a response to IHPA's assessment of Option 1 implications for how HACs will be treated in the context of national pricing.

Option 2: Funding Adjustments made on the basis of differences in HAC rates across hospitals

Consultation Question 19

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

Response

As outlined in the Consultation Paper, the IHPA is undertaking analysis to test the validity of a range of approaches for Option 2 that could be used to calculate funding when hospitals exceed a specified HAC rate. The statistical validity of these different approaches has not yet been verified and therefore limits WA Health's ability to comment with regard to Option 2.

In consideration of Option 2, WA Health would like to highlight that it should be the role of States and Territories, as public hospital system managers, to develop mechanisms to adjust provider funding towards quality improvement programs and performance management, tailored to local needs.

In general terms WA Health prefer an option that adjusts the underlying patient record where a HAC occurs rather than using ratio's to adjust all data.

Consultation Question 20

- ***Do you agree with IHPA's assessment of this option?***

Response

WA Health requires further information before it is able to provide a response to IHPA's assessment of Option 2.

Consultation Question 21

- ***What are the advantages and disadvantages of the approaches to risk adjustment?***

Response

In terms of the the risk-adjustment approaches that could be used within Option 2, WA Health initial views are that:

1. No-risk adjustment. This is a disadvantage to all hospitals as raw HAC rates can be influenced by size, patient cohort and other hospital specific factors.
2. Stratification of hospitals within states.
3. Stratification of hospitals within peer group. This is likely to be very difficult to do. For instance there is only 1 women's and newborn hospital in WA. Therefore, the comparison between peer groups would need to be a national comparison and policies and processes may vary across jurisdictions.
4. Risk adjustment. This approach would support equality across all services.

A review of the final risk adjustment methodology would be required before the advantages and disadvantages could be fully identified.

Option 3: A quality-adjusted NEP with funding incentives for hospitals with the lowest HAC rates

Consultation Question 22

- ***What are the advantages and disadvantages of Option 3 that combines funding incentives and penalties?***

Response

A quality-adjusted NEP with funding incentives for hospitals with the lowest HAC rates would have a system-wide reduction in the NEP and could result in public hospital services receiving reduced Commonwealth funding regardless of HAC rates.

The advantage of Option 3 as presented is that it has a greater potential to incentivise performance improvements as savings are returned to the system which would enable both a carrot and stick approach, providing greater incentives than an approach which penalises only. However, it could be viewed as inequitable by not

recognising that a service has been provided to the patient and may unduly disadvantage hospitals that see patients who have a greater risk of a HAC occurring.

Under Option 3 the hospitals and the State may also suffer a significant revenue shortfall if the funding is not redistributed back to the system, currently there is no requirement to do so making it difficult to support this option due to this uncertainty.

Furthermore it should be noted that none of the three options presented preclude the capacity to redirect any savings back into Safety and Quality initiatives, WA is unclear why only Option 3 has been presented this way.

In consideration of Option 3, WA Health would like to highlight that it should be the role of States and Territories, as public hospital system managers, to develop mechanisms to adjust provider funding towards quality improvement programs and performance management, tailored to local needs.

Consultation Question 23

- ***Do you agree with IHPA's assessment of this option?***

Response

WA Health requires further information before it is able to provide a response to IHPA's assessment of Option 3.

Consultation Question 24

- ***Are there any other pricing or funding options that IHPA should consider in relation to HACs?***

Response

WA Health does not have any other funding options in relation to Hospital Acquired Complications to provide in this submission.

Responding to Condition Onset Flag data Quality Issues

Consultation Question 25

- ***How should IHPA treat hospitals with poor quality COF reporting?***

Response:

The use of Condition Onset Flags (COF) to capture HAC is considered a reasonable approach. However, reporting COF codes accurately, means that hospitals will be penalised for that HAC incident while poor COF compliance means that hospitals could be exempt from funding adjustments.

WA has fully implemented COF reporting for all admitted episodes of care. However, there may be data quality issues with COF reporting due to a number of factors.

- Capacity to assign COFs is dependent upon the clinical coder determining the point of disease onset, which is impacted by variable levels of documentation quality;
- Coder proficiency is highly variable resulting from numerous factors including qualification level obtained, access to skills development opportunities and interpretation of the Australian Coding Standards.
- Some registered clinical coding courses have been identified that do not include COF assignment within their syllabi.
- Whilst *Australian Coding Standard 0048 Condition Onset Flag* has remained stable since its introduction, it is difficult to comprehensively measure COF accuracy by reviewing large datasets. The medical record is needed to truly assess if the COF is correct.
- Lack of clarity regarding criteria used by the IHPA to determine poor quality COF assignment, which may include, complete absence of COF codes, questionable assignment or unusual proportion of flags or an absence of COF=1 from submitted data.

Care should be taken in considering a policy that adjusts funding based on reported data that is not consistent across hospitals and/or jurisdictions.

While WA Health does not disagree with the concept of using the COF code to inform funding, there needs to be substantial mechanisms put in place, nationally and locally to drive improvement in understanding of HACs and COF assignment.

Placing a funding emphasis on COF coding to identify HACs may improve overall accuracy however, it may also impact upon coder productivity due to additional or biased scrutinisation of clinical documentation. WA Health considers that further work is required to understand and improve COF accuracy nationally before COF data can be used for funding purposes and to ensure that jurisdictions with better quality data are not adversely penalised. Hospitals with poor quality COF reporting should be given the worst performing peer rates applied to their activity.

Avoidable Hospital Readmissions

As per comments on previous sections, financial penalties for unplanned readmissions must be carefully considered to avoid unintended consequences for health service providers due to the causal factors underpinning the readmission in question. Financial penalties will need to be designed in such a way to target only those readmissions that are caused by wholly preventable aspects of care from preceding hospital admissions, rather than other causal factors such as lack of support from home or community.

This measure must be considered within the context of community healthcare provision such as general practice and hospital in the home programs. For this reason, WA Health suggests that IHPA consider opportunities for the Commonwealth to focus on pricing and funding approaches for community-based care, in addition to those for hospital-based care.

Consultation Question 26

- ***What approach is supported for setting timeframes within which avoidable hospital readmissions are measured?***

Response:

WA Health considers that financial penalties for avoidable readmissions should be carefully considered and ideally target only those readmissions that are caused by wholly preventable aspects of care from preceding hospital admissions.

Current performance indicators are not sensitive to the differences in AR-DRG severity and complexity. The implementation of pricing and funding for avoidable hospital readmission may need to consider the application of different timeframes for different groups of AR-DRGs.

The development of condition specific, time-based thresholds for a select group of preventable complications should be informed by thorough research and clinical advice. Mental health readmissions, which are considerably complex and can occur for a number of reasons (including, non-compliance with prescribed medications, social issues, impaired judgement and access to services) require specific considerations.

Recovery oriented mental health treatment that strives to minimise admission length and promote community integration would otherwise be penalised. It is clinically preferable to offer repeated crisis admissions to manage risk rather than lengthier admissions. Readmission rates are monitored and individual cases are reviewed to ensure optimum clinical management.

Consultation Question 27

- ***Is there Australian evidence (including guidelines or recommendations) that could be used to implement condition specific readmission timeframes?***

Response:

WA Health is not aware of any specific guidelines or recommendations that could be used to implement condition specific readmission timeframes.

Consultation Question 28

- ***Is there support for pricing and funding models to be based on avoidable hospital readmissions within the same LHN?***

Response:

WA Health has concerns that limiting the calculation of avoidable hospital readmissions within the same LHN may not be accurate or representative.

Patients treated within a tertiary hospital are likely to re-present to their closest hospital, which may not necessarily be the same facility where they were discharged. This is especially true for rural and remote patients.

The factors that contributed to the readmission need to be considered as non-medical factors, such as lack of support at home/community can also contribute to

the risk of unavoidable readmission as well as access to GPs, hospital in the home programs, and other community based care.

Consultation Question 29

- ***When should a pricing and funding approach for avoidable readmissions be implemented?***

Response:

An approach for avoidable hospital readmissions should be implemented when the following factors have been further considered;

- formulation of evidence based guidelines and definition pertaining to timeframes for readmissions;
- availability of unique patient identifiers (using the Medicare PIN) are incorporated into data collections in all jurisdictions;
- development of clear care pathways for conditions which will be impacted by the approach;
- availability of suitable post-discharge arrangements for all patients, including those in rural and remote areas;
- method of determining that appropriate primary care support was accessible and provided; and
- assessment of the model to adequately reduce unintended consequences occasioning representation following admitted care.

Implementation of a Pricing and Funding Approach

Consultation Question 30

- ***What do you think are the most important considerations for implementation of pricing and funding approaches for safety and quality?***

Response

Considerations for implementing approaches for pricing and funding for safety and quality include:

- ensuring budget neutrality for the State;
- policy fairness;
- robustness and consistency in data reporting across jurisdictions to be enhanced to support performance measurement and improvement;
- appropriately developed clinical care guidelines;
- positive rather than punitive financial incentives;
- reducing inappropriate interventions;
- innovation in service delivery;
- patient outcomes and patient satisfaction measures;

- phasing implementation process;
- engagement with jurisdiction and clinicians; and
- establish appropriate benchmarks.

An important consideration is the potential impact a financial disincentive would have upon rates of clinical incident reporting. Any perceived benefit that a particular penalty or incentive is calculated to have must be carefully weighed against the potential impact it may have upon the fragility of the underlying system.

A phased-in approach to pricing should be considered during a transition period so that any implications could be understood prior to full implementation.

Consultation Question 31

- ***Do you agree that IHPA would need to back-cast the impact of introducing new measures for safety and quality into the pricing and funding models?***

Response

Back casting is an important principle of the current IHPA models, without back-casting the motivation behind the safety and quality initiatives could be viewed as a mechanism to save money rather than promote a very important service initiative.

WA Health recognises the importance of back-casting to reflect changes to the factors underlying the NEP determination. An analysis of the effects of back-casting the NEP to take into account the impact of introducing new measures for safety and quality into the pricing and funding models should be undertaken. With the methodology accounting for the likely improvement to HAC reporting in recent years.