Feedback on Pricing Framework for Australian Public Hospital Services

AlfredHealth

As part of the consultation on the Pricing Framework for Australian Public Hospital Services 2020-21 released by the Independent Hospital Pricing Authority (IHPA) Alfred Health would like to provide the below feedback.

General Comment

A significant part of the basis of the pricing framework is the use of clinical costing information. There is an inherent assumption in this process that costing is robust and consistent enough to derive conclusions regarding the resource utilisation for hospital services. Alfred Health has a number of concerns about this assumption from reviewing benchmarking data available from Health Roundtable (HRT), Victorian Department of Health and Human Services (DHHS), and PowerHealth Solutions. Costing in general does not work at a granular enough level to identify the real cost of resource utilisation for Hospital Acquired Complications (HACs), for developing accurate classification models, or for deriving cost weights. For example, the additional nursing and medical costs associated with HACs are largely as a result of increased length of stay but not the interventions that occur from the incident.

Alfred Health also believes that there are a lot of assumptions around the cost of delivering services in public hospitals to private patients, via MBS clinics, and drugs funded through PBS that may not entirely be accurate. In particular, medical remuneration models for MBS funded activity can differ significantly both between and within health services. More work is needed to properly identify and understand these differences to more appropriately determine the private discount rates in NWAU.

Alfred Health believes that there is an opportunity for more granular costing standards on a national level with IHPA's involvement that will lead to a more robust funding framework.

4. What should IHPA prioritise when developing AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition?

Alfred Health has long believed that the classification model for low volume-high cost procedures such as transplants assumes a homogeneity of patients that is not entirely accurate. Patients in these groups often have other comorbidities which lead to significant variations in patient care which can include interventions such as ECMO. Furthermore, the DRG classification model has peculiarities such as a patient receiving a heart transplant (F23Z) has an inlier weight of 27.0065 while a patient receiving both a heart and a lung transplant (E03Z) has an inlier weight of 21.6183. At the NEP of $5,134 under NWAU 19 a patient receiving both organs gets funded $27,663 less.

Due to these issues, along with the fact that the delivery of these services requires a significant amount of fixed cost regardless of volumes, Alfred Health believes that alternative funding models or classification models be investigated as a priority.

5.2. Are there adjustments for legitimate and unavoidable cost variations that IHPA should consider for NEP20?

Alfred Health believes that high acuity services such as transplants, burns, and trauma can result in unavoidable cost variations due to differing levels of complexity not adequately described in the classification model. This can include delivery of ECMO, infection management, and behavioural issues. Alfred Health acknowledges that these issues would be difficult to include in any co-payment adjustments.

5.4.2. Is there any objection to IHPA phasing out the private patient correction factor for NEP20?

There is a general lack of costing data appropriately reflecting the variations in doctor remuneration for private patients. In particular this applies to whether they receive their money via salary under a donation model or variations of a retention model. Furthermore, some public health services outsource diagnostic services to private businesses that directly bill for private patients. Under this agreement the health service will reflect no expenditure for the

diagnostic service in their costing data so this will have a follow on impact on the development of cost weights. Alfred Health believes more work needs to be done to understand the impact on costing data for private patients.

6.3. Do you support IHPA making the NBP publicly available, with appropriate safeguards in place to protect patient privacy?

Alfred Health fully supports the intention of the NBP being made available to the public however at this time doesn't believe that the data is sufficiently reliable. It is difficult enough in the health services with people of sufficient experience to be able to understand the information and the drivers behind variation. Further work is required to improve the robustness of the data before being made more widely available.

6.5. Should a national PROMs collection be considered as part of national data sets?

Alfred Health fully support the concept of PROMs and feels that the most appropriate way to establish consistency across jurisdictions would be to develop a national dataset. This should be considered a priority before variations between jurisdictions create an obstacle for future development.

9.2. Are there any alternative funding models IHPA should explore in the context of Australia's existing NHRA and ABF framework?

Alfred Health has previously had discussions with the Victorian DHHS and IHPA regarding the pricing for a number of services including, but not limited to, transplants and bariatric surgery. Existing activity-based funding models do not currently support the ongoing care required for these patients both before and after their procedures. Furthermore, with bariatric surgery in particular, it incentivises hospitalisation and surgery as opposed to alternative interventions that lead to better patient outcomes. For bariatric surgery bundled payments would appropriate. For transplants, due to the long-term support needs of these patients, a more appropriate pricing method would be an initial upfront payment to cover the cost of the intervention with an ongoing capitation payment to support their ongoing needs.

10.3.1. Is IHPA's funding approach to HACs improving safety and quality?

Alfred Health has experienced clinician scepticism about the robustness of HAC data and how the funding discounts are being applied. Under the existing risk model Alfred Health has patients who have undergone a lung transplant categorised as a low risk for respiratory infections and heart transplants as a low risk for cardiac complications. This undermines the intention of IHPA to improve safety and quality through pricing.