Inquiry Secretary
Senate Finance and Public Administration Committees
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Secretary,

Thank you for the opportunity to comment on the National Health Reforms Amendment (Independent Hospital Pricing Authority) Bill 2011. This Bill is for an Act to amend the National Health Reform Act 2011, and for other purposes. My comments build on my previous submissions to Senate Inquiries relating to the National Health Reform Amendment (National Health Performance Authority) Bill 2011, COAG Reforms Relating to Health and Hospitals, the National Health and Hospital Network Bill 2010 and the Federal Financial Relations Amendment (National Health and Hospitals Network) Bill 2010. It also builds on the issues and recommendations by the Senate Committees in their final reports that related to my submissions [1] [2] [3] [4] [5] [6] [7]

My submission strongly supports the intent of the Bill and the work of the government in this very important area of health and regulatory reforms in Australia. I do, however, raise several issues relating to the legislation to enable greater alignment with the various commonwealth-State health agreements and the broader policy imperatives of the Government. Section 1 considers the sections of the legislation and/or related health agreements signed in July 2011, that may require clarification and revision. Section 1.4 considers the implications of my recommendations to COAG and other Senate Committees relating to risk adjustment to enable *valid pricing* for Activity Based Funding. These comments draw on my experience leading the reform of Activity Based Funding in Victoria as Chair of the Victorian Government's Risk Adjustment Working Group (RAWG) which included representatives across the major Victorian hospital networks and the State Government and undertook work in collaboration with world leading experts[8]. This work of RAWG was a consequence of my work when a member of the Senior Management of Bayside Health (now Alfred Health) in successful negotiations with the Victorian government for Risk Adjusted Specified Grants under the system of Victorian ABF, also known as casemix funding. The extra 'risk adjusted' funding was required given hospitals incurred significant funding deficits under the ABF arrangements because funding does not meet the health need in the absence of such adjustments. This is especially true for providers of State-wide referral services such as The Alfred. The results of the RAWG analyses, which aimed to apply the Alfred's methodology 'state-wide' have been published internationally and have served as a model for other countries to follow.

The role of the recommended State Centres for facilitating EBM translation , the evaluation of performance and their capacity to provide input into the deliberations of the Independent Hospital Pricing Authority about quality and efficiency and related implications of the 'efficient price' is covered in section 2. The funding streams in the new National Health Reform Agreement and related Partnership Agreements (COAG, July 2011) relating to the State Centre concept are highlighted, along with the Cost Benefit Analysis of national implementation of the State Centres. As previously advised to other Senate Inquiries, the economic evaluation is based on the evaluation of the Victorian initiatives in the areas in the context of ABF and network governance structures. Since the new national arrangements are modeled on Victorian network governance and ABF, they are considered highly relevant.

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1 http://www.aph.gov.au/Senate/committee/economics_ctte/health_finance_10/submissions.htm (Antioch KM: submission 1)
2 http://www.aph.gov.au/Senate/committee/clac_ctte/Nat_hlth_hospital_network_43/submissions.htm (Antioch KM: submission 10)
3 http://www.aph.gov.au/senate/committee/fapa_ctte/coag_health_reforms/submissions.htm (Antioch KM: submission 20)
4 http://www.aph.gov.au/senate/committee/clac_ctte/nhpa/submissions.htm (Antioch KM Submission 14)
5 http://www.aph.gov.au/Senate/committee/economics_ctte/health_finance_10/report/index.htm
6 http://www.aph.gov.au/senate/committee/clac_ctte/Nat_hlth_hospital_network_43/report/report.pdf
7 http://www.aph.gov.au/senate/committee/clac_ctte/nhpa/report/index.htm
8 Antioch KM & Ellis RP et al (2007) "Risk adjustment Policy Options for Casemix Funding: International Lessons in Financing Reforms" *European Journal of Health Economics*. September. http://people.bu.edu/ellisrp/EllisPapers/2007_AntiochEllisGillett_EJHE_RiskAdj.pdf

1 National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011

1.1 Definitions

Part 4.2, Section 132 of the legislation relating to Intergovernmental Agreements states that the Pricing Authority must have regard to the intergovernmental agreements and the pricing authority must follow the processes in the National Health Reform Agreements (NHRA). I note below the following discrepancies in the definitions for the term "Emergency Department" shown in NHRA (2011) and the National Healthcare Agreement (2011).

I recommend that this discrepancy be clarified and/or rectified to resolve the anomaly as outlined below

The National Health Reform Agreement, dated July 2011, down loaded from the COAG website on 31 August, 2011[9] *states on page 68 the following definition:*

'Emergency department: Means admission level three or above emergency service under the Australian College for Emergency Medicine guidelines, or as otherwise recommended by the IHPA and agreed by the Standing Council on Health'.

Whereas the National Health Care Agreement 2011, downloaded from the COAG website on 31 August, 2011[9] *states at page A-18:*

'Emergency department: "Means the dedicated area in a hospital that is organized and administered to provide a high standard of emergency care to those in the community who perceive the need for, or are in need of acute or urgent care, including hospital admission'

1.2 Privacy Issues

This issue was previously raised in the context of my submission about the National Health Reform Amendment (National Health Performance Authority) Bill 2011 (See Antioch 2011[10]). The Final report of the Community Affairs Senate Committee cited my recommendation in their final report as follows:

"2.36 Dr Antioch suggested that an even wider approach be taken throughout the amendments proposed by the Bill through broader reference to the Privacy Act stating:

Recommendation:

The intent of the legislation in Sections 54(J), 54(K), 54(L) and Sections 120, 121, 122, 123, 124, 127 128 and 129 and disclosure to researchers could be improved with linkage/reference in the Bill to the Privacy Act 1988… Relevant aspects could be highlighted in the new legislation where appropriate[11].

I also noted that the National Privacy Principles are outlined at Schedule 3 of the Privacy Act 1988 10.

I note that with regard to the legislation currently under review that Part 4.14 Secrecy, subsection 213 (2) that exemptions to the prohibition to disclosure in subsection 213 (1) include, under paragraph (b), the disclosure or use is in compliance with a requirement under (i) a law of the Commonwealth or (ii) a prescribed law of a state or a territory. This would include the Privacy Act 1988. Further, the new National Health Reforms Agreement, dated July 2011, specifies provisions at Clause B31 (page 34), which make the Privacy Act 1988 more explicit. Privacy issues specified in clause B87 (page 41) refer to the application of relevant legislation and the National Privacy Principals, ethical guidelines and practices in order to protect the privacy of individuals. Clause 94 (page 42) of the NHRA states that "*where patient identified data is required it will be subject to existing commonwealth statutory protection of individuals privacy*". There is extensive coverage of privacy issues in clauses B86(d), (e) and various clauses B93 through to B104.

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[9] http://www.coag.gov.au/ (downloads 31 August, 2011).

[10] http://www.aph.gov.au/senate/committee/clac_ctte/nhpa/submissions.htm (Antioch KM Submission 14)

[11] http://www.aph.gov.au/senate/committee/clac_ctte/nhpa/report/index.htm

I recommend that the Committee note that in my view these privacy inclusions are an excellent development and clarify the privacy issues in the NHRA (July 2011).

1.3 Chapter 4 Independent Hospital Pricing Authority

Risk Adjustment in pricing and funding processes: Important lessons from Victorian ABF arrangements

Part 4.2, Paragraph 131(1)(a) of the legislation refers to the Hospital Pricing Authority's function to determine the efficient price for services funded on an activity basis, and Paragraph 131(1)(d) refers to the Pricing Authority's function to determine adjustments to the national efficient price to reflect legitimate and unavoidable variation in the costs of delivering health care services. Further, paragraph 131(1)(e)(ii) refers to the function of the Pricing Authority to determine data requirement and data standards to apply in relation to data to be provide by the States and Territories including requirements and standards relating to patient demographic characteristics and other information relevant to classifying, costing and paying for pubic hospital functions.

Subsection 131(3) highlights that the Pricing Authority must have regard to:

(a) relevant expertise and best practice within Australia and internationally
(b) submission made at any time by the Commonwealth, a State or a Territory;
(c) the need to ensure:
  (i) reasonable access to health care services; and
  (ii) safety and quality in the provision of health care services; and
  (iii) continuity and predictability in the cost of health care services; and
  (iv) the effectiveness, efficiency and financial sustainability of the public hospital system

(d) the range of public hospitals and the variable affecting the actual cost of providing health care services in each of these hospitals.

With regard to meeting all of the above specifications, I should emphasise the high importance of risk (severity) adjustment methodologies and variables in the application of ABF to avoid underfunding of services and to avoid inappropriate risk to ensuring quality of patient care as a consequence of inadequate funding to cover health need. In my view this is a critical consideration.

The work of the RAWG in Victoria, which investigated the need for risk adjustment at the state level in the context of ABF is instructive in this regard and is discussed in more detail below. The work of RAWG built upon the earlier analyses by Antioch and Walsh (2000[12], 2002[13] and 2004[14]) which documented that hospitals such as The Alfred which is a State-wide provider to services tor Trauma, Cystic Fibrosis, health and lung transplantation, and chronic heart failure treat patients that are more complex and hence more expensive that the AR-DRGs casemix arrangements (ie ABF arrangements) would indicate (see Antioch Ellis and Gillett 2007[15] for a review). An additional $15m over five years was negotiated through The Alfred's analyses for some of these AR-DRGs in the form of Risk Adjusted Specified Grants (RASG). The analyses by RAWG was published in the European Journal of Health Economics in 2007, and explored the impact of state-wide referral services for the major teaching hospital networks in Victoria. The analyses involved 70 AR-DRGs which had high deficits and the key risk adjustment variables considered were diagnostic and procedure based severity markers (relating to state wide referral services), counts of diagnosis and procedure codes, disease types, complexity, day outliers, emergency admissions and 'transfer in' (from other hospitals). Risk Adjustment through the various approaches explored can reduce teaching hospital underpayment by 10% (Antioch Ellis and Gillett 2007)15

[12] Antioch KM and Walsh MK (2000) "Funding issues for Victorian hospitals: The risk adjusted vision beyond casemix funding" *Australian Health Review* Vol 23, No 3, 145-153.
[13] Antioch KM and Walsh MK (2002) "Risk adjusted capitation funding models for chronic diseases in Australia: Alternatives to Casemix Funding". European Journal of Health Economics 3:83-93
14 Antioch KM and Walsh MK (2004) "Risk adjusted Vision Beyond Casemix (DRG) Funding in Australia: International Lessons in High Complexity and Capitation" *European Journal of Health Economics*.5: 95-109
15 Antioch KM & Ellis RP et al (2007) "Risk adjustment Policy Options for Casemix Funding: International Lessons in Financing Reforms" *European Journal of Health Economics*. September. http://people.bu.edu/ellisrp/EllisPapers/2007_AntiochEllisGillett_EJHE_RiskAdj.pdf

The State-wide referral concept should be carefully analysed and relevant variables included in the data by the Independent Hospital Pricing Authority in order to achieve the goals clearly specified in Paragraph 131 (1)(e) (ii), Paragraph 131(3)(c) and given 131 (3) (a) specifications for consideration of best practice in Australia and internationally. The Victorian model and the insights on risk adjustment in ABF have served as a model for other countries to follow in their development and implementation of ABF. Ensuring adequate risk adjustment will enable reasonable access, quality, predictability of costs and effectiveness, efficiency and financial sustainability given the price could more accurately reflect the costs required to meet health need. This would thereby fulfill the goals in 131 (3)(c) of the legislation. *This is a serious matter and should not be taken lightly given the experience where ABF has been implemented in Victoria. ABF in the absence of adequate risk adjustment has been associated with underfunding of hospital networks and would have further implications for patient safety (in the absence of adequate EBM initiatives) and stretches the capacity of dedicated staff.*

The appropriate data could be developed in consultation with the Clinical Advisory Committee at Part 4.10 Section 177 of the new legislation and also by the Jurisdictional Advisory Committee at Part 4.11 Subsection 196(1). Clause A56 of the National Health Reform Agreement 2011 states that the IHPA will determine loading for patient characteristics and service location. Clause B13 notes that in determining adjustment to he national efficient price the IHPA must have regard to the legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery including hospital types and size; hospital location including regional and remote status and *patient complexity including indigenous status.* Clause B71 of the NHRA (2011) that the "administrator will determine the minimum level of data required to calculate the commonwealth contribution to the national efficient price…".

It is recommended that

Bodies determining the data collection on' patient complexity' and other patient characteristics that is to be provided, could consider the results of the Victorian analyses by the State government's Risk Adjustment Working Group (RAWG) as published. Processes should be established to ensure that adequate consideration be given into the future to the ***data on severity markers relating to state-wide referral services*** *to identify adjustments to adequately capture risk (severity) to enable funding to more accurately meet health need.*

The foregoing matter should be considered as a high priority by the relevant national bodies and committees involved in the costing, pricing, and classification including, inter alia, the National Health Funding Body, Independent Hospital Pricing Authority, Jurisdictional Advisory Committee (JAC) and the Clinical Advisory Committee (CAC). It would also be of considerable interest to the deliberations of the National Health Performance Authority to enable reliable and valid evaluations. The process of severity marker identification should be ongoing and could build upon the initial work of RAWG to comprehensively cover all State-wide referral services nationally. Processes of JAC and CAC can undertake further work in this area.

The legislation could be amended to include reference to the need for adequate risk adjustment in the deliberations of the Independent Hospital Pricing Authority to avoid reductions in quality that may result from underfunding if the funds do not adequately match health need.

Part 4.4 Constitutional and membership of the Pricing Authority

Subsection 144(4) specifies that at least one member of the Pricing Authority should have experience or knowledge and significant standing in health care needs and service provision in regional or rural areas. I had previously addressed this issue in my submission to the Community Affairs Legislation Committee Inquiry on the National Health Reform Amendment (National Health Performance Authority) Bill 2011.

With regard to the appointment of members to the Performance Authority, the Final Senate report stated at section 2.32 that: "In addition, Dr Antioch suggested amending proposed subsection 72(4) to include explicit indigenous health representation by amending the subsection to read as follows: "*the provision of health care services in regional and rural* ***including indigenous health services*** *(addition in bold). This will enable consistency with all Federal State financing agreements, which include indigenous health as an overarching top priority for Australian governments"*.

The Senate report included a final recommendation as follows:

2.33 The committee recommends that COAG should consider a broader range of mandated representation on the Authority and in particular should consider representation of consumers and indigenous health stakeholders[16].

I note that the current Bill has not addressed this issue in the context of the Pricing Authority for either indigenous health stakeholders nor for consumers. I further highlight that representation for indigenous health is of particular relevance to the Pricing Authority, given the specification at Clause B13(c) of the NHRA (2011) at page 31 which includes an adjustment variable to the efficient price of *patient complexity, including indigenous status*.

I recommend:

*That **Sub-Section 144 (4)** be amended. I recommend explicit reference be made to indigenous health representation and suggest amendments as follows: **Amend paragraph 144 (4) (d)** to read as follows: "The provision of health care services in regional and rural areas **including indigenous health services**". (Addition is in bold) This will enable consistency with all Federal–State financing agreements which include indigenous health as an overarching top priority for Australian Governments.*

2. State Centres of EBM, Health Services and Workforce Redesign: Cost Benefit Analysis (CBA)

My submission to the Community Affairs Legislative Committee (National Health Reform Amendment (National Health Performance Authority) Bill 2011 provided details of the role of proposed state centres in the context of the performance authority and has also been raised with regard to the Quality Commission. I highlighted that such Centres could provide input into the deliberations of the Independent Pricing Authority about the quality and efficiency implications of the efficient price by hospital services. That submission also provided the results of a Cost Benefit Analysis of national implementation of such centres with net cost savings of $269.6m per annum or $1,348m over 5 years. (see Antioch 2011[17] for details). The concept of such centres is relevant to the provisions of the National Health Reform Agreement- National Partnership Agreement on Improving Public Hospital Services (July 2011).

I recommend that the Committee note that the State Centres could be funded in the following funding streams identified in the Partnership Agreements:

*Schedule B 4(a)- Funding for the purchase of surgical equipment, **Information Technology to improve clinical and management systems** and*

Schedule E - New sub-acute beds guarantee funding E13 (c) ' Co-ordination across relevant Australian Government and State and Territory programs and activities to ensure seamless and high quality patient care, including development and application of agreed nationally consistent performance measures, uptake and dissemination of relevant evidence – based guidelines and IT systems to improve the management of patient flows across the health care system.

Importantly, Clause C16 indicates that States and Territories can flexibly move funding allocated in Table C1[Estimated Facilitation Funding] to other schedules with this agreement but only in strict accordance with requirements set out in clause 32. That clause states that redirecting funds can only be done with prior written agreement from the Commonwealth.

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[16] http://www.aph.gov.au/senate/committee/clac_ctte/nhpa/report/index.htm

[17] http://www.aph.gov.au/senate/committee/clac_ctte/nhpa/submissions.htm (Antioch KM Submission 14)

Recommendation

That you note the above issues and recommendations in the document. In my view the overall direction of the government in these reforms represents excellent Evidence Based Policy.

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Dr Antioch currently holds appointments to Government Expert Panels (Federal and State) relating to Activity Based Funding and Casemix Reforms. She led the risk adjustment reform of Activity Based Funding (ABF) in Victoria for the Victorian Government, applying performance and clinical evaluation data and worked in the Senior Management of Hospital Networks. She has worked in Australian Federal and State Governments on ABF classification systems and funding models. She worked with the Australian Casemix Clinical Committee (ACCC) and the Technical Reference Group (TRG) previously in developing Australian DRGs when working in the Federal Department of Health and Ageing. She previously held two ministerial appointments, to the Principal Committees of the National Health and Medical Research Council (NHMRC) for six years to 2009. These were the Health Advisory Committee and National Health Committee. She was also an appointed member of the NHMRC's Privacy Working Committee and Lead Committee. She was previously appointed by the Victorian Governor in Council to a Victorian Health Practitioners Registration Board and worked on a Canadian Royal Commission on Health Care and Costs on hospital and aged care reforms.