# Submission by

# *Australian Healthcare & Hospitals Association*

## to the Senate's
## Standing Committee on Finance and Public Administration

## Legislation Committee

## Inquiry into
## National Health Reform Amendment
## (Independent Hospital Pricing Authority) Bill 2011

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# 1. Introduction

The **Australian Healthcare and Hospitals Association (AHHA)** welcomes the opportunity to provide a written submission on the National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011, to give effect to the relevant sections of the National Health Reform (NHR) Agreement.

*The Australian Healthcare and Hospitals Association is the independent peak membership body and advocate for the Australian public and not-for-profit healthcare systems and a national voice for universally accessible, high quality healthcare in Australia. It represents providers in the acute, community, primary and aged sectors. The Association has expertise in coordinating the views of a wide range of stakeholders.*

The following submission sets out the Association's comments on the Bill taking into account the Committee's request to consider:

- the impact that the IHPA will have on the nation's hospitals; and
- its relationship with the Safety and Quality Commission and the National Performance Authority.

In relation to this request, this submission provides advice on important issues related to the implementation of the IHPA in the context of the NHR.

# 2. Summary of comments and recommendations

## 2.1 Independence and transparency

The AHHA commends the capacity for the IHPA to provide independent advice to governments on the funding of public hospitals (Clauses 129 and 130). It is essential for the benefit of the general community, and for the public hospital sector, that the IHPA maintains a high level of independence from all governments. Its advice must be based on national and international evidence and not impacted by political or parochial influences.

It is not clear, however, that the IPHA's advice to governments about funding models for hospitals (Clause 131 1 (h)) will be made available to the public and/or the public hospital sector. The AHHA seeks clarification on this issue. The acute sector will be responsible for implementing decisions and hence informed stakeholder involvement will be critical to the success of the program.

Furthermore, the commitment to transparency (Clause 129 (2)) is not reflected in the provision for the IHPA to give *confidential* advice to governments on future health care services (Clause 131 1 (i)). The AHHA cannot support this provision and requests that the requirement for confidentiality be removed. The community and the health sector, the key vehicle for service delivery, are best served if full transparency in the deliberations of the IHPA is preserved.

## 2.2 Public hospital functions

Unless the Commonwealth and States take a visionary approach to defining hospital services, the IHPA will have no capacity to price services that substitute for in-patient care and no capacity to price innovative models of care created by the need to integrate services across hospital and primary/community care boundaries. This will be particularly so for the chronically ill and aged care sectors.

To ensure the IHPA is provided with the necessary tools to gear incentives for care in the most appropriate setting, the meaning of 'hospital care' must be flexibly defined so that it can encompass all the services delivered, or contracted out, by Local Hospital Networks. To this end, the AHHA recommends that the meaning of 'hospital care' explicitly include community health services and centres. This will require the Commonwealth to fund growth in alternative models of care better delivered outside traditional hospital settings. It will also require the States and Territories to commit to appropriate funding for community care services.

## 2.3 Activity based funding

The AHHA supports moving to a national activity based funding system as it will ensure a consistent approach by all States and Territories to the most appropriate mix of services provided public hospitals and their concomitant use of resources.

There is a serious risk that the introduction of Activity Based Funding (ABF) will simply reinforce existing models of care. The proposed legislation does not sufficiently recognise and minimise this risk. It is recommended that the terms of reference for both the clinical and the jurisdictional committees explicitly require them to advise the IHPA on emerging models of care that should be classified and priced prior to their widespread introduction.

The AHHA notes that the IHPA, in performing its functions, must have regard to *'relevant expertise and best practice within Australia and internationally'* (Clause 131 3 (a)). The Association believes that in Canberra there may not be the required skills base workforce for this task and recommends that the IHPA be established in a major capital city (other than Canberra) to capture requisite, independent expertise.

The IHPA will have a key role in determining new classifications and data requirements. A significant challenge to overcome before costing and clinical data can be properly interpreted and applied, will be understanding and dealing with the significant differences in how health services are delivered and counted both between and within States/Territories. In this context, the AHHA supports the provision for a Clinical Advisory Committee to be formed (Clause 4.10) to inform the IHPA's work.

In addition, linking patient-centric activity data sets will be essential. These data sets which show utilisation of services by patients are held by the Commonwealth Department of Health and Ageing, the Australian Institute of Health and Welfare and the States/Territories.

While the AHHA welcomes the move to national consistency, due consideration must be given to the burden of compliance on hospitals and the fact that development of new classification systems invariably translates into additional requirements for the information systems capturing data.

## 2.4 National efficient price

The concept of the 'efficient price', to be defined by the IHPA, will set the value for hospital services. To date, there is lack of clarity about how the value of the efficient price will be set, particularly in order to value innovation and substitutability. This will be a complex task and presents a significant challenge, particularly within the agreed implementation timeframe.

There is a serious risk that the introduction of Activity Based Funding (ABF) will simply reinforce existing models of care. The proposed legislation does not sufficiently recognise and minimise this risk. It is recommended that the terms of reference for both the clinical and the jurisdictional committees explicitly require them to advise the IHPA on emerging models of care that should be classified and priced prior to their widespread introduction.

There is lack of information about how the 'efficient price' will be indexed in order to calculate annual rises in hospital costs (as distinct from increases in volume). The AHHA recommends that the following indices (or other replacement measures) for the national efficient price should be applied quarterly in the first few years of operation, and then applied annually:

- the AIHW health price index;
- the Productivity Commission index of technology growth; and
- projected increases in population by region adjusted for likely hospital utilisation (which will not be covered totally by volume growth).

## 2.5 Public hospital access, sustainability and continuity

Future access will be influenced by governments ensuring innovative use of Activity Based Funding (ABF). This includes the development of a comprehensive understanding of how ABF systems for non-admitted patients are constructed in order to fund care delivery in the setting most appropriate to the patient needs. Without this, there is the potential for skewing of incentives resulting in some patients being treated inappropriately as in-patients.

Maintaining appropriate standards of training and sufficient opportunities for research cannot be underestimated. They are essential to ensure the future development of the skills and innovations necessary to deliver the complex care required in our public hospitals. The AHHA understands that the IHPA will be responsible for calculating Commonwealth funding levels for training and research activities and that this is envisaged in the IHPA's function to determine block funded services. However, the AHHA seeks clarification of this.

Future access, continuity/predictability and effectiveness/efficiency and sustainability will be influenced by governments ensuring innovative use of ABF. This includes the development of a comprehensive understanding of how ABF systems for non-admitted patients are constructed in order to fund care delivery in the setting most appropriate to the patient needs. Without this, there is the potential for skewing of incentives resulting in some patients being treated inappropriately as inpatients.

## 2.6 Safety and quality

Determining how price is linked to quality is a critical issue that requires significant clinical advice. While the draft legislation uses the term 'efficient' throughout, this term is never defined. An 'efficient price' which does not adequately take account of investment in access, quality, innovation, research and teaching, will risk taking hospital services backwards in terms of patients being able to access the most effective treatments and technologies to support efficient and high quality care.

The AHHA recommends that:

- a definition of the term 'efficient' be included in the legislation; and
- this definition include concepts of both technical and allocative efficiency

# 3. Independent Hospital Pricing Authority

The pivotal role of IHPA to the successful implementation of the National Health Reforms cannot be underestimated.

## 3.1 Independence and transparency

This legislation will establish the IHPA as the body to give independent and transparent advice in relation to funding public hospitals (Clause 129).

The Bill sets out the IHPA's two objects (Clause 130) as:

i) promoting efficiency in, and access to, public hospitals services by providing independent advice to governments in relation to the efficient costs of hospital services ;and

ii) developing and implementing robust systems to support activity based funding for hospital services.

**AHHA comments**

The AHHA commends the capacity for the IHPA to provide independent advice to governments on the funding of public hospitals (Clauses 129 and 130). It is essential for the benefit of the general community, and the public hospital sector, that the IHPA maintains a high level of independence from all governments. Its advice must be based on national and international evidence and not impacted by political or parochial influences.

A corollary of being independent is the provision for the IHPA's advice to be transparent (Clause 129). The AHHA notes the effect of this provision in requirements for the IPHA to:

i) publish an annual report on the national efficient price including supporting material (Clause 131 1 (g)); and

ii) publish reports and papers relating to its functions (Clause 131 1 (k)).

It is not clear, however, that this commitment extends to releasing the IPHA's advice to governments about funding models to the public and/or the public hospital sector (Clause 131 1 (h)). The AHHA seeks clarification on this issue.

Furthermore, the commitment to transparency is not reflected in the provision for the IHPA to give *confidential* advice to governments on future funding of health care services (Clause 131 1 (i)). The AHHA cannot support this provision. The community and the health sector are best served if full transparency in the deliberations of the IHPA is preserved.

As this is a publicly funded environment in which market mechanisms do not operate, the IHPA will have a vital responsibility to provide the micro-level information that enables the policy shapers (public servants, academics and health-related associations) to engage in a dialogue that ensures ongoing innovation and value creation in publicly funded hospital services.

In the context of transparency, the AHHA welcomes the provisions for the IHPA to:

i) call for and accept annually, public submissions on its functions which relate to determining the efficient price, block funding, activity based funding (data requirements and standards) and public hospital functions (Clause 131 1 (l)); and

ii) have regard to submissions made at any time by governments (Clause 131 3 (b)).

## 3.2 Public hospital functions

A central task of the IHPA will be to determine current and future public hospital functions (except where otherwise agreed between the Commonwealth and a State or Territory) that are to be funded by the Commonwealth in the State/Territory (Clause 131 1 (f)).

**AHHA comments**

A major implementation challenge, and one that will strongly influence the success of the Reforms, is the extent to which the funding regimes either incentivise or deter more cost effective and appropriate models of patient care. In the recent AHHA NHR Simulation (June 2011), participants acknowledged this as being '*most important in producing positive behaviour change in the system*'. Participants agreed that financial instruments need to be finely-tuned in order to drive incentives towards delivery of care in the most appropriate settings.

Unless the Commonwealth and States take a visionary approach to defining hospital services, the IHPA will have no capacity to price services that substitute for in-patient care and no capacity to price innovative models of care created by the need to integrate services across hospital and primary/community care boundaries. This will be particularly so for the chronically ill and aged care sectors.

To ensure the IHPA is provided with the necessary tools to gear incentives for care in the most appropriate setting, the meaning of 'hospital care' must be flexibly defined so that it can encompass all the services delivered, or contracted out, by Local Hospital Networks. To this end, the AHHA recommends that the meaning of 'hospital care' explicitly include community health services and centres. This will require the Commonwealth to fund growth in alternative models of care better delivered outside traditional hospital settings. It will also require the States and Territories to commit to appropriate funding for community care services.

The AHHA notes that the IPHA must have regard to submissions made at any time by governments (Clause 131 3 (b)). The AHHA envisages that this will give the jurisdictions the opportunity to provide submissions on new models of care that they wish to test and the IHPA the independent capacity consider these. The AHHA sees costs being initially modelled with a provisional price set, with that set being reviewed after the model had been established and tested.

The IHPA is also obliged to call for, and accept, public submissions annually in respect of the efficient price, block-funded costs, the case-mix system and public hospital functions. The Association welcomes this function which provides for input from interested parties and the general community.

## 3.3 Public hospital funding

From 1 July 2014 the Commonwealth's contribution to hospital funding will be based on funding levels set by the Intergovernmental Agreement on Federal Financial Relations and the National Healthcare Agreement (2008) plus 45% of the growth in activity (admitted and non-admitted) at the agreed efficient prices, rising to 50% from 1 July 2017, supplemented by incentive and other payments included in the Agreement.

The National Health Reform Agreement commits all governments to "*a national approach to activity based funding (ABF) and that public hospital services will be funded, wherever possible, on the basis of a national efficient price for each public hospital service provided to public patients*".

The IHPA's role is critical in determining funding models and costs. These important functions are set out in (Clause 131 1 (a-f)) and include:

- determining the national efficient price for services funded according to activity, including adjustments for unavoidable variations, and the efficient cost where services are block funded;
- developing classification systems for all services provided by public hospitals;
- developing activity based funding models based on cost weighted case-mix classification systems including adjustments to take account of unavoidable variations; and
- determining uniform data requirements and data coding standards.

AHHA comments are provided under the following two headings:
- Activity based funding and
- National efficient price

## 3.4 Activity based funding

**AHHA comments**

The AHHA supports moving to a national activity based funding system as it will ensure a consistent approach by all States and Territories to the most appropriate mix of services provided public hospitals and their concomitant use of resources.

There is a serious risk that the introduction of Activity Based Funding (ABF) will simply reinforce existing models of care. The proposed legislation does not sufficiently recognise and minimise this risk. It is recommended that the terms of reference for both the clinical and the jurisdictional committees explicitly require them to advise the IHPA on emerging models of care that should be classified and priced prior to their widespread introduction.

The AHHA notes that the IHPA, in performing its functions, must have regard to *'relevant expertise and best practice within Australia and internationally'* (Clause 131 3 (a)). The Association believes that in Canberra there may not be the required skills base workforce for this task and recommends that the IHPA be established in a major capital city (other than Canberra) to capture requisite, independent expertise.

It will be essential to ensure consistency in classifications and linkages between data sets held by various jurisdictional bodies to enable meaningful analysis of the performance and cost of the public hospital system across Australia. The IHPA will have a key role in this[1].

In relation to the IHPA's function to determine uniform data requirements and data coding standards, the AHHA makes two comments:

- Firstly, a significant challenge to overcome before costing and clinical data can be properly interpreted and applied, will be understanding and dealing with the significant differences in how health services are delivered and counted both between and within States/Territories (eg hospitals transferring patients between themselves as a network

[1] In this context, the AHHA notes that there are still major gaps in the measurement tools available. Acceptable measures exist for almost all in-patient services (which account for about 70% of hospital costs); but, as yet, there are no nationally acceptable measures for out-patients or for mental health.

service). In this context, the AHHA supports the provision for a Clinical Advisory Committee to be formed (Clause 4.10) to inform the IHPA's work.

- Secondly, linking patient-centric activity data sets will be essential. These data sets which show utilisation of services by patients are held by the Commonwealth Department of Health and Ageing, the Australian Institute of Health and Welfare and the States/Territories. Currently these data sets cannot be linked, making it impossible to follow patients and analyse service utilisation across sectors and States/Territories.

While the AHHA welcomes the move to national consistency, due consideration must be given to the burden of compliance on hospitals. Currently they are obliged to submit data to various Commonwealth agencies (Australian Institute of Health and Welfare, Australian Commission on Safety and Quality in Healthcare, the COAG Reform Council, the National Health Performance Authority and the IHPA) as well as to state/territory departments of health/human services.

In addition, the development of new classification systems invariably translates into additional requirements for the information systems capturing data. The cost of upgrades to systems and staff re-training to capture data consistent with any new classification systems (or indeed any additional information required by these Commonwealth authorities) could be a significant risk for hospitals and will need to be taken into consideration by the IHPA and others.

## 3.5 The National Efficient Price

The concept of the 'efficient price', to be defined by the IHPA, will set the value for hospital services. The AHHA's ground-breaking NHR Simulation (June 2011) was designed to test the IHPA's role in this respect and highlighted the lack of clarity about how the value of the efficient price would be set. Two critical issues were highlighted - how to value innovation and how to ensure substitutability. This will be a complex task requiring considerable high level experience and skills. It presents a significant challenge, particularly within the agreed implementation timeframe (see 3.4 above - activity based funding).

The IHPA will be responsible for developing the process of transition to the national efficient price within the following timetable:

- admitted acute services, emergency department services and non-admitted patient services (initially using the Tier 2 outpatient clinics list) commencing on 1 July 2012; and. The AHHA assumes that funding will initially be according to state-specific prices, transitioning over time to a national efficient price but requests confirmation that this is the case;
- other non-admitted services, mental health and sub-acute services commencing on 1 July 2013.

While the IHPA will need high-level technical skills as a pricing authority, it is not intended to be a fund holder. It will not be able to assess prices for services which are currently not funded or delivered, even if they are the best model of care, unless these initiatives are submitted to the IHPA by governments or by the public for costing (see 3.3 above - public hospital functions).

There is lack of information about how the 'efficient price' will be indexed in order to calculate annual rises in hospital costs (as distinct from increases in volume). The AHHA understands that IHPA will be responsible for indexing the 'efficient' price, which will need to be applied to the base funding. In line with past National Healthcare Agreements this indexation, when

applied to the base funding, must be transparent, acceptable to all parties, and take into account the cost of non-volume-related costs such as quality of care, expanding medical and communication technologies and increasing private health insurance premiums. National Partnership payments must not be included in the calculation of the base efficient prices.

The AHHA recommends that the following indices (or other replacement measures) for the national efficient price should be applied quarterly in the first few years of operation, and then applied annually:

- the AIHW health price index;
- the Productivity Commission index of technology growth; and
- projected increases in population by region adjusted for likely hospital utilisation (which will not be covered totally by volume growth).

Given the short timeframe for the IHPA to be established, and also to deliver on the national efficient price, the AHHA recommends that a responsive mechanism be put in place to review prices at a minimum of quarterly each year in the first few years of operation, after which time it should revert to an annual cycle.

Over time, the national efficient price should also be applied to private hospital services. Its definition, therefore, will need to be informed by practices in these hospitals.

## 3.6 Public hospital access, sustainability and continuity

The AHHA notes that the IHPA must ensure reasonable access to healthcare services (Clause 131 3 (c) (i), the continuity and predictability in the cost of health care services Clause 131 3 (c) (iii), and the effectiveness, efficiency and financial sustainability of the public hospital system (Clause 131 3 (c) (iv).

**AHHA comments**

The decisions the IHPA makes about both efficient price and efficient cost will have an immediate and wide impact on hospital services across Australia and must be robust, fair and evidence based, subject to regular review, and with an eye to quality and safety implications as well as efficiency.

In relation to access, there is little or no genuine discretion over admissions to the acute public hospital system. Fifty percent of all public hospital admissions are emergencies and, of the remainder, about thirty percent are non discretionary (patients who would become emergency admissions within days or weeks if not admitted) leaving only approximately twenty percent of all admissions which are discretionary. However, the great majority of these patients are urgent and semi urgent elective surgical and medical patients[2].

Future access, continuity/predictability and effectiveness/efficiency and sustainability will be influenced by governments ensuring innovative use of ABF. This includes the development of a comprehensive understanding of how ABF systems for non-admitted patients are constructed in order to fund care delivery in the setting most appropriate to the patient needs. Without this, there is the potential for skewing of incentives resulting in some patients being treated inappropriately as inpatients.

[2] Dr Chris Brook: Casemix Funding for Acute Hospital Care in Victoria, Australia accessible on http://www.health.vic.gov.au/__data/assets/pdf_file/0005/403169/casemix_funding.pdf

The AHHA warns that governments may have unrealistic expectations of possible savings to be made out of hospital activities. Australia's public hospitals have already achieved remarkable efficiency gains in recent decades such that further efficiencies will be difficult to achieve. Between 2005-06 and 2009-10 the rate of available beds in Australia remained steady at about 2.5 per 1,000 head of population while the number of ED presentations increased significantly with over a quarter of these patients being admitted. Overall demand on emergency departments increased by 17% during this period and is likely to continue at this rate unless a significant focus on better management of mental health, drug and alcohol and aged care is made. For overnight separations, the average length of stay was 5.9 days in 2009–10, down from 6.2 days in 2005–06[3].

Furthermore, evidence shows that the adjusted cost of service delivery is very similar across jurisdictions despite decade-old differences in funding methodologies. This result can be viewed as arising from one of the most important natural experiments in Australian health funding. For example, while Victoria has funded by case-mix for many years, NSW by a mix of needs-based funding and case-mix and Queensland by cost-based historic funding, there is no significant difference in the case-mix adjusted cost of the services provided in these jurisdictions[4].

Maintaining appropriate standards of training and sufficient opportunities for research cannot be underestimated. They are essential to ensure the future development of the skills and innovations necessary to deliver the complex care required in our public hospitals. The AHHA understands that the IHPA will be responsible for calculating Commonwealth funding levels for training and research activities and that this is envisaged in the IHPA's function to determine block funded services. However, the AHHA seeks clarification of this.

## 3.7 Safety and quality

The AHHA notes that the IHPA must ensure safety and quality in the provision of healthcare services (Clause 131 3 (c) (ii)).

**AHHA comments**

Determining how price is linked to quality is a critical issue that requires significant clinical advice. While the draft legislation uses the term 'efficient' throughout, the term 'efficient' is never defined. An 'efficient price' which does not adequately take account of investment in access, quality, innovation, research and teaching, will risk taking hospital services backwards in terms of patients being able to access the most effective treatments and technologies to support efficient and high quality care.

The AHHA recommends that:

- a definition of the term 'efficient' be included in the legislation; and
- this definition include concepts of both technical and allocative efficiency

There are significant challenges to overcome in setting health outcome indicators (to measure safety and quality) in order to achieve national conformity while also being sufficiently flexible to guide continuous improvement at the service delivery interface. The roles of the ACSQHC,

[3] 2011: Australian Hospital Statistics 2009-10, Australian Institute of Health and Welfare: Canberra

[4] Professor Kathy Eagar: ABF Information Series No. 4: The cost of public hospitals – which State or Territory is the most efficient? http://ahsri.uow.edu.au/chsd/abf/index.html

in developing outcome measures, and the NHPA, in measuring performance, will be relevant to the IHPA's development of the efficient price.

# 4. Conclusion

The new Commonwealth-State financing arrangements are a central feature of the NHR, providing a new framework for improved transparency of, and accountability for, the shared funding arrangements between the Commonwealth and State/Territory governments, particularly in relation to public hospitals. This has the potential to minimise cost and blame shifting between jurisdictions.

The new arrangements will be achieved through:

- confirmation of the role of States/Territories as 'system managers', recognising their traditional expertise in the delivery of health services;
- a national public hospital funding system involving the Independent Hospital Pricing Authority (IHPA), a joint funding pool and a national funding body; and
- a nationally consistent Activity Based Funding (ABF) system using case-mix classifications for each public hospital service (except where the service is block funded).

The way in which the IHPA carries out its functions will be instrumental to the success, or otherwise, of the new funding arrangements.