Christine McDonald
Secretary
Senate Standing Committee on Finance & Public Administration – Legislation Committee
Parliament House
Canberra ACT 2600
by email fpa.sen@aph.gov.au

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

Dear Ms McDonald,

Thank you for notifying us that the Senate Standing Committee on Finance & Public Administration – Legislation Committee is inquiring into the National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011. Please find attached a joint submission from Women's Hospitals Australasia (WHA) and Children's Hospitals Australasia (CHA) to this Inquiry.

Both WHA and CHA welcome the introduction of this legislation to the federal Parliament as a key element of national health reform. Our comments in the attached submission are intended to support successful implementation of this significant reform to funding of hospital services.

WHA and CHA are both not-for-profit peak bodies of hospitals in Australia and New Zealand that provide healthcare to women and babies, and to children and young people respectively. Our collective vision is to enhance the health and well-being of women and children through supporting member hospitals to achieve excellence in clinical care. This is achieved through

- Benchmarking performance to support reflection on practice and striving for best practice;
- Leading and facilitating the sharing of knowledge and evidence underpinning best practice;
- Professional networking through multidisciplinary Special Interest Groups focusing on topical issues such as children's rights, women's health or medication safety to name a few;
- Delivering high quality forums and conferences showcasing best practice and recent research evidence on a wide range of women's and children's healthcare matters.

WHA and CHA together represent the majority of tertiary women's and children's hospitals in Australia as well as many regional and rural general hospitals that provide care to women and/or children.

We would be happy to provide further information if that would be of assistance.

Yours sincerely,

Dr Barbara Vernon
Chief Executive Officer
2 September 2011

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

Joint Submission from Women's Hospitals Australasia and Children's Hospitals Australasia.

Summary of key points:

The Independent Hospital Pricing Authority is an important reform - Women's Hospitals Australasia and Children's Hospitals Australasia (referred to jointly as WCHA) welcome the introduction of legislation into Federal Parliament to provide for the establishment of the Independent Hospitals Pricing Authority (IHPA). This new institution will have an important role to play in the delivery of national health and hospital reforms agreed by COAG.

It is vital that the IHPA be an independent statutory body, at arms lengths from both commonwealth and state governments, with the ability to marshal appropriate expertise to make robust and evidence based decisions on the areas of responsibility outlined in section 131(1).

WCHA particularly welcome the following elements of the Bill:

- Provisions for a **Clinical Advisory Committee** to be formed (Part 4.10) to inform the IHPA's work;
- **The subsections of 131(3)** outlining the range of factors the IHPA must have regard to in performing its functions;
- Provisions for the IHPA to investigate and give an **independent assessment** of **cost shifting and cross border disputes** (Part 4.3)
- The requirement in s131(1) (l) for the Authority "to call for and accept, on an annual basis, **public submissions**" in relation to the Authority's functions as detailed in s131(a-f).
- The commitment to **transparency** in s210 on annual reporting to Parliament.

Minor adjustments to the Bill could strengthen the design of the IHPA, through:

- Ensuring inclusion of **consumer representatives** in the makeup of the IHPA itself and both the Clinical Advisory Committee and the Jurisdiction Advisory Committee, to ensure the IHPA remains focused on the consequences for healthcare consumers of its decision making and advice to governments on funding models At least one of these consumer representatives should be familiar with hospital and healthcare for children and young people;
- Ensuring inclusion of an individual on the IHPA with recognised **expertise and standing in children's healthcare**, given the unique issues and challenges involved in caring for children and young people

While we support the objectives of this Bill, our members have some concerns about its **implementation**. In finalising this legislation, WCHA urges Senators to be mindful of the following implementation issues:

- 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 decisions**, subject to regular review, and with an eye to quality & safety implications as well as efficiency;
- **Children's healthcare costs more** than the provision of the same healthcare services to adults and **must be appropriately funded**;
- Activity based funding is to be introduced from 1 July 2012 for acute inpatient care, emergency department care and Tier 2 outpatient services. **It's important that the increased costs of delivering care to children across all 3 patient types are recognised and that these services are adequately funded**;
- **Hospitals have different cost structures** depending on the clinical and demographic profile of patients, as well as by the different costs of qualified labour in different parts of Australia.
- It is not yet clear how **training and research activities of public hospitals** will be funded in the future. We understand this will be decided by COAG not by the IHPA. It is vital these activities continue to be adequately funded.
- Changes needed to create national classification and data management systems, while essential and welcome, need to be implemented efficiently, and to **minimise the burden** on hospitals of adjusting their reporting systems and of reporting to multiple national and state/territory agencies.

The Bill should be passed - WCHA urges the Inquiry to recommend to the Senate that it pass the Bill. We ask that the Committee to consider the following minor amendments*:*

1. Re the **expertise required of members of the IHPA** itself in s144(4), we recommend addition of 2 new subclauses reading:
    a. (e) "the provision of hospital services to children & young people and
    b. (f) "healthcare consumer representation".
2. Re the **expertise required of members of the Clinical Advisory Committee (s 179)**: we recommend adding a subclauses to provide for a non-clinician with capacity to represent consumer perspectives
3. Re **support from the IHPA to the Clinical Advisory Committee**: we recommend s204 and s207 saying the IHPA may provide assistance to the various Committees should also apply to the Clinical Advisory Committee, i.e. be copied and added to Part 4.10.

Expansion on the key points

WCHA urges all political parties to support this legislation and facilitate the timely establishment of the IHPA as a statutory authority.

We have a few specific comments on the Bill, and also some contextual comments that relate more to the implementation of the IHPA once the legislation is passed. We appreciate that the terms of reference of the inquiry necessarily relate specifically to the Bill but believe it is important for the Senators to be aware of the implications of this legislation for hospital services to women, babies, children and young people when considering its design and passage.

WCH offer comments on the following:

1. the design & governance of the IHPA;
2. the delivery of hospital care to children and young people;
3. the delivery of hospital care to women and babies;
4. other issues common to all hospitals.

1. Issues related to the design & governance of the IHPA

Inclusion of a children's health expert on the IHPA

While CHA has confidence that the Minister will seek to ensure the IHPA comprises individuals with appropriate experience and expertise to ensure the IHPA's successful execution of its responsibilities, we believe nonetheless that the IHPA would be enhanced through inclusion in s144(4) of the Bill of a specific provision for at least one of the 9 IHPA members to have particular expertise in, and understanding of children's healthcare.

Children's healthcare is not just another specialty area of health as it is sometimes regarded. It involves the full suite of medical, nursing and allied health services provided to adults being provided to children and young people whose needs often differ from those of adults even when the same condition, disease or treatment is involved. Children's healthcare is more costly than adult care for at least 3 main reasons:

- Children have a limited capacity to look after themselves and articulate their health needs.
- Children's normal developmental trajectory is characterised by change.
- Children have differential morbidity (type, prevalence & severity of illness)[i].

Given the responsibility of the IHPA to determine a national efficient price for public hospital services provided on an activity base (including acute inpatient, outpatient and Emergency Department care), as well as the efficient cost of block funding, a thorough appreciation of the costs involved in providing care to children will be essential to the IHPA ability to meet s131(3)(c) in ensuring access, safety and quality and financial sustainability in children's hospital services.

WCHA therefore recommends that provision be made to include at least one person with substantial experience and knowledge, and significant standing in children's healthcare.

Inclusion of consumer representatives on the IHPA and its Advisory Committees

There is no mention of consumer involvement in the IHPA's governance structures, yet the IHPA is one of a number of new agencies being formed with the overarching policy objective of ensuring health and hospital services focus more strongly on the needs, decisions and journey of healthcare consumers.

There are now a range of organisations representing consumer perspectives in Australia, and it would not be difficult to identify individuals with the necessary expertise and experience to value add to the IHPA's work by providing timely advice and raising questions about the impact of decisions on prices, costs, classification systems and data collection on consumers.

WCHA strongly recommend the Bill be amended in sections related to the IHPA's membership (s144), and that of the Clinical Advisory Committee (s179) and the Jurisdictional Advisory Committee (s198).

Clinical Advisory Committee

WCH welcome the commitment in statute to the IHPA having a Clinical Advisory Committee. We believe this will be an important body of expertise and advice on which the IHPA can draw to ensure it makes fair and appropriate decisions but to also ensure that those decisions have credibility with clinicians across Australia's public hospitals.

Part 4.10 establishing the Clinical Advisory Committee (CAC), says that a person is not eligible for appointment as a Clinical Advisory Committee member unless they are a clinician (s 179 (3)). However, in Section 177 (a) it states that the CAC will advise the Pricing Authority in relation to developing and specifying classification systems for healthcare and other services provided by public hospitals. In order to fulfil this function, the IHPA should perhaps have the freedom to appoint individuals to the CAC who have specific expertise in coding and clinical classifications. Such individuals are typically not clinicians, though they work closely with clinicians. They will be able to bring not only a knowledge of casemix funding systems but insights into the behaviour such funding mechanisms produce in service delivery environments. Too often those designing funding systems are not aware of the impact $$ have on the behaviour of hospital managers and clinicians.

We therefore recommend that s179 be amended to allow the Minister to appoint individuals with coding and classifications expertise in addition to clinicians to the Clinical Advisory Committee.

On a minor point, it seems odd that s204 says the IHPA may provide assistance and advice to the Jurisdictional Advisory Committee (and s207 does the same for other committees) but there is no corresponding clause for the Clinical Advisory Committee. If it is necessary to make provision for such support in legislation at all, we recommend that similar support be provided for in Part 4.10.

Transparency

Section 131(1) (l) of the *Bill* requires the IHPA "to call for and accept, on an annual basis, public submissions" in relation to the Authority's functions as detailed in s131 (a-f). We welcome the inclusion of this requirement. It will help to ensure the IHPA has ready access to a range of

information and views in its decision making on all its functions even beyond the committee it formally establishes. It will also ensure that the views and information provided by all parties seeking to inform or influence the decisions of the Pricing Authority on the national efficient price for particular hospital services will be on the public record.

2. Issues specific to hospitals providing care to children & young people

In considering the finalisation of this legislation, WCHA urges the Committee to bear in mind a number of issues associated with the implementation of this significant reform to hospital funding, of which the IHPA's establishment is but one part.

There are at least 2 key issues that are pivotal in the provision of healthcare to children, which the new IHPA will need to take into account in making determinations on both the efficient price of hospital activity and the efficient cost of block funding.

a) The current classification used to fund acute inpatient care (AR-DRGs) in general do not differentiate adult from paediatric care and yet there are significantly higher costs in paediatric care compared to adults.

A published study commissioned by CHA in 2008 into the healthcare costs in Australian Specialist Paediatric Hospitals[ii] found that the AR-DRG (the classification code used to cost patient care for in-patients) "fails to account for a large number of complications and co-morbidities that materially affect the cost of care of children particularly those cared for by specialist paediatric hospitals", because the Australian DRG does not include almost 1,500 diagnosis codes included in the international ICD-10-AM.

The study also found that while relative cost differences between adult and children's care (in specialist hospitals) were greatest for neonates and children under 3 years of age, they nevertheless applied across all age ranges. Paediatric care costs more because of the different needs of children summarised on page 4 above.

Another study by Durojaiye & O'Meara[iii] also found differences in Emergency Department care between specialist children's hospitals and EDs in general hospitals. A child may present in a general hospital and be triaged as a 3. The same child may be triaged as a 4 or 5 at a children's hospital, where the staff have more regular exposure to emergency care for children. Since the funding system is based on urgency, with allocation of money largely dependent on triage, children's hospitals tend not be equitably or suitably funded under this arrangement.

This means that "pure' casemix funding of specialist paediatric hospitals could have a major impact on the financial viability of those hospitals unless weaknesses in the classification system used to code occasions of service are addressed.[iv] The IHPA clearly has scope in the legislation to determine efficient cost for services that are block funded, but our members remain concerned about how the cost differences for activity based funded services will be recognised and funded if a consistent national price is applied without recognition of the increased costs involved in delivering paediatric care. We recognise that there is currently a national project looking at the DRGs and that the impact of the DRG on paediatric care is being considered as part of this project.

b) The second issue relates to the extensive community care provided by paediatric hospitals compared to adults. This is not currently adequately funded.

The *Costing Kids Care* study (2008, 52) found an average of 69% of patients being cared for by specialist paediatric hospitals are outpatients, compared to an average of 54% of patients in all hospitals. This includes outreach visits by specialists, support to regional hospitals and GPs, and other services covered as part of hospital duties (child protection, sexual abuse, support of community teams – child development team, Child Mental health, etc). The extent of such activity across hospitals caring for children is influenced in part by the demographics of and geography of the local community and in part by the extent to which private practitioners are available to offer community based services to children and young people, who without such services end up in the care of the local public hospital.

Not only is the extent of outpatient care higher for children's hospitals, but the costs are also higher, for the same reasons as for inpatient care. Outpatient care is currently underfunded and our members are concerned to see the IHPA make determinations on activity based costing of outpatient services that better reflect the costs of delivering those services.

The same challenges appears to apply to emergency department care between EDs in specialist paediatric hospitals and those providing mixed care to children and adults, although there is currently no reliable data analysing the extent and causes of these cost differences.

3. Issues specific to hospitals providing care to women and babies

A wide range of hospitals, from large tertiary centres to small rural hospitals provide maternity care to women across Australia. The key issues these members are mindful of as the IHPA begins its work will be:

- How activity based funding might influence efforts to expand community based outpatient maternity care (for pregnancy and postnatal care), recognising that pregnancy is for most women a 'wellness' episode and that non-hospital delivery of care is often preferable to providing wellness care within a hospital;
- how a nationally efficient price will address the costs of caring for a small cohort of women with multiple co-morbidities who require highly complex antenatal and labour and birth care needs.
- the need to address the long-running non-funding of neonates cared for on postnatal wards with their mothers instead of in Special Care Nurseries, but who require therapy (e.g. IV fluids, antibiotics, photo-therapy etc) that incurs costs but is currently not funded because babies that are not admitted to a SCN or NICU are not recognised as patients.
- how ABF funding will keep pace with changes in contemporary clinical practices especially around how respiratory support is counted and classified for neonates – e.g. invasive vs non invasive and increasing frequency of utilisation of CPAP (continuous positive airway pressure). These treatments are cost intensive particularly for nursing dependency and consumable, and the pricing model needs to reflect this.

4. Other issues common to all hospitals

Efficient price

WCHA members recognise that the Council of Australian Governments agreement which prompted the development of this Bill says that the amount of funds to be paid to public hospitals will be determined by State and Territory governments through Service Level Agreements. It is therefore understood that although the IHPA will determine a national efficient price, it will remain a responsibility of State and Territory Governments to determine the actual amounts paid for hospital services.

The process to develop a definition of a national efficient price is not described in the Bill and nor does it need to be. But the key questions on the minds of all of our members are:

- what will be the definition of a national efficient price?
- how will the IHPA set the 'efficient national price' for inpatient, outpatient and Emergency Department care,
- what additions/exceptions e.g. Aboriginality, remoteness, fixed costs for regional services etc will be factored in and how? and
- what will the impact of its decisions be on their capacity to continue to meet public needs and demands for hospital services?

WCHA is also keen to see that the IHPA will take quality issues into consideration when determining an 'efficient price' for services. An 'efficient price' which does not account for investment in quality, innovation, research and teaching will risk undermining the aims of the IHPA to promote more efficient and cost-effective care. We are therefore reassured by clause 131(3)(c).

Hospitals have different cost structures

The clinical and demographic profile of patients, the different costs of qualified labour in different parts of Australia, and the different state government service designs, all influence the relative efficiency of hospitals. For example DOHA prefers to treat all of Tasmania as one rural region, therefore it is conceivable that the same price might be applied, yet the services, demand, demographics, epidemiology etc across that State are not the same

This is recognised in the COAG National Health Reform Heads of Agreement which says:

> "The efficient price set by the IHPA will take into account a small number of loadings to reflect legitimate and unavoidable variations in the costs of service delivery, including those driven by hospital location"

The question is how the IHPA will make these decisions and what input the sector will be able to have to its deliberations?

Planning for future funding

The shared funding and additional funding outlined in the COAG National Health Reform Agreement of 2 August 2011 is premised on the States maintaining and matching Commonwealth funding. Some of our members have genuine reasons to be concerned that they may never see the promised 45 to 50% Commonwealth growth funding from 2014 if their state reduces the funding base for hospital care before then, or cannot match the funding growth. What happens if this occurs? In particular what happens if the demand is still there but the matching state funding is not?

Funding for training and research

Our members also remain uncertain about how funding for training and research will be administered in the new arrangements, and whether the IHPA will have responsibility for this as part of considering the efficient cost of block funding. There is currently no mention of training or research in the list of the IHPA's responsibilities in section 131. Perhaps this item is covered by s131(1)(b) on block funding or s131(1)(f) in which the IHPA will determine which public hospital functions are to be funded by the Commonwealth. If the IHPA is to have a role in determining the 'efficient price' or the 'efficient cost' of training and research activities by public hospitals then this should be made clear in section 131.

Impact of the Bill on non-government hospitals

WCHA recognises that the intention of the IHPA is to make decisions about efficient cost and price for public hospitals. Some of our members are not-for-profit private hospitals that are contracted to provide public services, and which make a significant contribution to the care of women, babies, children and young people in their local district. It will be important for the IHPA to consider such providers when making its determinations about efficient cost and efficient price, particularly given that such providers typically incur differential costs to government owned public hospitals for commodities like insurance, major IT infrastructure, payroll tax, council rates, etc.

Reporting burden

The IHPA will have a key role in determining new classifications and data requirements. While WCHA welcomes the move to national consistency, our members are mindful of the need for such reform to give due consideration to the burden of compliance on hospitals, obliged to submit data to different commonwealth agencies (like AIHW, IHPA the ACSQHC and the new Performance Authority) as well as to state/territory departments of health/human services.

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.

We strongly support the new IHPA taking a leadership role in establishing nationally consistent patient-centric data collections that harmonise the different data collection practices in the states and territories and between different Commonwealth agencies. But it will be essential to ensure consistency in classifications and linkages between data sets held by various national bodies to enable meaningful analysis of the performance and cost of the public hospital system across Australia.

References

[i] Mangione-Smith R & McGlynn EA, 1998 Assessing the quality of healthcare provided to children,

[ii] Aisbett C. Aisbett K, Sutch S, 2008 *Costing Kids Care: A Study of the Health Care Costs in Australian Specialist Paediatric Hospitals,* Study undertaken by Laeta for Children's Hospitals Australasia.

[iii] Durojaiye L, and O'Meara M. 2002 'A Study of Triage of Paediatric Patients in Australia' *Emergency Medicine,* 14(67-76)

[iv] Aisbett C. Aisbett K, Sutch S, 2008 *Costing Kids Care: Op.Cit.*