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Dear Committee Secretary

Thank you for the opportunity to provide a submission to the Senate Inquiry on the Outcomes of the 42nd meeting of the Council of Australian Governments held on 1 April 2016. My submission addresses some key issues relating to hospital funding as specified in the Heads of Agreement between the Commonwealth and the States and Territories on Public Hospital Funding

1. Background

COAG considered hospital funding and health reform and reaffirmed that providing universal health care for all Australians is a shared priority at the 1 April 2016 meeting. COAG agreed a Heads of Agreement for public hospitals funding from 1 July 2017 to 30 June 2020 prior to considering longer-term arrangements. The Commonwealth will provide $2.9 billion in additional funding for public hospital services. Growth in Commonwealth funding is capped at 6.5% per annum.

The Agreement preserves important parts of the existing system, including the national efficient price and Activity Based Funding (ABF). It also focuses on reducing unnecessary hospitalisations, improving patient safety and service quality. All jurisdictions agreed to take action to improve the quality of care in hospitals and reduce the number of avoidable admissions as part of the Agreement, by:

- reducing demand for hospital services through better coordinated care for people with complex and chronic disease. The current system does not always provide the care the chronically ill require and they are therefore hospitalised more than is necessary;
- improving hospital pricing mechanisms to reflect the safety and quality of hospital services by reducing funding for unnecessary or unsafe care. Reducing hospital-acquired complications will improve patient safety; and
- reducing the number of avoidable hospital readmissions. Too many patients are readmitted to hospitals as a consequence of complications arising from the management of their original condition (COAG, 2016a)[1].

The Commonwealth will continue its focus on reforms in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions (COAG, 2016a)1 The agreement builds on, and complements, the policy and reform directions outlined in the National Healthcare Agreement (NHA) and the National Health Reform Agreement (NHRA). It is also subject to the Intergovernmental Agreement on Federal Financial Relations and should be read in conjunction with that agreement and any subsidiary schedules (COAG, 2016b)2 The Agreement forms the basis of negotiations leading towards a time-limited addendum of the National Health Reform Agreement, in the form of an additional schedule, to commence on 1 July 2017. The addendum will amend specified elements of the operation of the National Health Reform Agreement for a period of three years, ceasing 30 June 2020 (COAG, 2016b)2

2. COAG Heads of Agreement

2.1 Pricing for Quality and Safety

The Agreements at Schedule 2, Clause 9 to 11, state:

9 "While most health care in Australia is associated with good clinical outcomes, preventable adverse events or complications continue to occur across the health system. By reducing hospital acquired complications, there is potential to not only improve patient safety, but also achieve efficiencies.

[1] COAG communiqué 1 April 2016 https://www.coag.gov.au/sites/default/files/COAG_Communique.pdf

[2] https://www.coag.gov.au/sites/default/files/Heads%20of%20Agreement%20between%20the%20Commonwealth%20and%20the%20States%20on%20Public%20Hospital%20Funding%20-%201%20April%202016_0.pdf

10. The Parties, in conjunction with the Australian Commission on Safety and Quality in Health Care (ACSQHC) and the IHPA, will develop a comprehensive and risk-adjusted model to integrate quality and safety into hospital pricing and funding.

a. The model will determine how funding and pricing can be used to improve patient outcomes and reduce the amount that should be paid for specified adverse events, ineffective interventions, or procedures known to be harmful.

b. This could include an adjustment to the amount the Commonwealth contributes to public hospitals for a set of agreed hospital acquired conditions. Any downward adjustment to an individual state would not be deducted from the available pool of funding under the overall cap of 6.5 per cent.

11 The Parties agree to develop the model for implementation by 1 July 2017". (COAG, 2016b)2

2.2` Reducing avoidable readmissions

The Agreements at Schedule 2, Clauses 12 to 13 State:

12 "The Parties agree to work together to reduce avoidable readmissions to hospital within 28 days of discharge, with a particular focus on avoidable readmissions within 5 days of discharge, for conditions arising from complications of the management of the original condition that were the reason for the patient's original hospital stay.

13. The Parties, in conjunction with the ACSQHC and the IHPA, will develop a comprehensive and risk adjusted strategy and funding model that will adjust the funding to hospitals that exceed a predetermined avoidable readmission rate for agreed conditions and the circumstances in which they occur by 1 July 2017". (COAG, 2016b)2

3. Issues

Greater measurement of the quality of healthcare is supported. The stated 'goal' of 'a risk adjusted strategy and funding model' is also supported. However, it is crucial to ensure adequate risk adjusted funding formulae in the arrangements at the outset (ie *prior* to the abovementioned adjustments). That is, the Independent Hospital Pricing Authority (IHPA) funding formulae should adequately reflect the health need of complex patients to in its national formulas to avoid inappropriate underfunding hospitals. This would assist in improving both equity and health outcomes overall. *From a legal perspective, it could facilitate natural justice/ procedural fairness.*

The IHPA facilitates thorough and high quality work in areas such as stabilizing the national funding models[3], the financial review of the national hospital cost data collections[4], National Weighted Activity Unit (NWAU) calculators for sub-acute, Emergency Departments, non-admitted and acute activity [5], development of the recent AR-DRG Version 8 [6], review of the AR-DRG Case-Complexity Process [7] along with annual reviews of the national efficient price and cost determinations [8] [9].

Recent developments by IHPA in analysing casemix complexity are promising[10]. *However, it would assist if IHPA could provide evidence that IHPA's formulae and any 'casemix complexity calculations' adequately risk adjust for the flow on effects of State-wide referral services.* The evidence for the need for such risk adjustment using Victorian hospital data was published internationally by Antioch Ellis and Gillett and Victorian government officials[11]. That evidence and earlier international publications by Antioch and Walsh demonstrated that State-wide referral services impacted on DRG funding in Victoria resulting in underfunding due to more

[3] https://www.ihpa.gov.au/publications/national-pricing-model-stability-policy
[4] https://www.ihpa.gov.au/publications/round-18-independent-financial-review-national-hospital-cost-data-collection
[5] https://www.ihpa.gov.au/publications https://www.ihpa.gov.au/publications/nwau16-calculator-subacute-activity
https://www.ihpa.gov.au/publications/nwau-calculator-acute-activity-2016-17
[6] https://www.ihpa.gov.au/publications/development-australian-refined-diagnosis-related-groups-v80
[7] https://www.ihpa.gov.au/publications/review-ar-drg-case-complexity-process
[8] https://www.ihpa.gov.au/publications/national-efficient-price-determination-2016-17
[9] https://www.ihpa.gov.au/publications/national-efficient-cost-determination-2016-17
[10] https://www.ihpa.gov.au/publications/review-ar-drg-case-complexity-process
[11] http://people.bu.edu/ellisrp/EllisPapers/2007_AntiochEllisGillett_EJHE_RiskAdj.pdf

complex casemix, culminating in significant hospital deficits in the face of efficient health care provision by clinical staff[12].

Further, in recent years, several Australian States and Territories have reported significant hospital deficits. For example, in November 2015, Victoria reported annual deficits of more than $700m[13]. In the ACT, Calvary Hospital reported a loss of $12m in just one year in 2014[14]. During December 2015, Western Australia reported that hospital deficits increased to $3.16b.[15]

It would be helpful if IHPA could provide insights into whether the State wide referral status effect is adequately captured in the funding models as such status could be a contributing factor to such deficits. For example, does recent work on the Episode Clinical Complexity (ECC)7, which measures the cumulative effects of Diagnosis Complexity Level (DCL)[16] for a specific episode, ***fully*** capture the complexity associated with 'severity markers' linked to state-wide referral services? For example, cardiomyopathy is a 'severity marker' for heart transplant patients and may occur in a patient awaiting a heart transplant and admitted under other DRGs for cardiac procedures or medical treatment in hospital episodes prior to transplantation. Such 'heart transplantation patients' would be more costly than other patients in these (non transplant) DRGs receiving care in other hospitals.

If there is inadequate risk adjustment in the funding arrangements in the national formulas, there will be inappropriate underfunding which would only exacerbate declining health outcomes for high complexity patients. The Agreements at Schedule 2 refer to imperatives to 'reduce the amount that should be paid for specified adverse events, ineffective interventions, or procedures known to be harmful'. This represents a punishment to hospitals for some avoidable adverse events. *Certainly it is appropriate to reduce and/or stop funding ineffective interventions or procedures known to be harmful as they can directly result in health deterioration of patients.*

However, some adverse events have multiple causes, some actually exacerbated by a lack of funding. It is difficult to accurately measure adverse events fairly across the hospital system. For example, redness around a wound could be considered an infection by a heath worker, whereas others will not. Some hospitals may have higher rates of adverse events such as pressure ulcers because of the age, complexity, and immobility of their patients[17]. Hence risk adjusted measurement tools/classifications should be mandatory to ensure *accurate* measurement and comparisons between hospitals of their health outcomes.

Assuming an adequate and transparent risk adjusted funding formulae, then financial incentives (rather than punishments) for performance could be preferable. *Where COAG is unwilling to consider financial incentives, rather than punishing hospitals, then the need for transparent evidence of adequate risk adjustment of IHPA's national funding formulae is even more imperative.* The agreements and related legislation should therefore ensure transparent evidence of adequate risk adjustment of the formulae.

Other concerns relating to the Heads of Agreements concern the level of hospital funding. South Australian Premier proposed to COAG that the GST be extended to financial services, which would raise about $3 to $4 billion a year. [18] [19] Further, $70 million to fund the Commonwealth's primary care reforms is consistent with the guidelines for spending from the Medical Research Future Fund which has over A$3 billion in assets interest.[20] [21]

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12 http://www.health.gov.au/internet/ihpa/publishing.nsf/Content/F7F044CD6146FF45CA257A7F0003F03B/$File/Dr%20Kathryn%20Antioch.pdf. (eg see pgs 21 to 47)

13 http://m.theage.com.au/victoria/victorias-hospitals-cant-pay-bills-after-facing-700-million-annual-deficits-20151112-gkx084.html

14 http://www.canberratimes.com.au/act-news/calvary-hospitals-budget-woes-deepen-12-million-loss-in-12-months-20141125-11u28e.html

15 http://www.perthnow.com.au/news/western-australia/wa-budget-was-deficit-blows-out-to-3-billion/news-story/3c661c7007cd2789641006949e8317ff

16 The Diagnosis Complexity Level is the casemix complexity weight assigned to each diagnosis within a particular DRG

17 http://www.smh.com.au/federal-politics/federal-election-2016/hospital-funding-could-help-fund-federal-health-reforms--draft-coag-agreement-20160331-gnvew4.html

18 http://www.news.com.au/national/breaking-news/states-urge-fed-govt-partnership-on-health/news story/6b28ac7ea347876e1bb5e3575da43aaa

19 http://www.abc.net.au/am/content/2016/s4432856.htm

20 http://theconversation.com/another-day-another-hospital-funding-dispute-how-to-make-sense-of-todays-coag-talks-57058

21 http://www.smh.com.au/federal-politics/federal-election-2016/hospital-funding-could-help-fund-federal-health-reforms--draft-coag-agreement-20160331-gnvew4.html

Recommendations

1. IHPA to provide transparent evidence of adequate risk adjustment of ABF classification and funding. IHPA to address whether the funding formulae adequately takes account of impacts of severity markers arising from State-wide referral services.

2. Risk adjusted measurement tools/classification systems should be mandatory to ensure accurate measurement of costs and *outcomes*, including comparisons between hospitals. This requirement should be included in the work to be undertaken by the Parties in conjunction with the Australian Commission on Safety and Quality in Health Care (ACSQHC) and the IHPA The *Agreements at Schedule 2, Clause 9 to 11, especially Clause 10 (a) and (b) do not make any such requirement explicit and only refer to funding and pricing. Legislation should ensure adequate measurement tools to ensure equity, natural justice/ procedural fairness.*

3 Recommendation 2 is also applicable to the intention at Schedule 2, Clauses 12 and 13 concerning funding adjustments for readmissions to hospitals. If measurement tools/classification systems are inadequate then there will be a lack of equity and natural justice.

4. The agreements and related legislation should ensure transparent evidence of adequate risk adjustment of the funding arrangements and comparative data of adverse events across hospitals.

5. COAG to note that large hospital deficits can be significantly attributable to inadequate risk adjustment of hospital formulas and not necessarily attributable to inefficient clinical practice[22]. Further inadequate funding can result in adverse outcomes due to lack of resources.

6. A risk adjustment factor in the funding formulae for hospitals that have multiple State-wide referral services could be developed if transparent evidence in recommendation 1 is not available. Methods published in the *European Journal of Health Economics* by Antioch, Ellis and Gillett et al (2007)22 to be considered as input into the development of a risk adjuster where there are Multiple State-wide Referral Services (MSRS) in the one Local Hospital Network.

7. To enable increased funding to hospitals:

   (a) The GST should be extended to financial services to raise $3b to $4b per annum and

   (b) $70 million to fund the Commonwealth's primary care reforms to be obtained from the Medical Research Future Fund which has A$3 billion in assets interest.

Your Sincerely,

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[22] http://people.bu.edu/ellisrp/EllisPapers/2007_AntiochEllisGillett_EJHE_RiskAdj.pdf