

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority

Via email: submissions.ihpa@ihpa.gov.au



Dear James,

Thank you for the opportunity to comment on the proposed Pricing Framework for Australian Public Hospital Services 2018-19.

Children's Healthcare Australasia, which now represents approximately 90 paediatric hospitals and units across Australia, consulted its members on the draft Framework and offers the following comments for consideration by IHPA. The comments arose mainly from the children's hospitals and relate to IHPA question:

'Do you support the proposed risk adjustment model for HACs? Are there other factors that IHPA should assess for inclusion in the model?'

The Children's Hospitals have advised CHA that they generally support the development of an equitable risk adjusted model for Hospital Acquired Complications, but raised a few concerns about the details of the risk adjustment model in relation to some specific cohorts of paediatric patients:

Age Group Risk Adjustment Model

- The proposed Age groups including banding 0 – 4 years (and in particular the first few days of life) excludes the impact of the comorbidity (including congenital factors) and complexity of babies and children under one year where the model of care is 'treat at all costs'. For example the model could include age in days under one year, neonatal care type or birth weight as risk factors.

HACs that are expected complications

- In specialist paediatric hospitals, there are a range of patients whose underlying conditions driving admission are known to have complications like renal failure, cardiac complications, and/or gastrointestinal bleeds and are therefore an expected complication that is typically not present on admission. As the risk adjustment model does not adjust to 'zero', coding standards may need to be adjusted to reflect complications and or comorbidities that are not present on admission but are an expected part of the disease process e.g. Renal failure following admission for septic shock. Alternatively, paediatric services should have the ability to exclude such episodes from quality adjustment based on DRG.

Charlson Index not suitable in Paediatric setting

- The Charlson Comorbidity Index does not adequately reflect paediatric patient acuity and it is recommended that an expanded/ separate risk-adjusted comorbidity model for children should be considered to include conditions such as congenital disorders. For example the Derek Tai et al paper Arch Pediatr Adolesc Med. 2006;160(3):293-299. doi:10.1001/archpedi.160.3.293 describes the approach undertaken to develop a Paediatric Comorbidity model in Ontario, Canada.

Fixed v Percentage Adjustment

- There are some mixed views about this issue among the Children's Hospitals.

The proposed proportional adjustment based on each individual patient's NWAU value and therefore associated AR-DRG assumes the HAC cost is dependent on the DRG, not the complication that has occurred. Some children's hospitals are concerned this is inequitable and penalises Hospitals providing Tertiary/ Quaternary paediatric services.

CHQ proposes that a 'fixed' risk adjusted HAC adjustment is a fairer and more transparent means of reflecting the actual HAC Cost as currently adopted by Queensland Health for adverse events. A number of other children's hospitals support this proposal.

Sydney Childrens Hospital Network (SCHN) notes the concern regarding the impact of a percentage based adjustment on high NWAU episodes but points to Section 5 of the technical specification document which details how the percentage adjustments are calculated based on the incremental cost of the HAC (first use LOS and DRG for non-HAC episodes to predict the cost of a HAC episode with the same LOS and DRG). This largely controls for the effect of DRGs in determining the adjustment. While it is true that the magnitude of the NWAU adjustment / HAC cost depends on the DRG, the argument could be made that this is valid e.g. more complex patients require additional time / resource to fully recover from the same HAC compared to less complex patients. They suggest maintaining the percentage based adjustment but considering options to handle outlier episodes e.g. introducing a maximum NWAU adjustment amount for each HAC.

Finally, the children's hospitals agree that the technical specifications paper is difficult to fully understand and does not allow readers to fully reconcile the model. They would appreciate having access to a fully functioning risk adjustment software grouping model to allow individual analysis, reconciliation and full assessment of local data.

CHA would like to particularly acknowledge Children's Healthcare Queensland for their assistance in preparing this submission. We would be happy to facilitate further conversation with relevant contacts in the Children's Hospitals if IHPA was interested to do so.

Yours sincerely,



Dr Barb Vernon
Chief Executive Officer
Children's Healthcare Australasia

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