Activity Based Funding for Australian Public Hospitals

February 2012
1 Background

The Independent Hospital Pricing Authority (IHPA) has appointed Health Policy Solutions, in association with Casemix Consulting and Aspex Consulting; to develop a comprehensive Pricing Framework that will be used in the implementation of activity based funding (ABF) for Australian public hospitals from 1 July 2012.

IHPA released the Draft Pricing Framework\(^1\) for public comments on 16\(^{th}\) January 2012. The Discussion Paper outlines the implementation issues that need to be resolved in introducing new funding arrangements for public hospitals. Tuesday, 21 February 2012, is the deadline for submission of any comments on the Draft Pricing Framework.

2 Summary

The Draft Pricing Framework proposes a set of 15 principles as a guide to help making better decisions about how to price and fund a range of eligible service activities provided by Australian public hospitals. The proposed principles are outlined below:

1. **Timely–quality care**: ABF should support timely access to quality health services.
2. **Efficiency**: ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of hospital services.
3. **Fairness**: ABF payments should be fair and equitable.
4. **Maintaining agreed roles and responsibilities of governments**: ABF design should recognise the complementary responsibilities of each level of government in funding health services.
5. **Transparency**: all steps in the ABF process should be clear and transparent.
6. **Administrative ease**: ABF should not unduly increase the administrative burden on hospitals.
7. **Stability**: the payment relativities are consistent over time.
8. **Evidence based**: ABF should be based on best available information.
9. **Supporting innovation**: ABF pricing should respond in a timely-way to introduction of evidence-based, effective new technology and innovation.
10. **Price harmonisation**: Pricing should facilitate best practice provision of appropriate site of care.
11. **Minimising undesirable and inadvertent consequences**: ABF design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.
12. **ABF pre-eminence**: ABF should be used for funding wherever practicable.

13. **Single unit of measure and price equivalence**: ABF pricing should support dynamic efficiency and changes to models of care with the ready transferability of funding between different care types and service streams through a single unit of measure and relative weights.

14. **Patient-based**: Adjustments to the standard price should be, as far as is practicable, based on patient-related rather than provider-related characteristics.

15. **Public-private neutrality**: ABF pricing should not disrupt current incentives for a person to elect to be treated as a private or a public patient in a public hospital.

The report further discusses the scope of public hospital services that should be included under new funding arrangements. In particular:

**Section 2: Why Australia is implementing activity-based funding for public hospitals**

This section provides a brief history to various approaches taken by the Australian governments in funding public hospitals. It tries to provide answers to the following questions:

1. Why did Australian governments decide to reform public hospital funding arrangements? and

2. What would be the anticipated benefits of these reforms?

**Section 3: Governance of activity based funding: the National Health Reform Agreement**

The section provides a background on the governance model under which activity based funding will operate. Its main purpose is to create a common baseline of understanding of the key propositions of the National Health Reform Agreement (NHRA), and other relevant Agreements and legislation governing the implementation of ABF.

**Section 4: Principles**

This section discusses three types of principles involved in the design of an ABF system. The three types of principles are:

1. Overarching principles which express the overall policy intent of ABF;

2. Process principles, which are principles to guide ABF process; and

3. System design principles, which inform detailed system design choices.

**Section 5: The scope of public hospitals and services included under new funding arrangements**

In order to define what a public hospital service is, a set of draft criteria has been developed which would be used by the Independent Hospital Pricing Authority (IHPA) in reviewing recommendations by states for services to be included as eligible to receive Commonwealth funding. The section emphasises on the importance of keeping up-to-date the set of criteria for funding the services delivered by public hospitals as these services continue to evolve.

Furthermore, the section tries to provide an answer to the question of when should public hospital services be funded on an activity basis or a block grant basis? It gives a short description of the services that will be funded in the short- medium- and long-term through block grants, activity based funding and a mixture of both. It further asks for input on how to define the appropriate factors and set the thresholds for future review of these services provided by public hospitals.
Section 6: Setting the national efficient price

In other words, how should the national efficient price be set?

The section provides a definition to the “national efficient price” and further proposes a set of steps to be adopted in price-setting process. In particular:

1. What is the price for?
2. What should the level at which the price is set? and
3. What is the role of states and territories in pricing?

Section 7: Adjusting the national efficient price

In other words, should there be any adjustments to the national efficient price?

This section discusses the factors which might lead to “legitimate and unavoidable” variations in the cost of same service provided by different hospitals and the approach that would be taken to address these issues. In particular, this section discusses the following related factors:

1. Adjusting for patient related factors, such as indigenous status;
2. Adjusting for unavoidable hospital related factors, such as location;
3. Adjusting patient-related payments for provision of other hospital services, such as teaching; and
4. Adjusting for quality

Section 8: pricing private patients in public hospitals

The purpose of section is to deal with the question of how the national efficient price should be set for private patients in public hospitals.

This section provides discussion and analysis of the current funding arrangements and highlights the potential options for setting a discounted price for treating private patients in public hospitals. It is introduced by a description of the current status of private patients in public hospitals. This is accompanied by an example from NSW’s public hospitals (based on the National Hospital Cost Data Collection) to illustrate the costs of treating private patients in public hospitals. The authors of the paper state that the average cost of treating private patients in NSW public hospitals is more than 12% of average cost of all patients in NSW public hospitals. Furthermore, it is stated that private health insurers met only one third of the actual cost.

APHA has investigated how the authors of the Report arrived at the figures provided in the example. Our investigation shows that there is no (publicly available) detailed information in NHCDC database regarding the cost/number of private patients in public hospitals kept by IHPA. However, since the authors of the Draft Report are commissioned by the IHPA they might have had access to additional information (if such information exists). Regardless, the upshot of this analysis is that they acknowledge the cost associated with treating private patients. A corollary conclusion of the high costs associated with the treatment of private patients is the complexity of these admissions.
Section 8 further describes the revenue streams and costs for private patients in public hospitals such as medical services, prostheses and accommodation services. Section 8.4 of the Report provides options for determining the national efficient price for the purpose of treating private patients in public hospitals.

Section 9: Block grant funding

Although the report emphasises on the use of activity based funding (ABF) for services provided by public hospitals, it also acknowledges the difficulties associated with the implementation of ABF for some services (for the year 2012/13 and beyond). It therefore, provides some criteria for the determination and eligibility of services for block grant funding.

Section 10: Phasing

This section provides a discussion on timeframes for a suitable implementation of ABF, and its enhancements and evolution over time.

3 Consultation Questions

The Discussion Paper asks stakeholders to submit their responses to the issues and consultation questions included in the report. APHA’s response to the consultation questions included in Chapter 8, “Pricing private patients in public hospitals” is set out below.

1. Do you agree with the principles (transparency, evidence-based, stability and public-private neutrality) identified as most important in determining the national efficient price for private patients in public hospitals? Or, are there other factors that should be considered?

Any approach in controlling the costs of health care should not compromise the access to health services and the level of care provided to all patients. Therefore, we recommend addition of a highly weighted factor (to those already mentioned in Section 7.5 – Adjusting for quality) that measures the level of improved patient care within the hospitals. This would further insure the improvement in patient care as well as controlling the costs.

2. Are there particular issues relating to the identification of costs and/or revenue for the components of services (accommodation, medical costs, and diagnostic imaging, prostheses) provided to private patients?

a. APHA notes that the indexation factor suggested (at section 6.4 on page 48) is the GFCE as used by the AIHW in its reporting. We do not think that this index is appropriate to deal with, for example, increases in labour costs or the costs of technology on a long term basis. APHA acknowledges the reasons why the Commonwealth would prefer this output costs index, but we suggest that there needs to be more discussion about the most robust index that allows the true costs of hospital treatment to be captured and dealt with fairly over time.

b. APHA agrees with the Discussion Paper on the necessity of having effective classification systems and reliable costing data in determining a national effective price. However as it is suggested by the Discussion Paper (at introductory Section on Page 10), one of the key decisions agreed by governments concerning the issue is:

“Acute admitted services will be classified using AR-DRGs v6.0x”
Whilst, APHA acknowledges the need for a new version of AR-DRGs and recognises that there will be some changes, the new version of AR-DRGs has not been released. This will create significant complications for all hospitals (both public and private). It is therefore recommended that, for the sake of transparency and avoiding potential complications, the ABF pricing mechanism should be either based on the current versions of AR-DRGs, or be halted until the release of the new version of AR-DRGs (i.e., 6.0x).

c. APHA also notes that there is a lack of detail around the discussion of errors and complications. This is an important issue which has significant complications both for specialists and the hospitals and warrants more clarity in order to be able to deal, efficiently and consistently, with numerous uncertainties surrounding the issue. APHA is firmly of the view that any alteration in payment due to Hospital Acquired Conditions can only fairly be applied to those conditions that acquired where the circumstances are directly under the control of the hospital.

d. In relation to exclusion of specific costs such as training/research, we recommend that attention be given to ensure that a robust definition of the term “training/research” is developed and be used by IHPA when considering the effect of teaching, training and research on hospital services that are provided to patients. It would then be easier to track from the model the true cost of treating patients within those hospitals which provide other services such as teaching, training and research.

e. The paper makes various references to “specialist Treatment”. APHA believes that it is important to state consistently that this means “treatment by a registered medical specialist”, to remove any confusion for hospitals about the use of registrars, for example.

3. Is there support for the proposed approach to adjusting the costs of various components in calculating the national efficient price for private patients in public hospitals?

In setting the national efficient price (NEP) for a private patient in a public hospital, the option preferred by the Discussion Paper is to start with the NEP applicable for all patients in public hospitals and adjust/reduce this price by the value of revenues derived from other sources contributing to the cost of treatment of the private patient e.g., health insurance benefits for accommodation and prostheses, MBS payments to private treating doctors – in this way the Commonwealth avoids double-payment. APHA agrees with and supports the proposed approach of setting the national efficient price for private patients in public hospitals.

4. Will the proposed approach achieve the aim of ensuring public-private neutrality?

APHA notes that the definitions and goals of “public-private neutrality” provided in the Discussion Paper are not only in conflict with each other but also open to misinterpretation. For example, on page 24, Section 4.3 under “Systems design principles”, the “public-private neutrality” is defined as:

“ABF pricing should not disrupt current incentives for a person to elect to be treated as a private or public patient in a public hospital.”

On the other hand, at the end of the section (i.e., page 26) it is noted that:

“The public-private neutrality principle is framed such that the existing balance and system of indirect subsidies should be maintained. Introduction of ABF should not lead to any change in the public private balance within public hospitals, nor any increased burden on private health insurance funds through cost-shifting or incentives to increase private patient activity.”
APHA agrees with the principles of the ABF on the public-private neutrality and emphasises on the fact that “neutrality” should be considered from the patient’s point of view and not be influenced in any way by the setting where the treatment occurs. We are aware that currently there are some financial incentives for public hospitals to treat private patients in preference to public patients, with various schemes, currently existing within public hospitals, to encourage the practice. Therefore, APHA does not believe that existing arrangements in some public hospitals can or should be considered as representing public-private neutrality. The ABF principles should not, whether by accident or design, maintain any current imbalances between public and private hospitals in terms of private patients.

Therefore, APHA recommends a more robust and consistent, definition of public-private neutrality be adopted in order to minimise and control undesirable and inadvertent consequences such as “gaming” or “perverse incentives” by some hospitals.

5. Are alternative approaches preferred? If so, what specific alternative is preferred and what are the criteria or principles driving support for this alternative approach?

APHA does not suggest any alternative approach at this stage.

6. Is there support for future work on harmonising default benefits to achieve consistency across classification systems used for public and private patients in public hospitals?

APHA’s position has been, and remains, that private patients should be treated in private hospitals. Public hospitals should focus on treating public patients, and not divert their resources into attracting private patients to shore up their revenues. See our commentary above in response to Question 4. That point made, APHA would be prepared to lend its expertise to any future work related to this issue, provided that such work were carried out in a rigorous and consultative way.

4 Other comments:

1. Section 3.2.3 (Private or not-for-profit provision of public hospital services), pp. 18-19:
   a. All sentences that include “private or non-for-profit” should be corrected to read as “private (for-profit or non-for-profit)”. The Discussion Paper’s terminology is misleading, as it implies that only for profit entities operate, or are, private hospitals.

2. Section 8.1 (“current status of private patients in public hospitals”), pp. 62-63:

   For reasons that are not entirely clear the Discussion Paper has been inconsistent, not only in the definition of “private patients”, but also in the use of statistics related to these patients throughout Chapter 8. In fact, the Discussion Paper interchanges between “private patients” and “privately insured patients” and their corresponding statistics to legitimise the conclusions made in the section. These inconsistencies render some of the analysis provided therein, at best, misleading. For example:
   
   a. In the opening paragraph of Section 8.1, p.62, the Discussion Paper states: “Private patients represent a relatively small share of patients treated in public hospitals, with this share having declined over the past two decades”.

Other comments:
The Discussion Paper attempts to support this claim by providing analysis based on the “Australian Hospital Statistics (AHS)” reports published by Australian Institute of Health and Welfare (AIHW). See the dot-points on page 62 of the Discussion Paper.

First, we note that, until 1996/97, AIHW used the term “private patients” in its AHS reports to describe all “non-public” as opposed to “public” patients. Since then, AIHW has further segmented “private patients” into different sub-categories. A list of all sub-categories of “non-public” or “private” patients (along with their share) used by AIHW in its AHS publications since 2002/03 is provided in table 1 below.

<table>
<thead>
<tr>
<th>non-public or private sub-categories</th>
<th>2002/03</th>
<th>2003/04</th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private health insurance</td>
<td>55.5%</td>
<td>56.0%</td>
<td>57.6%</td>
<td>59.2%</td>
<td>60.6%</td>
<td>62.5%</td>
<td>64.3%</td>
<td>66.6%</td>
</tr>
<tr>
<td>Self-funded</td>
<td>7.5%</td>
<td>9.1%</td>
<td>9.0%</td>
<td>8.8%</td>
<td>8.5%</td>
<td>8.2%</td>
<td>8.3%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Worker’s compensation</td>
<td>3.8%</td>
<td>3.8%</td>
<td>3.8%</td>
<td>3.8%</td>
<td>3.6%</td>
<td>3.5%</td>
<td>3.2%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Motor vehicle third party personal claim</td>
<td>3.8%</td>
<td>3.8%</td>
<td>3.6%</td>
<td>3.6%</td>
<td>3.4%</td>
<td>3.3%</td>
<td>3.3%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Department of Veterans’ Affairs</td>
<td>26.0%</td>
<td>25.1%</td>
<td>24.2%</td>
<td>22.7%</td>
<td>20.7%</td>
<td>18.7%</td>
<td>17.5%</td>
<td>15.7%</td>
</tr>
<tr>
<td>Other</td>
<td>3.2%</td>
<td>2.2%</td>
<td>3.0%</td>
<td>3.1%</td>
<td>3.2%</td>
<td>3.4%</td>
<td>3.5%</td>
<td>3.8%</td>
</tr>
<tr>
<td>private total *</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

*Note that the sum of all sub-categories might not add up to 100% in sum years. This is due to the published figures in AHS reports for “private total” which do not add up to the sum of all corresponding sub-categories.

However, for unstated or unknown reasons, the Discussion Paper considers “private patients” to be **only** those patients whose treatment is funded by private health insurance (only one of the six sub-sets categorised under “private patients” in the AHS reports). This is clearly stated in footnote 14 of page 62 of the paper and the analysis provided, therein, for the first five dot-points are related to this sub-set only.

In the last dot-point, the Discussion Paper states: “**the national share of private patients in public hospitals has declined significantly over time**”. The paper continues with a carefully crafted sentence to which continues the misinterpretations. That is, “The earliest Australian Hospital Statistics report identified that in 1993/94, 17.6% of public hospital separations were **private patients, almost twice the current level of utilisation of public hospitals by privately insured patients** (AIHW 1997, table 3.1).”

It seems as if the ambiguity created around the definition of “private patients” and the use of “private patients” and “privately insured patients” is deliberate, in order to buttress the statement that “**the national share of private patients in public hospitals has declined significantly over time**”.

8

**APHA Response to Draft National Pricing Framework**
The following analysis of AHS data2 by APHA sheds some light on this issue.

Figure 1, shows the national share of public and non-public (or private total) patients treated in public hospitals since 1993/94. As clearly illustrated, in 1993/94, the share of non-public (or private total) patients of all patients treated within public hospitals was 16.5%. In 2009/10, this share was reduced to 14.9%, a reduction of 1.6%. Given the inherent uncertainty in the data, the reduction of 1.6% is not statistically significant (contrary to the claims made in the Discussion Paper).

Furthermore, as shown in Figure 1, the national share of private patients with private health insurance in 1996/97 (when AIHW first began to segment private patients in its AHS reports) was 10.9%. In 2009/10, this share was reduced by one percentage point to 9.9% (again, a statistically insignificant reduction). Therefore, the claims made by the authors of the Discussion Paper that “the national share of private patients in public hospitals has declined significantly over time”, is simply, incorrect and unfounded. In fact, in their independent review of the impact of the new Medicare Levy Surcharge thresholds on public hospitals, (KPMG, 2011, p. 2), note that:

“In 2008-09, there was a 3.2 percent increase in the number of public patient separations, from the previous year. During the same period, there was an 8.3 percent increase in the number of privately treated patients in public hospitals ...”

And in their summary of key findings, (KPMG, 2011, p. 4), KPMG states that:

“Indeed, the finding of increasing private patient utilisation of public hospitals would suggest an increasing proportion of public hospital(s) operating costs are being met through private patients payments.”

From Figure 1, it is clear that the ratio of non-public (or private total) patients (in 1993/94) to those private patients with private health insurance (in 2009-10) is 1.67 (i.e., 16.5/9.9 = 1.67). Therefore, the second part of the last dot point on page 62 of the Discussion paper, is true. In fact, one could easily see from Table 1 and Figures 1 and 2 below that the ratio of non-public (or private total) patients to those private patients with private health insurance is between 1.4 to 1.8 throughout its history, i.e., since 1996/97. In other words, private patients with private health insurance comprise, on average, 63.4% of non-public (or private) patients treated within public hospitals. The problem, however, arises when this fact is distorted to attempt to show that the share of non-public (or private) patients treated within public hospitals has been halved since 1993/94.

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2 For this analysis, data from 1995 to 2010 was used. Data for 1993-94, 1994-95 and 1995-96 was extracted from (AIHW, 1997, pp. 20, Table 3.1), data for 1996-97 was extracted from (AIHW, 2002, pp. 97, Table 6.5), data for 1997-98 were extracted from (AIHW, 2003, pp. 107, Table 6.5), data for 1998-99 were extracted from (AIHW, 2004, pp. 119, Table 6.5), data for 1999-00 were extracted from (AIHW, 2005, pp. 135, Table 7.1), data for 2004-05 were extracted from (AIHW, 2006, pp. 138, Table 7.1), data for 2005-06 to 2009-10 were extracted from (AIHW, 2011, pp. 139, Table 7.1).
b. Below, APHA provides a more complete analysis of the “current status of private patients in public hospitals”. The analyses provided hereafter are based on quarterly data published by Private Health Insurance Administrative Council (PHIAC (a), 2011). Note that, as hospital separations are very seasonal in nature, the analyses that follow are based on a 12-month window of total number of episodes. The September quarter was also selected as this is the most up-to-date data available at the time of preparing this commentary.
Based on PHIAC data (PHIAC (a), 2011), the number of privately insured episodes in both public and private hospitals in 2001 (i.e., the 12 months to 30 September 2001) was recorded at 222,039 and 1,223,841 episodes, respectively. The same number in 2011 (i.e., the 12 months to 30 September 2011) in both public and private hospitals was recorded at 515,227 and 2,348,249 episodes, respectively. From the above figures, it is easy to see that the number of privately insured episodes within public hospitals had a growth of 102.5% since 2001, while the number of privately insured episodes within private hospitals, in the same period, has a growth of 91.9%.

The Discussion Paper claims that:

“Private patients represent a relatively small share of patient treated in public hospitals, with this share having declined over the past two decades”

Figure 3 illustrates some interesting facts regarding the annual growth rate of the number of privately insured episodes in both public and private hospitals. For example, since 2004 the annual growth rate of the number of privately insured episodes in public hospitals remained – by at least 2 percentage points – above that of private hospitals. This gap has increased by 8 percentage points in September 2011. Does this have anything to do with the so called “private patient marketing” schemes implemented in some public hospitals? In fact, such schemes are so widely in use within public hospitals that KPMG, in their independent review paper (KPMG, 2011, p. p7), note that:

“Strategies by public hospitals to maximise the rates at which privately insured patients elect to be treated as private patients may lead to an increase in the number of private patients treated in public hospitals. A number of jurisdictions are implementing ‘no gap’ arrangements for private patients treated in public hospitals. This may lead to some patients choosing private treatment in a public hospital instead of treatment in a private hospital”

APHA questions why the authors of the Discussion Paper did not look at the “current status of private patients in public hospitals” from this point of view.
c. In the same vein, the Discussion Paper provides an example (last paragraph in Section 8.1, p.63) from NSW’s public hospitals where the average cost of treating a private patient is calculated to be $4,606 with the hospital receiving $287/day/patient. Furthermore, the Discussion Paper assumes an average length of stay of 3.6 days per private patient and concludes that public hospitals received a total of $1,033 per private patient admission from the private health insurers in 2008/09.

Whilst authors of the Discussion Paper claim that their analysis is based on NHCDC data APHA could not find any document available from the Department of Health and Aging that specifically provides information on the cost of private patients within public hospitals. Nor could APHA find any information/attribute within the NHCDC data on the public or private status of patients treated within public hospitals. Furthermore, our queries to the IHPA confirmed that neither IPHA nor the Department of Health and Aging collects specific information/attributes on public or private status of patients treated within public hospitals. IHPA, however, suggested that the corresponding numbers provided in the Discussion Paper might have been based on some modelling done by the authors of the Discussion Paper. This is not clear from the paper, nor do the authors of the paper indicate that a model was used to come up with the above mentioned numbers.

Using PHIAC data (PHIAC, 2011), APHA has conducted its own analysis to find out the average payment paid by the private health insurers to NSW’s public hospitals in both 2008 and 2009.

As shown in Table 2, in 2008 and 2009, total benefits for overnight episodes paid by private health insurers to public hospitals in NSW was $275 and $304 million, respectively. This is equivalent to an average payment of $321/day or $2,054/episodes in 2008 and $336/day or $2,154/episodes in 2009. This yields an average length of stay of 6.4 days per private patient in both years.

Table 2: Payments made to NSW’s public hospitals by private health insurers for overnight episodes in 2008 and 2009.

<table>
<thead>
<tr>
<th>Year</th>
<th>Overnight Days</th>
<th>Overnight Episodes</th>
<th>Benefits for Overnight</th>
<th>Overnight Benefits per Day</th>
<th>Overnight Benefits per Episodes</th>
<th>average length of stay (day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>855,840</td>
<td>133,825</td>
<td>$274,816,762</td>
<td>$321</td>
<td>$2,054</td>
<td>6.4</td>
</tr>
<tr>
<td>2009</td>
<td>906,233</td>
<td>141,229</td>
<td>$304,227,050</td>
<td>$336</td>
<td>$2,154</td>
<td>6.4</td>
</tr>
</tbody>
</table>

Clearly, the above analyses point to a clear inconsistency regarding the payments received by public hospitals from private health insurers to that pictured by authors of the Discussion Paper.

APHA argues that the Independent Hospital Pricing Authority (IHPA) should re-examine the AIHW data in a more rigorous fashion, before proceeding to any work on a price for the treatment of private patients in the public sector.
5 Bibliography