Australian
**Private Hospitals**
Association

**APHA:** Summary Report & Initial Commentary

# Activity Based Funding for Australian public hospitals

**Australian Private Hospitals Association** ABN 82 008 623 809

**January 2012**

# 1 Background

The Independent Hospital Pricing Authority (IHPA) has appointed consultants 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 16th 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.

This report is a brief summary of the Draft Pricing Framework paper. APHA is doing a detailed analysis of the Section that is of most potential relevance to our sector – that is, Section 8, *"Pricing private patients in public hospitals".* The APHA's Policy and Advocacy Taskforce will discuss this response at its meeting on Wednesday, 15 February. In the meantime, any comments/concerns about the issues outlined in the Draft Pricing Framework, can be sent directly to APHA's Manager of Research and Data, Mehrdad Khodai-Joopari at: @apha.org.au.

# 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.

[1] The complete Discussion Paper, *Activity based funding for Australian public hospitals: Towards a Pricing Framework,* is available at: http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/publications.

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 hospitals and 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 provided 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 be operating. 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 and answer to 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 views on how to define the appropriate factors and set the thresholds for future review of these services provided y 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 cost of same service provided by different hospitals and the approach 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 should the national efficient price be set for private patients in public hospitals?

This section provides discussions 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 starts with a description of current status of private patients in public hospitals. This is accompanied by an example from NSW's public hospitals (based on National Hospital Cost Data Collection) to illustrate the costs of treating private patients in public hospitals. The example provided therein shows 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, private health insurers met only **one third of actual cost.**

APHA is currently investigating how the authors of the Report have come up with the figures provided in the example. Thus far, our preliminary 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 such information (if such information exists). Regardless, the upshot of this analysis is that they admit the cost associated with treating private patients. A corollary conclusion of the high costs associated with the treatments of private patients is the complexity involved in these kinds of treatments.

The section 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 Draft Discussion asks public and stakeholders to submit their responses to the issues and consultation questions included in the report. APHA is developing its response to consultation questions included in Chapter 8, *"Pricing private patients in public hospitals".* Below are some initial responses from APHA to these consultation questions.

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 (or patient experience) 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?**

In relation to the exclusion of the cost of all prostheses for private patients from the calculation of cost weights; it should be mentioned that not all prostheses are covered by private insurance funds. Therefore, excluding costs for all prostheses-related services might not be a through representative of the costs related to these services.

In relation to exclusion of the costs of medical specialist services from the cost weights; one should be cautious of the industrial implications of this as it links the income of the specialists' staff (working in public hospitals) directly to the level of private patients treated by the specialist (in the public hospitals). What are the potential contributions of this approach to the already existing long waiting lists in public hospitals?

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?***

APHA is developing its response to this question.

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

The proposed approach should be sufficient to minimise/control undesirable and inadvertent consequences such as 'gaming' or 'perverse incentives' by some hospitals. While we remain optimistic, the evidence should provide us with a strong base for the level of effectiveness of this approach.

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?***

An alternative approach in identifying the 'base' from which adjustments will be made is to compare the average cost of services (on a DRG basis) across both private and public sectors. Then the 'base' price can be set to the minimum of the two to ensure the most cost effective approach. If the average cost of providing a particular service in private hospitals is less than its corresponding cost in public hospitals, there should be no problem in adopting that cost as the benchmark or 'base' price.

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 is developing its response to this question.

# 4 Other comments:

1. **Section 3.2.3 (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)"***.