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Australian Healthcare & Hospitals Association Response

Activity based funding for Australian public hospitals: Toward a Pricing Framework (by Health Policy Solutions)

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Content

1. Introduction

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to comment on the paper titled: *Activity Based Funding for Australian Public Hospitals: Towards a Pricing Framework.*

The AHHA is the independent peak body and advocate for the Australian public and not-for-profit healthcare system. The AHHA is widely recognised across Australia as *the voice of public healthcare*. The Association has achieved this status by facilitating broad ranging policy discussions on critical issues and ensuring the view of members arising from these conversations are reflected in its policies and advocacy programs.

Our response discusses issues raised in the proposed Pricing Framework which are relevant to the Association's members, using each chapter heading as a guide.

2. Elements (Chapter1)

While the AHHA largely agrees with the elements of a Pricing Framework as outlined in Chapter 1, a feedback and evaluation process is a significant omission.

2.1 Evaluation

The Independent Hospital Pricing Authority (IHPA) [1] is established to 'give independent and transparent advice in relation to funding for public hospitals' including 'the efficient cost of such services' and 'developing and implementing robust systems to support activity based funding (ABF) for such services'.

The National Health Reform Amendment (Independent Hospital Pricing Authority) Act 2011 S131 (Appendix 1) describes the function of the Pricing Authority. These include determining the National Efficient Price (NEP) for health care services funded on an activity basis, and the efficient cost of health services where they are block funded. S 131(3)(c) requires the IHPA to ensure: reasonable access to healthcare services; safety and quality in the provision of those services; continuity and predictability in their cost; and the effectiveness, efficiency and financial sustainability of the public hospital system taking into account the range of public hospitals and the variables affecting the actual cost of providing services in them.

The AHHA recommends that a Continuous Quality Improvement (feedback and evaluation) process be incorporated into the Pricing Framework in order to continually assess the ongoing effectiveness of IHPA's functions, as distinct from a 'phasing and feedback adjustment' discussed in Chapter 10 of the draft Pricing Framework. The AHHA is already on the record as recommending the implementation of an evaluation process for the National Health Reform (NHR) as a whole. The Association has called for this process to be akin to Continuous Quality Improvement rather than a conventional academic evaluation to stimulate the system to 'learn and apply' as it goes, thus

[1] National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011 (The Parliament of the Commonwealth of Australia, House of Representatives)

engendering a research culture within health services for those in both health management and clinical roles. [2]

3. Governance (Chapter 3)

The COAG National Health Reform Agreement (NHRA) (August 2011) requires that an 'efficient' price be fixed for all services provided by public hospitals and that, as far as practicable, payment will be made on an activity basis. The Commonwealth's "share" will be transferred, on an individual State/Territory basis, to a pool from which the Local Health Networks (LHNs), and not individual hospitals, will be paid.

The Association notes that:

- The State and Territory governments will continue to be the 'system managers', determining the budget and the activity targets of the LHNs. They may vary their (majority) share of hospital funding based on local knowledge and conditions, but will be required to report the reasons for doing so. S A63 of the NHRA states that: State/Territory funding paid on an activity basis to LHNs will be based for each service category on:
  a) the price set by that State (which will be reported in service agreements); and
  b) the volume of weighted services as set out in service agreements.
- To achieve transparency and national comparability, the States and Territories are required to provide, to the Administrator [3] and the IHPA:
  a) the price per weighted service they determine;
  b) the volume of weighted services as set out by the national ABF classification scheme; and
  c) any variations to service loadings from the national ABF classification scheme (S A66).

For AHHA's hospital members, the main relationship will therefore be with the LHN authorities and, through them, with the State and Territory governments. However, Activity Based Funding (ABF), and the price on which it is based, will have a significant influence on the process.

4. Principles (Chapter 4)

4.1 Overarching principles

The Pricing Framework proposes four overarching principles.

In commenting on these, the AHHA has taken into account the fact that the legal and governance framework under which the reforms operate is provided by the National Health Reform Amendment (Independent Hospital Pricing Authority) Act (November) 2011(Appendix 1) and the COAG National Health Reform Agreement (NHRA) (August 2011). The Act states that the IHPA must comply with the NHRA where it 'sets out processes to be followed, or conditions or requirements to be met, by the Pricing Authority in performing a function' (S 132 (3). The Act does not give the IHPA any function or authority to alter, amend, augment or expand on the NHRA.

[2] Australian Healthcare & Hospitals Association National Health Reform Simulation and Master Class Report (June 2011)

[3] The Administrator will be an independent statutory office holder…to be jointly established by the legislation of the Commonwealth and all States/Territories by 1 July 2012 (National Health Reform Agreement S B23)

In addition, the Agreement provides explicit principles for determining the National Efficient Price in S B11-14 (Appendix 2), which can be altered only by COAG.

The AHHA is mindful that the following principles in the proposed Pricing Framework should reflect those in the Agreement.

The principles in the proposed Pricing Framework encompass:

- timely access to quality care
- efficiency and sustainability of public hospital care including the network of hospitals
- fair and equitable payment
- recognition of government roles at each level.

While the AHHA agree with these, we recommend inclusion of two additional principles:

Under the National Health Reform (NHR), new and existing national agencies, including the IHPA, the National Health Performance Authority (NHPA) and the Australian Commission for Safety and Quality in Healthcare (ACQHA), should be required to adopt a collaborative service improvement framework which is systematically applied to the most significant health challenges as agreed by COAG and Health Ministers. While agreement on what these health challenges are, and the order in which they are tackled, is essential, the AHHA believes that the introduction of a national ABF system is one of these major challenges. The three national bodies must work together proactively to set up a prospective quality framework.

> *National service improvement framework: an ABF system should be an integral element in an agreed national service improvement framework*.

The Association is acutely aware that financial instruments need to be finely tuned in order to drive incentives towards delivery of cost-effective care in the most appropriate setting, ensuring the balance of investment across all care types reflects the needs of patients (ie allocative/dynamic efficiency). While this is referred to in the system design principles (see price harmonisation), the Association recommends an additional overarching principle to incorporate this notion.

> *Dynamic efficiency: ABF should contribute to delivery of cost-effective care in the most appropriate setting and to investment across the continuum of care*.

Challenges inherent in these principles will need to be addressed in the Continuous Quality Improvement process (recommended above), including:

- the extent that ABF (price) can/will/should impact on quality
- the extent to which ABF can influence allocative / dynamic efficiency a well a technical efficiency
- the tension between equitable allocation of resources for populations and fair resourcing of hospital services.

4.2 Process principles

The AHHA agrees with the process principles: transparency; administrative ease; stability; and evidence based.

The Association notes that there will be an increase in administrative load at State, LHN and hospital level to develop and maintain the national ABF system. Reliable data will underpin the values and success of the national ABF system. To ensure the reliability of the data, it will be important to educate and involve managers and clinicians in data collection, management, coding, analysis and reporting.

It will be important that these activities are monitored by the evaluation process described in paragraph 2.1 above to ensure data consistency across all States and Territories.

4.3 System design principles

The AHHA supports the system design principles (below) with the exception of Principles 5 and 6:

1. ABF pricing should respond in a timely way to introduction of evidence-based, effective new technologies and innovation…
2. Pricing should facilitate best practice provision of appropriate site of care (price harmonisation) …..
3. ABF deign should minimise susceptibility to gaming, inappropriate reward and perverse incentives
4. ABF should be used for funding wherever practicable
5. ABF pricing should support dynamic efficiency and change 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
6. Adjustment to the standard price should be, as far as is practicable, based on patient-related rather than provider-related characteristics
7. ABF pricing should not disrupt current incentive for a person to elect to be treated as a private or a public patient in a public hospitals

Principle 5: While we recognise that this principle is well-intentioned and may be possible in the future, a single unit of measure and relative weights cannot be supported at this stage (see paragraph 6.2).

Principle 6: While this is a worthwhile principle, the AHHA notes that the exiting and justified referral patterns to specialist hospitals may make it difficult to apply (the DRG classification system may not be sufficiently sensitive to identify certain patients) and some provider loading may well be needed.

5. Scope (Chapter 5)

Defining the criteria to guide which public hospital services will be included in the General List of Services eligible for a Commonwealth funding contribution (activity or block grant funded) is of intense interest to AHHA's members.

S 10 a) and S 10 b) of the National Reform Agreement (NHRA) cover

a. all admitted patient services, including Hospital in the Home services
b. emergency services in a recognised Emergency Department

(unless a State or Territory chooses to reach a bilateral agreement by 1 May 2012 according to S A18-23).

S 10 c) provides for the inclusion of other outpatient, mental health, sub-acute and other services that could reasonably be considered as a public hospital service in accordance with S A11-17 (Appendix 3).

The base year for considering whether the service is a 'public hospital service' will be 2010, with provision for State or Territory Ministers to apply to IHPA to extend the range of services covered.

Specific inclusions and exclusions will be subject to consideration by the Standing Council on Health (Health Ministers) until 30 June 2013. Special provision will apply for services purchased or provided from the private and non- profit sector by specific hospitals and some community-based services provided through hospitals in rural and remote areas (A17).

The current variation that exits across Australia in the mix of public hospitals and models of care, plus the difficulty in what 'reasonable consideration' actually means, create complexities in reaching an equitable starting point for a national hospital funding system. The proposed Pricing Framework does not consider how variability in models of care across Australia will be dealt with. However, the Association believes it is critical that national consistency in the definition of hospital and hospital-related services is achieved from the outset, while not unintentionally excluding desirable, albeit minority, models.

5.1 Propositions as a starting point

The Act requires IHPA to determine the public hospital functions that are to be funded in the State or Territory by the Commonwealth (except where otherwise agreed between the Commonwealth and a State or Territory) (S 131(f)).

The NRHA does not include definition for a 'public hospital' or a 'public hospital service' except that the service 'could reasonably be considered to be a public hospital service during 2010' (S A15).

Therefore, the proposed Pricing Framework puts three propositions:

1. A public hospital is not the same as a public hospital service
2. Public hospitals provide both public hospital services and other 'non-public hospital services'
3. Public hospital services are provided both in public hospitals and in, or by, other entities that are not public hospitals.

In this context, the AHHA recommends the following:

- *All services managed by a public hospital should be classified as a public hospital service with the only exception being a service that is formally recognised as being other than a hospital service. For example, inpatient care provided to patients approved for residential aged care placement would be included; but, an aged care assessment service, which may be physically located in the grounds of a hospital but which is funded separately as part of a recognised national program, would not be included. Equally, licensed residential aged care beds in the hospital would not be included as a hospital service for ABF purposes.*

- *There should be consideration of place-based factors as they relate to individual patients. For instance, a patient from an isolated area poorly equipped with domiciliary care services cannot be discharged as early as a patient in a better serviced area. Keeping that patient in*

hospital therefore remains a legitimate and important part of that public hospital' service, wherever the hospital is located.

- *Other entities that provide public hospital services include community health services and Non-Government Organisations.*

The Association notes that the NHRA supports the clinically appropriate transfer of services to community settings by providing for ongoing Commonwealth funding for hospital services subsequently provided outside a hospital in response to change in clinical pathways (S A23).

The AHHA is also hopeful that, through being 'exposed' to potential increases in public hospital utilisation demand, currently being managed by the States/Territories, the Commonwealth will have stronger incentives to implement and/or expand effective health promotion, illness prevention and early intervention services.

5.2 Developing criteria

In commenting on the criteria, the Association is mindful that:

- the success of the National Health Reforms will depend on the development of more integrated models capable of delivering care across the Local Hospital Networks – community/primary health care (Medicare Local) boundaries
- an artificial distinction between hospital and community health care has the potential to create perverse incentives and to contravene the principles set out in the previous chapter
- there is wide variation in service delivery models across State/Territories
- the NHRA states that no State will be disadvantaged through this process.

The AHHA recommends the insertion of an additional criterion (see below) to take account of good clinical practice and innovative models of care, already implemented in the community sector, which are designed to manage hospital-type patients in the community and to substitute for in-patient care whether funded by hospital or not (in 2010).

Criterion	Service Analysis Factors	AHHA response
1	Is the service currently provided (or was it provided in 2010) on an admitted patient basis?	Agree
2	Is the service currently provided (or was it provided in 2010) as an emergency department service through recognised emergency department?	Agree
3	Was the service provided in 2010 through outpatient clinic on the campus of public hospital?	Agree
4	Was the service a non-admitted specialised service that was: a. Causally and proximately related to an inpatient admission? AND b. Funded by a public hospital?	Remove 'proximately'. For example, an organ transplant patient may be seen for many years on a non-admitted basis (these circumstances are not just a result of a failed primary

Criterion	Service Analysis Factors	AHHA response
		healthcare sector) The concept of 'funded by a public hospital' is narrow and unclear; the AHHA recommends 'funded by or through a public hospital'
5	Was the service a non-admitted specialised service that was: a. Causally and proximately related to an emergency department visit? AND b. Provided via a referral from an emergency department? AND c. Funded by a public hospital?	As above
6	Was the service a non-admitted subacute service (rehabilitation or palliative care) that: a. Was provided through a 'designated subacute service' facility/unit/program? AND b. Was provided to the patient at a public hospital, in a community-based setting or at home? AND c. Was funded by a public hospital?	Include all four recognised subacute care type (rehabilitation, palliative care, geriatric evaluation and management (GEM), psychogeriatric care)
7	Was the service a non-admitted specialised mental health service that: a. Was delivered by a designated specialist mental health team? AND b. Provides a response primarily designed to manage high risk/crisis situation where there is high probability of admission? AND c. Was funded by a public hospital or an area mental health service (or State equivalent)?	Include all specialist public sector mental health services to avoid adverse incentives and ensure consistency with the principles set out in the previous chapter.
8	Was the service a non-admitted specialised service that was funded by a public hospital: AND: a. Was designed to directly substitute for, or avoid, an imminent admission or emergency department visit? OR b. Was delivered a part of a planned program for a defined population with a history of high hospital utilisation to provide an alternative care delivery model for this population through the provision of a planned schedule of care over a time-limited period?	Remove the word 'imminent' (see comment at beginning of section above)
insert	Was the service a non-admitted service that was funded (whether by a public hospital or not) to manage a hospital-type patient in the community: AND: a. Was designed to substitute for admitted care: OR	The AHHA recommend the insertion of an additional criterion to take account of good clinical practice and innovative

Criterion	Service Analysis Factors	AHHA response
	b. Was delivered a part of a planned program for a defined population with a history of high hospital utilisation to provide an alternative care delivery model for this population through the provision of a planned schedule of care over a time-limited period?	models of care already implemented in the community sector, whether funded by hospital or not (in 2010), which are designed to manage patients in the community substituting for inpatient care
9	This criterion is intended to define a 'non-public hospital service'. If the service does **not** otherwise meet any of criteria 1-8, was it a service that: a. Was included in the listing of 'GP and primary health care services currently funded by State governments' specified in Clause B10 of the 2010 National Health and Hospital Network Agreement? OR b. Was included in the listing of State services 'excluded from transfer to the Commonwealth' specified in Clause B9 of the 2010 National Health and Hospital Network Agreement? OR c. Was included in the listing of State services for future 'transfer to the Commonwealth or for strong national reform' specified in Clause B34 of the 2010 National Health and Hospital Network Agreement?	Further consideration is required - at this stage the implications of this definition need to be carefully considered: • refer to discussion above re community health services and to inclusion of additional criterion • note that early intervention community services are outside the scope but crisis oriented services are eligible – which as the potential to cause perverse incentive

6. National Efficient Price (Chapter 6)

There is no clear definition of what "the efficient price" means. In its absence, the proposed Pricing Framework canvases two measures of central tendency in cost per casemix-weighted separation by hospital: the arithmetic average and the median (with some preference for the median because it is less affected by extremes). However, on the present cost distribution, payment at the median would clearly underfund total expenditure.

The AHHA strongly supports average cost pricing at this stage. It may be possible to introduce pricing according to best-practice standards at some future time, but the necessary data do not exit as yet.

ABF is intended to provide incentives to efficiency by establishing some price indicators for individual hospital services. If DRG classifications fully captured the need of all patients, the allocation of cost were perfect and all the determinants of those costs were known, the result could be used as firm indictor of hospital efficiency. But none of these factors are sufficiently precise as yet and the AHHA is strongly opposed to their use.

Costs per case vary between hospitals and across the different case categories within a hospital for a variety of reasons. The average is, at best, an indicator of average efficiency, which as the recent Productivity Commission report on Public and Private Hospitals [4] showed, is almost the same in the

[4] Performance of Public and Private Hospital: Productivity Commission Research Report, December 2009

public and private sectors. Payment at less than average cost would invite trade-offs between quality and quantity that would be almost impossible to trace.

The AHHA supports ABF as providing indicators of where and how performance could be improved and the issues involved should certainly be pursued. But it does not support such arbitrary measures as, say, penalising hospitals in the upper quartile of cost without a transparent process and full knowledge of why that deviation may exit.

The AHHA notes that in practice, there will not be, and cannot be, one national benchmark price. There will be a set of prices as discussed in the proposed Pricing Framework.

The AHHA notes that the NHRA (Se B14) states that: While these adjustments to the national efficient price should provide a relevant price signal to State and Local Hospital Networks, the IHPA should not seek to duplicate the work of the Commonwealth Grant Commission in determining relativities. While not explicitly mentioned in the Proposed Pricing Framework, the AHHA assumes this to mean that that differences recognised by the Commonwealth Grants Commission for distribution of Commonwealth funds will be incorporated into the State/Territory efficient price.

6.1 Definitions

The proposed Pricing Framework defines an efficient hospital as able to:

- provide episodes of care (on average, across all type of care, as measured using agreed classification) at or below the national benchmark
- respond to new technologies which are cost-effective from a societal point of view
- minimise negative consequences that fall on patients (including those attributable to poor quality) or on other parts of the service system
- provide services which, at the margin, lead to the same improvement in individual or community health as services provided in other part of the health system.

The AHHA agrees with the last three dot points but recommends that dot point 1 be qualified by adding the words 'adjusted for justifiable differences in input costs' (eg to recognise the cost of delivering health care in remote locations).

6.2 Single unified measure (National Weighted Activity Unit)

The Association recognises that this principle is well-intentioned but notes that:

- *at this stage it is not clear that a single unit could be devised that would fairly and adequately reflect the overall work and mix of services at each LHN across hospitals or services (eg inpatient, outpatient, specialised services) and there are likely to be significant difficulties in attempting to do so through a single unit of measure*
- *a single unit of measure and relative weights across all services may lead to a lack of transparency*
- *there are no international examples to use as a precedent.*

6.3 Product definition (minimise cost shifting)

The AHHA agrees that:

- ABF implementation in 2012-13 should not involve any change to traditional product definition
- the IHPA Clinical Advisory Committee could play an important role in proactively identifying and examining any potential impact on patient care arising from product specification.

6.4 Approach

6.4.1 Best practice

The AHHA agrees that, in the ideal world, price would be based on best practice but that this is currently not possible, at least in the short term and that the IHPA could incrementally adopt best practice weights as the evidence becomes available.

6.4.2 Indexation

The proposed Pricing Framework emphasises the point that price-setting must take into account the fact that the costing data from the National Hospital Cost Data Collection used for the national ABF system will be about three years in arrears requiring estimates of inflation in moving to pricing. The proposed Pricing Framework recommends an output cost index to capture both cost and efficiency and prefers the Government Final Consumption Expenditure (GFCE) hospital and nursing home deflator (ABS), also used by the AIHW.

However, the AHHA strongly recommends that an index constructed separately for hospitals would be desirable and justified and that it should take into consideration the goal of ABF being able (?) to reward improved efficiency. Therefore, the Association recommends the development of a hospital-specific index over the forthcoming two years, for implementation in 2014-15. In the meantime the Association accepts the proposed index.

It is essential that block funding will also be indexed for price inflation as well as for increased activity, recognising the high fluctuation in demand for many rural and remote services with change in population flow, age profile and so on. It is desirable that the indexation factor should be transparent and stable.

7. Adjustment (loading) (Chapter 7)

The AHHA agrees that adjustment should be evidence based and, as much as possible, patient-based, recognising that it is sometimes necessary to use proxies for patient-based factors. However, as pointed out above, the AHHA notes that the existing and justified referral patterns to specialist hospitals may make it difficult to apply (the DRG classification system may not be sufficiently sensitive to identify certain patients) and some provider loadings may well be needed.

7.1 Aboriginal and Torres Strait Islander patients

The AHHA supports an additional loading for Aboriginal and Torre Strait Islander patients and notes that some State/Territories use a factor of 30% even though there is evidence to suggest a lesser amount.

The Association recommends adopting a 30% loading but would support a process to:

- *determine a more substantiated evidence based percentage loading over the next two years*
- *measure quality (eg accreditation) to justify the higher amount, noting that not all costs associated with provision of services to this population are readily identifiable nor easy to extract.*

7.2 Specialist services for children

The AHHA would prefer a separate adjustment to apply to paediatric patients in all hospitals and not just to paediatric patients in specialist hospitals as this overrides the 'patient related cost driver' principle.

However, the AHHA recognises that it is sometimes necessary to use other factors as proxies for patient factors and, therefore, adjusting the national price by hospital peer group (including, but not limited to, the specialist children's hospital peer group) may be both justifiable and desirable.

7.3 Location-based

The AHHA is open to the idea of different prices for different hospital peer groups which would address many of the issues relating to location.

However, there is evidence that, even after adjusting for peer group, there are unavoidable additional costs in geographically remote areas where populations are widely dispersed such as the Northern Territory, far north Queensland, far west and north Western Australia. Pricing of hospital services in rural and remote areas should reflect the greater health needs of the populations of those areas and the complexity of their health situation arising from common risk factors. Where it can be demonstrated that there are additional and unavoidable costs in specific locations, adjustments to the price are justified. Well-established models such as those in the US have long recognised locational cost differences.

7.4 Teaching, training and research

The NHRA makes provision for the additional costs of not only teaching but also training and research. The AHHA notes that it will be a complex exercise to quantify both direct and indirect costs associated with all three. [5] There is also a special case for hospitals that are in the process of development to full referral status. This issue is also linked to salaried medical officers' right of private practice because, in many cases, salaried specialist use their private practice earnings to cross-subsidise teaching and research.

Members of the AHHA have raised the difficulties of teaching, training and research in rural communities. In these areas, the costs of maintaining ongoing staffing competencies (eg procedural training for general practitioners) is high and may not be compensated for if these costs are excluded from being included in the cost data if classified as 'staff development' only.

[5] Eagar (2010) *ABF Information Series No. 7: Research and training*. http://ahri.uow.edu.au/chd/abf/index.html

7.5 Quality/Pay for Performance

The AHHA believes all healthcare funding models should have in place quality improvement programs and supports the concept of adjusting price for quality, provided implementation occurs in conjunction with broader policy solutions (e.g. accreditation and performance monitoring).

The AHHA notes however the difficulties associated with implementation, for example:

- recognising and defining a 'hospital acquired conditions', taking into account the higher risk (co-morbid) patients admitted in public hospitals (as compared to private hospitals)
- defining quality beyond a focus on adverse events and acute admitted care (eg, subacute, mental health, outpatient, community)
- recognising the nature of adverse events differs by care type; eg a certain number of falls may be expected in rehabilitation as patients are learning to walk again while falls in palliative care would be regarded as an adverse event
- including both a 'carrot and stick' approach.

When making adjustments to price based on quality, the AHHA supports an approach that recognises improvement in quality, not just meeting absolute thresholds (unless they are 'never-ever' events).

The AHHA also supports the inclusion of some process measure of quality, not just outcome measures (e.g. hospital acquired infection). While we appreciate that it may take time to develop and implement process measures of quality, it is important because true quality care means a 'quality process' not just a 'quality outcome'.

While taking a cautious approach, at least in the establishment stage of the national ABF system, the AHHA would consider it appropriate to apply financial penalties for 'never-ever' adverse events. However, perverse incentives could be introduced if the model is not well designed and adjusted for the care setting.

On the technical side, the AHHA believes that this section confuses classification and payment, recognising a DRG system has many uses other than paying for public hospital care. An adverse event can be included in the DRG assignment process but excluded or adjusted for payment purposes.

The AHHA would be pleased to work with the IHPA in the progressive development of performance incentives that can be built into the funding model.

8. Private patients in public hospitals (Chapter 8)

The AHHA supports the principle of public-private neutrality and that 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. However, it should be acknowledged that the Commonwealth's contribution to the National Efficient Price may have an impact on decisions of State and Territory governments about contracting some public hospital service to non-government providers. In some States, particularly NSW, private patient fee revenue is a critical factor in attracting and holding procedural medical specialists.

The AHHA also supports the approach that is outlined for pricing private patient care. However, the reduction to the price to reflect private health-insurance benefit should be based on State benefit rates and not the national default rate to take account of differences between the States and Territories in terms of the bargaining power they have when dealing with private insurers. Adjustment for private patients must be made at the pricing stage and not in the costing process. Obviously, however, pricing should be related to cost.

The AHHA notes that the issue of privately referred outpatients has not been addressed. It will be important to neutralise perverse incentives to change the mix of private and public outpatient clinics because patients classified as public outpatients will be funded under ABF and those who are privately referred will be funded under the Medicare Benefits Schedule.

Likewise, there is no mention of the important issue of incentives that may be created to change the mix of admitted and non-admitted care through classifying patients as outpatient or same-day admitted patients. How a patient is classified results from the financial incentives in the system despite there being no real distinction between the two in term of clinical care provision.

Implicit in the concept of a single unit of measure and price equivalent is the assumption that a single unit will address this issue. It may not because the issue is not about the unit of measurement but about relative price.

In addition, there is the need to consider the situation in which a hospital covers what might be regarded as the ancillary cost (such a provision of a nurse and consumable) of a private consultation undertaken by a medical practitioner in a public hospital setting and funded through Medicare. This is a frequent pattern of service in rural and remote areas, with many emergency and urgent care services provided by general practitioner in this way. It is therefore critical that those costs which are ancillary to the medical practitioner's MBS-funded consultation are not considered 'part of the same service' when interpreting the Commonwealth contribution to the public hospital' cost. If those costs to the hospital are excluded from the Commonwealth's contribution to hospital payment, these essential services may be lost to people in rural and remote areas.

9. Block grant funding (Chapter 9)

Block funding has been agreed upon for two groups of services where there is an absence of economies of scale - those provided in small rural and remote hospitals and those highly specialised services that are provided on a State-wide basis. The latter could, in principle, be funded by a complicated set of inter-LHN payments, but block funding is the simplest solution.

The small hospital problem arises because the fixed costs of service availability are high due to the significant professional staff shortages and the limited revenue available from their relatively uncomplicated casemix which make internal funding unviable. That is the so-called 'community service obligation', although the term is somewhat misleading. All public hospitals have an obligation to accept and treat any patient who presents, which the private hospitals do not. The AHHA would like to see much greater recognition of the fact that many hospitals have Community Service Obligations that will need to be funded by block grant.

The AHHA notes that services identified for block grant funding in 2012-13 may differ across State and Territories and a national approach to block grants is envisaged from 2013-14 including consideration of issues such as developing an appropriate accountability framework for block funded

services and functions and the application of price adjustments for quality (on which the proposed Pricing Framework is currently silent). For example, a quality framework must recognise the value of local access to hospital or acute care in a rural and remote community in balancing the risk to safety and quality of health care that lack of a service may pose. These include health deterioration and accidental injury during long trips for necessary health care, or even a decision not to access a health service because it is too far away. The obvious method for determining the efficient cost of a block grant funded service are costing studies and benchmarking.

The AHHA supports the approach outlined in relation to block funding including the application of a 'low volume' threshold for block grant funding related to the number of acute inpatient weighted separations as described in the proposed Pricing Framework.

In principle, resource distribution will be the responsibility of the LHN, but amongst AHHA members there is concern that the big hospitals will dominate the LHN and so threaten the small, remote area hospitals. Small rural and remote hospitals should continue to be block funded in the longer term and a simple quarantining of block funding money should prevent misallocation of resources.

The AHHA has worked over several years to support Multi-Purpose Services and believes that MPSs work effectively and meet the need of many small towns and communities in rural and remote areas. The pooling of Commonwealth and State/Territory funds for flexible use across aged and acute sectors enables MPSs to tailor the range of services they provide to address specific local needs. The Association understands that MPSs will receive funding through the same bilateral (Commonwealth/State) arrangement as currently exists in 2012-13 and that, from 1 July 2013, the level of block funding for MPSs (presumably for the public hospital component) will be determined by the IHPA. The AHHA recommends that, from 1 July 2013, MPSs should be treated in the same way as a small rural and small regional hospital and continue to be block funded in the longer term.

9.1 Mix of ABF/Block Funding

Decisions about whether a hospital is funded through ABF, block funding or mixed should be made jointly between IHPA, State/Territory and LHN and the allocation of block funding, mixed funding and ABF should be clearly specified in Service Level Agreement (SLA) with the State/Territory government. Many LHNs will cover a range of smaller hospitals providing a base for local service delivery, as well as larger regional hospitals. The requirement for community consultation and needs assessment to ensure acceptable coverage outside the regional centres should be part of the contractual arrangement with the LHN.

The role of the LHN in ensuring the availability of a comprehensive range of hospital services will be particularly important in rural and remote areas and must include outreach as well as in-hospital services. Larger rural hospitals will need to be funded at a level which enables them to provide outreach services (specialist, community health services, allied health) to smaller outlying hospitals and communities. Smaller hospitals will need adequate funding to transport patients to larger facilities when necessary. Smaller hospitals will need funding to provide facilities (accommodation, clinical and administration) for visiting health professionals.

9.2 Mental health

Mental health is included in the chapter on block grant funding. Yet the section on mental health goes much further than block funding. The AHHA disagrees with the overall approach taken in this

section. Mental health has its own Minister and its own national Mental Health Commission. Specialist mental health services need their own funding model.

The AHHA represents salaried psychiatrists working in the public sector and these psychiatrists have been active in developing the following recommendations which are fully endorsed by the Association:

- That the IHPA recommends to COAG that the scope of the national health reform agreement include all public specialist mental health services
- That specialist mental health be recognised as a distinct care type (just as services such a rehabilitation and palliative care already are)
- That specialist mental health has its own ABF model that is developed specifically to meet the needs of people requiring mental health care
- That, until this model has been developed and is ready for implementation, all public specialist mental health services be block-funded
- That, as part of this development, the IHPA funds a mental health casemix classification study and the development of an integrated mental health funding model. This would build on exiting work, including the Mental Health Classification and Service Cost (MH-CAC) study completed in 1998. It would require 1-2 years to develop this casemix classification as it must incorporate admitted and non-admitted specialist clinical mental health services and take account of the patient complexity factors that drive mental health costs
- That public mental health services not be disadvantaged by being block funded in the interim period. This can be achieved by the Commonwealth agreeing to increase its contribution to public mental health at (at least) the same rate as its contribution to public hospitals.

9.3 Subacute care

The AHHA's overall comment on subacute care is that it is not sufficiently recognised throughout the document. Subacute inpatient care now represent around 15% of all bed days in public hospital and this figure is growing rapidly due to significant investment in recent years.

Many of the issues for mental health (see previous paragraph) apply equally to subacute care. Subacute clinical streams such a rehabilitation and palliative care are not appropriately classified by DRG. These streams need their own classifications covering all care settings (inpatient, outpatient and community). It is therefore of concern that the proposed Pricing Framework implies that subacute patients treated on an outpatient basis should be classified a 'outpatient' rather than 'subacute'. It is also of concern that the proposed Pricing Framework proposes a piecemeal approach to implementation with some subacute services being funded through ABF in 2012 and others commencing in 2013. This is inconsistent with several of the principles set out at the beginning of the report.

The Association recommends that:
1. as with mental health, there be an integrated approach to subacute classification and funding and
2. issues such as including incentives for quality, loadings for hospital type and other issues raised

elsewhere in the proposed Pricing Framework be specifically considered for subacute care (across all care settings).

10. Other issues

The AHHA essentially agrees with the range of issues outlined in this chapter that will need to be addressed in future years. However, what is missing in this section is a coherent ABF research and development strategy.

11. Conclusion

The AHHA would welcome further discussion to expand on our response.

Appendix 1: National Health Reform Amendment (IHPA) Act 2011

130 Object of the Pricing Authority

The object of the Pricing Authority is to promote improved efficiency in, and access to, public hospital services by:

(a) providing independent advice to governments in relation to the efficient costs of such services, and

(b) developing and implementing robust systems to support activity based funding for such services.

131 Functions of the Pricing Authority

(1) The Pricing Authority has the following functions:

(a) to determine the national efficient price for health care services provided by public hospitals where the services are funded on an activity basis;

(b) to determine the efficient cost for health care services provided by public hospitals where the services are block funded;

(c) to develop and specify classification systems for health care and other services provided by public hospitals;

(d) to determine adjustments to the national efficient price to reflect legitimate and unavoidable variations in the costs of delivering health care services;

(e) to determine data requirements and data standards to apply in relation to data to be provided by States and Territories, including:

(i) data and coding standards to support uniform provision of data; and

(ii) requirements and standards relating to patient demographic characteristics and other information relevant to classifying, costing and paying for public hospital functions;

(f) except where otherwise agreed between the Commonwealth and a State or Territory—to determine the public hospital functions that are to be funded in the State or Territory by the Commonwealth;

(g) to publish a report setting out the national efficient price for the coming year and any other information that would support the efficient funding of public hospitals;

(h) to advise the Commonwealth, the States and the Territories in relation to funding models for hospitals;

(i) to provide confidential advice to the Commonwealth, the States and the Territories in relation to the costs of providing health care services in the future;

(j) such functions as are conferred on the Pricing Authority by Part 4.3 of this Act (cost-shifting disputes and cross-border disputes);

(k) to publish (whether on the internet or otherwise) reports and papers relating to its functions;

(l) to call for and accept, on an annual basis, public submissions in relation to the functions set out in paragraphs (a) to (f);

(m) such functions (if any) as are specified in a written instrument given by the Minister to the Chair of the Pricing Authority with the agreement of COAG;

(n) to do anything incidental to or conducive to the performance of any of the above functions.

(2) COAG is to give its agreement for the purposes of paragraph (1)(m) by a written resolution of COAG passed in accordance with the procedures determined by COAG.

(3) In performing its functions, the Pricing Authority must have regard to the following:

(a) relevant expertise and best practice within Australia and internationally;

(b) submissions made at any time by the Commonwealth, a State or a Territory;

(c) the need to ensure:

(i) reasonable access to health care services; and

(ii) safety and quality in the provision of health care services; and

(iii) continuity and predictability in the cost of health care services; and

(iv) the effectiveness, efficiency and financial sustainability of the public hospital system;

(d) the range of public hospitals and the variables affecting the actual cost of providing health care services in each of those hospitals.

Appendix 2: Principles for Determining the National Efficient Price (COAG NHR Agreement)

B11. The role of the national efficient price is to:

a. form the basis for the calculation of the Commonwealth funding contribution; and

b. provide a relevant price signal to States and Local Hospital Networks.

B12. In determining the national efficient price, the IHPA must:

a. have regard to ensuring reasonable access to public hospital services, clinical safety and quality, efficiency and effectiveness and financial sustainability of the public hospital system;

b. consider the actual cost of delivery of public hospital services in as wide a range of hospitals as practicable;

c. consider the expected changes in costs from year to year when making projections;

d. have regard to the need for continuity and predictability in prices;

e. have regard to any input costs funded through other Commonwealth programs, such as pharmaceuticals supplied under arrangements pursuant to section 100 of the *National Health Act 1953* and magnetic resonance imaging services funded through MBS bulk-billing arrangements; and

f. develop methods which allow consideration of reasonable and likely growth in cost inputs, so that the national efficient price can be projected into the future in a predictable and transparent manner.

B13. In determining adjustments to the national efficient price, the IHPA must have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery, including:

a. hospital type and size;

b. hospital location, including regional and remote status; and

c. patient complexity, including Indigenous status.

B14. While these adjustments to the national efficient price should provide a relevant price signal to States and Local Hospital Networks, the IHPA should not seek to duplicate the work of the Commonwealth Grants Commission in determining relativities

Appendix 3: Clause A11-17 (COAG NHR Agreement)

A11. States will provide the IHPA with recommendations for other services that could reasonably be considered to be a public hospital service and which are not captured by clause A10(a) and A10(b) that they consider should be eligible for a Commonwealth funding contribution.

A12. The IHPA will develop and publish criteria for assessing services for inclusion on a general list of hospital services eligible for Commonwealth growth funding. The IHPA will consider each State's recommendations against the published criteria and establish a general list of other services eligible for a Commonwealth funding contribution.

A13. The Standing Council on Health may then:

a) until 30 June 2013, direct the IHPA with regard to specific inclusions or exclusions of services to or from the general list; and

b) request the IHPA to reconsider its determination of services included on or excluded from the general list. If the IHPA considers the service should continue to be included or excluded, it will publicly release its determination and the basis of that determination.

A14. The IHPA may update the criteria and will update the general list based on any updated criteria, or as required to reflect innovations in clinical pathways. States may request the IHPA to update the list or to assess specific services against the criteria for inclusion on the general list.

A15. In establishing the published criteria a primary consideration will be whether the service could reasonably be considered to be a public hospital service during 2010.

A16. Services named on the general list will attract a Commonwealth funding contribution if provided by any Local Hospital Network as agreed between the State and that Local Hospital Network.

A17. A service not already captured within the general list and which is not eligible for Commonwealth funding under clause A10 will be eligible for Commonwealth funding for a specific hospital if that service was purchased or provided by that hospital during 2010. States will provide the IHPA with a list of such services provided by each hospital during 2010. This may include services, if not captured by the general list, provided by hospitals in rural and remote areas, hospital avoidance programs, particular existing services provided by outpatient clinics, and existing outreach services such as renal dialysis, chemotherapy, palliative care, rehabilitation and mental health crisis intervention teams. The IHPA may request additional information to confirm the services were provided during 2010.