



The Pricing Framework for Australian Public Hospital Services

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Acknowledgements

The Pricing Framework was produced in association with a consortium led by Health Policy Solutions Pty Ltd. Team members comprised Sharon Willcox, Stephen Duckett, Peter Axten, Andrew Street, Helen Owens and Sabrina Stow.



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Dear Commonwealth, State and Territory Ministers of Health

On behalf of the Independent Hospital Pricing Authority, I am pleased to present the inaugural Pricing Framework for Australian Public Hospital Services.

The national implementation of activity based funding for Australian public hospitals, commencing on 1 July 2012, is one of the most significant reforms impacting on public hospitals in recent history. Governments have tasked the Independent Hospital Pricing Authority with responsibility for setting the national efficient price for public hospital services. The implementation of activity based funding, including the national efficient price, creates new transparency and strengthened incentives for efficiency in the delivery of public hospital services. In taking on this responsibility, the Independent Hospital Pricing Authority is guided by the principle that an efficient public hospital system must also be able to provide services that are accessible and meet national standards of quality.

The reform of public hospital funding is occurring in a reform-rich environment. The Independent Hospital Pricing Authority welcomes the opportunity to work in partnership with other national agencies including the Australian Commission on Safety and Quality in Health Care and the National Health Performance Authority. This will ensure that pricing, quality and performance measures for public hospitals are complementary and, together, create a strong national framework for the delivery of public hospital services.

The Independent Hospital Pricing Authority also recognises the vitally important role of States and Territories as system managers of public hospitals, working in partnership with Local Hospital Networks and local communities. The aim of the Authority has been to set a national efficient price that enables Local Hospital Networks, clinicians and hospital staff to make choices about how best to deliver 'the right care at the right time in the right setting' for their local communities.

Finally, I would like to affirm the commitment of the Independent Hospital Pricing Authority to transparency and continuous improvement in how it undertakes its delegated functions, grounded in an open, consultative approach to working with the health sector in the implementation of funding reform for public hospitals.

Yours sincerely

Shane Solomon
Chair
Independent Hospital Pricing Authority

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1. Pricing Guidelines

Understanding this element of the Pricing Framework

Governments agreed to establish the Independent Hospital Pricing Authority (the IHPA) to provide independent advice about the efficient cost of public hospital services. Much of this advice will be evidence-based, drawing on technical knowledge and expertise about the classification, costing and funding of public hospital services. But, the IHPA must also balance a range of national policy objectives including improving the efficiency and accessibility of public hospital services. This role requires the IHPA to exercise judgement on the weight to be given to different policy objectives.

In order to be transparent about how it makes decisions that involve policy choices, the IHPA has developed a set of Pricing Guidelines. These Pricing Guidelines will be used to explain the key decisions made by the IHPA in this Pricing Framework. The Pricing Guidelines may also be used by Governments and other stakeholders to evaluate whether the IHPA is undertaking its work in accordance with the explicit policy objectives included in the Pricing Guidelines.

The Pricing Guidelines signal the commitment by the IHPA to transparency and accountability in how it undertakes its work.

Provisions of the Act and/or the Agreement

The National Health Reform Act 2011 ('the Act') says that the object of the IHPA is "to promote improved efficiency in, and access to, public hospital services by providing independent advice to Governments in relation to the efficient costs of such services" (Clause 130).

The Agreement 2011 ('the Agreement') includes a set of principles that the IHPA must use in determining the national efficient price of services funded on an activity basis (Clauses B11-B14). This includes, for example, that the IHPA must 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".

The National Healthcare Agreement 2011 provides another important context for the IHPA. It is the overarching agreement that sets out "the collective aspirations of Commonwealth, State and Territory Governments on prevention, primary and community care, hospitals and related care and aged care".

Approach used by the IHPA

The IHPA used the following approach to develop the Pricing Guidelines:

- In November 2011 the IHPA commissioned a literature review that examined international best practice in activity based funding and payment reform. This identified that different policy objectives can result in varying approaches to the design and pricing framework under which activity based funding is implemented. It is therefore important to be explicit about the policy objectives that underpin the work of the IHPA.
- In January 2012 the IHPA released a Discussion Paper that included a set of Draft Principles (the predecessors to the final Pricing Guidelines). These Draft Principles were informed by a review of relevant intergovernmental agreements and legislation, as well as experience about health system funding reform in Australia and internationally.
- In February 2012 consultation meetings were held across Australia and almost 100 written submissions were received on the Discussion Paper. Many of the meetings and submissions provided

feedback on the Draft Principles. This feedback was analysed and the Draft Principles were modified to develop the final set of Pricing Guidelines.

The IHPA's decision

The IHPA has developed, and will use, a set of Pricing Guidelines (specified in Box 1) to guide its decision-making, where it is required to exercise policy judgement in undertaking its legislated functions.

The following table shows the source and/or application of each of the Pricing Guidelines, based on the Agreement (NHRA) and/or the National Healthcare Agreement (NHA). This table makes explicit that the IHPA will operate under policy objectives that have been determined by the Commonwealth, State and Territory Governments as specified in these agreements.

Pricing Guideline	Basis in the NHRA or NHA
Timely-quality care	NHRA Clauses 13(d), B12(a); NHA Clause 4(d);
Efficiency	NHRA Clauses 3(a), B12(a); NHA Clauses 6, 13(g), 33
Fairness	NHRA Clause B12(a)
Maintaining agreed roles and responsibilities of Governments determined by the Agreement	NHRA Clauses 3-10
Transparency	NHRA Clause 3c; NHA Clause 7
Administrative ease	NHRA Clause B12(d)
Stability	NHRA Clause B12(d)
Evidence-based	NHA Clause 8
Supporting innovation	NHRA Clause 13(b); NHA Clause 8
Price harmonisation	Linked to: NHRA Clauses A23, 13
Minimising undesirable and inadvertent consequences	NHRA Clause 18(c), A24-26, A99-101
ABF pre-eminence	NHRA Clause A2, Clause A1(c)
Single unit of measure and price equivalence	Linked to: NHRA Clauses A23, 13
Patient-based	Linked to: NHRA Clause 7(a-b)
Public-private neutrality	NHRA Clause 4(a); NHA Clauses 21-22

Next steps and future work

The IHPA will actively monitor the impact of the implementation of activity based funding. This will include monitoring changes in the mix, distribution and location of public hospital services, consistent with its responsibilities under Clause A25 of the Agreement.

Box 1: Pricing Guidelines

The Pricing Guidelines comprise the following overarching, process and system design guidelines.

Overarching Guidelines that articulate the policy intent behind the introduction of funding reform for public hospital services comprising activity based funding (ABF) and block grant funding:

- **Timely–quality care:** Funding should support timely access to quality health services.
- **Efficiency:** ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services.
- **Fairness:** ABF payments should be fair and equitable, including being based on the same price for the same service across public, private or not-for-profit providers of public hospital services.
- **Maintaining agreed roles and responsibilities of Governments determined by the Agreement:** Funding design should recognise the complementary responsibilities of each level of government in funding health services.

Process Guidelines to guide the implementation of ABF and block grant funding arrangements:

- **Transparency:** all steps in the determination of ABF and block grant funding should be clear and transparent.
- **Administrative ease:** Funding arrangements should not unduly increase the administrative burden on hospitals.
- **Stability:** the payment relativities for ABF are consistent over time.
- **Evidence based:** Funding should be based on best available information.

System Design Guidelines to inform the options for design of ABF and block grant funding arrangements:

- **Fostering clinical innovation:** Pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the model of care that improve patient outcomes.
- **Price harmonisation:** Pricing should facilitate best practice provision of appropriate site of care.
- **Minimising undesirable and inadvertent consequences:** Funding design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.
- **ABF pre-eminence:** ABF should be used for funding public hospital services wherever practicable.
- **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.
- **Patient-based:** Adjustments to the standard price should be, as far as is practicable, based on patient-related rather than provider-related characteristics.
- **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.

2. In-scope Public Hospital Services

Determining what is a “public hospital service”

Making decisions about what is, or is not, a public hospital service for funding purposes is one of the important tasks of the IHPA.

In August 2011 Governments agreed to be jointly responsible for funding growth in ‘public hospital services’. But, as there is no standard definition or listing of public hospital services, Governments gave the IHPA the task of deciding which services will be ruled ‘in scope’ as public hospital services, and so eligible for Commonwealth Government funding.

The reformed funding arrangements agreed by Governments apply to ‘public hospital services’, not public hospitals. Many public hospitals provide some services, such as residential aged care services, that are not generally regarded as public hospital services. In addition, organisations other than public hospitals may provide ‘public hospital services’. This happens, for example, if Governments or public hospitals contract out the provision of some public hospital services to private hospitals and non-government organisations.

Provisions of the Act and/or the Agreement

The IHPA is required under Section 131(1) of the Act “to determine the public hospital functions that are to be funded in the State or Territory by the Commonwealth”, except where this has already been bilaterally agreed between a State/Territory and the Commonwealth.

The Agreement (Clauses A10-A17) sets out the process that the IHPA is required to use in deciding which services will be ruled in-scope as public hospital services. First, it states that all care provided to inpatients (including people receiving care through hospital in the home programs) and to people treated in emergency departments is automatically included as public hospital services. Second, it states that the IHPA has to make decisions about whether other services (including outpatient clinics, mental health services, subacute services including rehabilitation and palliative care, and other non-admitted services) will be classified as in-scope, public hospital services.

The IHPA is required to develop and publish criteria for assessing which services could be included on a General List of public hospital services eligible for Commonwealth funding. States can then use these criteria to make recommendations to the IHPA, as can Health Ministers jointly, for particular services to be included on, or excluded from, the General List.

The Agreement says that a primary consideration to be used by the IHPA in developing the criteria is whether a service “could reasonably be considered to be a public hospital service during 2010” (Clause A15).

Policy drivers underpinning the IHPA’s decision

The way in which public hospital services are delivered is evolving, with many services now being provided in different settings. For example, dialysis is now frequently provided in a person’s home or in satellite clinics located outside public hospitals. Hospital-in-the-home programs allow people to receive chemotherapy, intravenous antibiotics and antiviral therapy in their homes under the supervision of hospital outreach staff. In order to provide these new approaches to patient care, funding has to follow the patient outside the hospital.

Clause A23 of the Agreement guarantees that if services move outside hospitals in response to changes in clinical practice, these services will still be funded as if they were provided in hospitals. To do otherwise when funding is based on activity could create incentives to admit more patients into public hospitals, rather than treat them in the community when it is safe to do so.

The determination that a service is in-scope as a public hospital service has significant financial implications. It means that from 1 July 2012 the Commonwealth Government will pay a share of the national efficient price when these services are funded on an activity basis. From 1 July 2014 onwards, the Commonwealth Government will also contribute to growth in the national efficient price and volume of these services. This creates a strong financial incentive on States, Territories and health services to have as broad a range of services classified as in-scope public hospital services by the IHPA. In recognition of this financial incentive, the Agreement (Clause A24) requires that States “will not change the management, delivery and funding of health and related services for the dominant purpose of making that service eligible for Commonwealth funding”. The IHPA is required to undertake analysis if it is suggested that services have been transferred from the community to public hospitals for the purposes of making these services eligible for Commonwealth funding. Following analysis and consultation, the IHPA can then make a determination as to whether such services will or will not be eligible for Commonwealth funding.

The implementation of activity based funding of public hospital services does not change the existing responsibilities of Governments for funding other health services. These ongoing responsibilities of each level of government are specified in the Agreement. One of the IHPA’s Pricing Guidelines is that it will “recognise the complementary responsibilities of each level of government in funding health services”. This includes funding of GPs, private medical specialist services, pharmaceuticals and aged care by the Commonwealth Government, and the provision and funding of a range of public health, community health and other specialised services by the States and Territories.

Similarly, the IHPA’s responsibility for making decisions on the scope and pricing of public hospital services is intended to complement (not to replace) the ongoing autonomy of States, Local Hospital Networks and clinicians to make decisions about desirable models of care to meet the needs of their local communities. The IHPA will price public hospital services, recognising that they may be provided in different settings and be based on different models of care.

Approach used by the IHPA

The IHPA undertook extensive analysis and consultation to develop the Criteria for in-scope services and a General List of in-scope public hospital services as follows:

- Subsequent to the decision to use the National Hospital Cost Data Collection (NHCDC) Tier 2 Clinic classification for activity based funding of non-admitted services, States, Territories and the Commonwealth undertook extensive work during 2011 to refine this classification. This included commissioning a due diligence review on the Tier 2 classification that included expert clinical review, refinements of clinic service descriptions and definitions and assessment of the classification against mapping of non-admitted services undertaken by States and Territories. This work culminated in a refined Tier 2 classification, which is available on the IHPA website (together with all classifications used by the IHPA for activity based funding).
- In November 2011 the IHPA initiated a separate review of non-admitted services. The purpose of this review was to develop, in consultation with States and Territories, a catalogue of non-admitted services provided in each State and Territory. This review involved mapping these services into a nationally consistent list of non-admitted services in order to identify the types of services that might potentially be in scope as public hospital services.
- In January 2012 the IHPA released a Discussion Paper that included a set of Draft Criteria that could be used to determine the scope of eligible public hospital services. These Draft Criteria were informed by the catalogue of existing non-admitted services provided in each State and Territory and the review of relevant intergovernmental agreements and legislation.

- In February 2012 consultation meetings were held across Australia and almost 100 written submissions were received on the Discussion Paper. Many of the meetings and submissions provided feedback on the Draft Criteria. This feedback was analysed and the Draft Criteria were modified to develop a set of Revised Criteria, together with a General List of in-scope public hospital services. As the criteria were being modified, the IHPA sought feedback on a continuous basis from the Commonwealth, State and Territory Governments.

The IHPA's decision

The IHPA has determined that, from 1 July 2013, the scope of public hospital services eligible for Commonwealth funding will be:

- All admitted programs, including hospital in the home programs
- All emergency department services
- Non-admitted services that meet the Criteria for inclusion on the General List, with further specification in Box 2 at the end of this Chapter.

There are several important aspects of the Criteria and General List that warrant further explanation.

1. In-scope public hospital services may be provided by public hospitals and by other organisations.

Public hospitals are the main provider of public hospital services. However, the Agreement (Clauses A52-A57) also recognises that other organisations may provide public hospital services as follows:

- There are hospitals owned by charitable organisations that are recognised as public hospitals in most States and Territories; and
- States and Territories may contract with a private or not-for-profit provider to operate a public hospital;
- There may be contracting by a State/Territory (centrally) or by a Local Hospital Network with the private or not-for profit sector for the provision of specific public hospital services by private providers.

Accordingly, the Criteria determined by the IHPA do not require that public hospital services have to be directly provided by public hospitals. It is the decision of States and Local Hospital Networks about how best to provide public hospital services.

2. In-scope public hospital services may be funded on an activity basis, through block grants, or using a mix of activity based and block grant funding.

The decision by the IHPA as to which services are in scope as public hospital services is separate from a subsequent decision as to how in-scope services will be funded. Not all in-scope public hospital services will be funded on an activity basis; some services will be funded through block grants and some other services will be funded through a mix of activity based and block grant funding.

In 2012/13, the proportions of Commonwealth funds for block funding will be determined via a bilateral agreement between State and Commonwealth Health Ministers, as detailed in the NHRA (Clause A32 (b)).

The IHPA will make decisions about whether in-scope public hospital services will be funded on an activity basis or a block grant basis in accordance with the Agreement. The IHPA's approach to decision-making on setting prices for activity-based and block grant funded services is outlined in Chapters 3 & 4.

3. In-scope, non-admitted services may be provided in any setting.

In-scope non-admitted services do not have to be provided on the campus of a public hospital. They can be provided at a hospital, in the community, or in a person's home. For example, paediatric services could be provided on an outreach basis by a specialist children's hospital at a community-based clinic. Services may also be provided in a person's home (such as home haemodialysis or palliative care) and be included in-scope as eligible for Commonwealth funding.

This ensures that decisions about the scope of included public hospital services should not create an incentive for services to be provided in a particular setting. In making this decision:

- The IHPA is affirming the important role of States and Territories as system managers to be responsible for planning how best to organise and deliver public hospital services for their populations; and
- The IHPA recognises that decisions about where public hospital services will be provided for individual patients are clinical decisions involving patients and health professionals.

4. In-scope, Specialist Outpatient Clinic Services will be required to report as public hospital services in a national dataset.

The flexibility to provide non-admitted public hospital services identified as Specialist Outpatient Clinic Services in any setting is balanced by the requirement of the AGREEMENT that IHPA give 'primary consideration' to whether a service has been reported 'as a public hospital service' in the 2010 Public Hospital Establishments Collection in terms of its activity, staffing or expenditure".

The IHPA has decided to include this reporting requirement for two reasons:

- First, some of the non-admitted services included as in-scope on the General List may be provided privately or may be funded by Governments through other programs that are separate from public hospitals. That is, there is some potential overlap in the types of services recognised as 'in scope public hospital services' with services delivered by other providers. This means that the IHPA needs to establish whether services are 'related' to public hospitals. This is achieved through requiring that in-scope public hospital services report through a national public hospital dataset.
- Second, the Agreement requires that a primary consideration in determining the scope of eligible public hospital services is whether "the service could reasonably be considered to be a public hospital service during 2010". The way in which this will be tested is to identify whether the service reported through the Public Hospital Establishments Collection in 2010. The Agreement specifies 2010 as the relevant year because Governments wanted to establish a baseline of what were considered public hospital services, prior to the implementation of funding reform for public hospitals.

The IHPA recognises that some non-admitted services (especially community-based services) may not report data on their activity, due in part to the under-development of classifications for ambulatory services. Hence, the IHPA will seek to verify that in-scope, non-admitted, public hospital services identifying as Specialist Outpatient Clinic Services reported *any* data in 2010 through the National Public Hospital Establishments Collection. This may include data on activity, expenditure or staffing.

5. The criteria used to assess eligibility for Commonwealth funding apply to all non-admitted services including mental health and subacute services.

The IHPA has not established separate Criteria or separate sections of a General List for mental health and subacute services. Instead, the Criteria will be used to assess the eligibility of all non-admitted services for inclusion as in-scope public hospital services.

This means, for example, that community-based mental health services will be assessed as in-scope public hospital services if:

1. The service meets the definition of a service event; and

2. It meets the criteria for inclusion as a 'Specialist Outpatient Clinic Service'; or
3. It meets the criteria for inclusion as an 'Other Non-admitted Patient Service'.

As noted above, the Specialist Outpatient Clinic Service listing (see Category A in Box 2) is based on the Tier 2 classification and includes a Specialist Mental Health clinic classification, but requires that such service have been reported in 2010 through the National Public Hospital Establishments Collection. As previously noted, these services can be provided in any setting including in the community. The IHPA's decisions on the scope and pricing of public hospital services are not intended to replace the role of Local Hospital Networks and clinicians to determine the best models of care, including the settings in which care is provided. This principle applies equally for mental health services.

The 'Other Non-admitted Patient Services' listing (see Examples in Box 3) requires that the primary target group for a service must be provision of care in the community described at Category B in Box 2 which is:

1. Directly related to an inpatient admission or an emergency department attendance; OR
2. Intended to substitute directly for an inpatient admission or an emergency department attendance;
OR
3. Expected to improve the health or better manage the symptoms of persons with physical or mental health conditions who have a history of frequent hospital attendance or admission; OR
4. Was reported in the 2010 Public Hospitals Establishment Collection.

6. Not all non-admitted services provided by public hospitals will be included as in-scope public hospital services.

The refinement of the Tier 2 Outpatient Clinic classification, together with the review of non-admitted community based health services, identified that public hospitals provide some non-admitted services that are not generally regarded as 'public hospital services'. This includes, for example, services provided by GP clinics or aged care assessment teams that act as 'gatekeepers' to residential aged care. These services may be provided at a public hospital campus, but they will be funded separately through the Medicare Benefits Schedule or other programs.

The Tier 2 clinics that provide primary care and other non admitted services that the IHPA concludes would not normally be eligible for Commonwealth funding as public hospital services are listed in the Category A section of Box 2.

IHPA will seek advice from jurisdictions as to whether they consider any specific services or programs should be included or excluded from this list of services that IHPA considers not likely to be eligible for Commonwealth funding. Jurisdictions will be asked to justify the inclusion or exclusion of these services against the criteria described in Box 2.

Next steps and future work

The Agreement (Clauses A13-A14) provides that the Criteria and General List can be updated by the IHPA at any time, including revisions to reflect innovations in clinical pathways. Updating of the Criteria and General List may be initiated by the IHPA or may be undertaken in response to requests from the Standing Council on Health or from individual Governments.

The IHPA will consult and publicly release the basis for any changes it makes to the Criteria and General List.

The IHPA will invite jurisdictions to review any proposed services that are currently listed as those that would not normally be considered to be eligible for Commonwealth funding as a public hospital service. IHPA will request that jurisdictions that seek to include or exclude services or programs that are on this list of services to justify their inclusion or exclusion based on the criteria listed in Box 2.

Box 2: Scope of Public Hospital Services and General List of Eligible Services

In accordance with Section 131(f) of the *National Health Reform Act 2011* and Clauses A9–A17 of the Agreement, the scope of “Public Hospital Services” eligible for Commonwealth funding under the AGREEMENT are:

- All admitted programs, including hospital in the home programs. Forensic mental health inpatient services are included as recorded in the 2010 Public Hospitals Establishment Collection.
- All emergency department services.
- Non-admitted services as defined below.

Non-admitted Services

This listing of in-scope non-admitted services is independent of the service setting in which they are provided (e.g. at a hospital, in the community, in a person's home). This means that in scope services can be provided on an outreach basis.

To be included as an in scope non-admitted service, the service must meet the definition of a Service Event which is:

- An interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient’s medical record.

Consistent with Clause A25 of the AGREEMENT, the Independent Hospital Pricing Authority will conduct analysis to determine if services are transferred from the community to public hospitals for the dominant purpose of making those services eligible for Commonwealth funding.

There are two broad categories of in-scope, public hospital non-admitted services:

A. Specialist Outpatient Clinic Services

B. Other Non-admitted Patient Services

Box 2: Scope of Public Hospital Services and General List of Eligible Services (ctd)

A. Specialist Outpatient Clinic Services

This comprises all clinics on the Tier 2 list (see Appendix 1) that were reported as a public hospital service in the 2010 Public Hospital Establishments Collection in terms of their activity, expenditure or staffing.

The following clinics are considered by IHPA to be unlikely to be considered eligible for Commonwealth funding as a public hospital service under Category A: Specialist Outpatient Clinic Services:

- Commonwealth funded Aged Care Assessment (40.02)
- Family Planning (40.27)
- General Counselling (40.33)
- General Practice and Primary Care (20.06)
- Primary Health Care (40.08)

Jurisdictions that consider that there are exceptions where the above services should be included as eligible for Commonwealth funding as a public hospital service will be asked to provide evidence to support their inclusion based on whether the clinic was reported as a public hospital service in the 2010 Public Hospitals Establishment Collection.

B. Other Non-admitted Patient Services

To be eligible, this service must be:

- 1) directly related to an inpatient admission or an emergency department attendance; OR
- 2) intended to substitute directly for an inpatient admission or emergency department attendance; OR
- 3) expected to improve the health or better manage the symptoms of persons with physical or mental health conditions who have a history of frequent hospital attendance or admission; OR
- 4) reported as a public hospital service in the Public Hospitals Establishment Collection 2010.

Jurisdictions will be invited to propose programs that will be included or excluded from Category B “Other Non-Admitted services”. Jurisdictions will be required to provide evidence to support the case for the inclusion or exclusion of services based on the four criteria above, and may draw on the examples listed in Box 3.

For the purposes of clarification, relevant subacute and mental health services may be included under either the Specialist Outpatient Clinic Services category or the Other Non-admitted Patient Services category.

The full list of *Specialist Outpatient Clinic Services* and *Other Non-admitted Patient Services* clinics eligible for Commonwealth funding is provided at Appendix 1.

Box 2: Scope of Public Hospital Services and General List of Eligible Services (ctd)

Appendix 1

Category A - In Scope Tier 2 Clinics List

- 10.01 Hyperbaric Medicine
- 10.02 Interventional Imaging
- 10.03 Minor Surgical
- 10.04 Dental
- 10.05 Angioplasty/Angiography
- 10.06 Endoscopy - Gastrointestinal
- 10.07 Endoscopy- Urological/Gynaecological
- 10.08 Endoscopy- Orthopaedic
- 10.09 Endoscopy - Respiratory/ENT
- 10.10 Renal Dialysis
- 10.11 Medical Oncology (Treatment)
- 10.12 Radiation Oncology (Treatment)
- 10.13 Minor Medical Procedures
- 10.14 Pain Management Interventions
- 20.01 Transplants
- 20.02 Anaesthetics
- 20.03 Pain Management
- 20.04 Developmental Disabilities
- 20.05 General Medicine
- 20.07 General Surgery
- 20.08 Genetics
- 20.09 Geriatric Medicine
- 20.10 Haematology
- 20.11 Paediatric Medicine
- 20.12 Paediatric Surgery
- 20.13 Palliative Care
- 20.14 Epilepsy
- 20.15 Neurology
- 20.16 Neurosurgery
- 20.17 Ophthalmology
- 20.18 Ear, Nose and Throat (ENT)
- 20.19 Respiratory
- 20.20 Respiratory - Cystic Fibrosis
- 20.21 Anti coagulant Screening and Management
- 20.22 Cardiology
- 20.23 Cardiothoracic
- 20.24 Vascular Surgery
- 20.25 Gastroenterology
- 20.26 Hepatobiliary
- 20.27 Craniofacial
- 20.28 Metabolic Bone
- 20.29 Orthopaedics
- 20.30 Rheumatology

Box 2: Scope of Public Hospital Services and General List of Eligible Services (ctd)

Category A - In Scope Tier 2 Clinics List (ctd)

20.31 Spinal
20.32 Breast
20.33 Dermatology
20.34 Endocrinology
20.35 Nephrology
20.36 Urology
20.37 Assisted Reproductive Technology
20.38 Gynaecology
20.39 Gynaecology Oncology
20.40 Obstetrics
20.41 Immunology
20.42 Medical Oncology (Consultation)
20.43 Radiation Oncology (Consultation)
20.44 Infectious Diseases
20.45 Psychiatry
20.46 Plastic and Reconstructive Surgery
20.47 Rehabilitation
20.48 Multidisciplinary Burns Clinic
20.49 Geriatric Evaluation and Management (GEM)
20.50 Psychogeriatric
20.51 Sleep Disorders
30.01 General Imaging
30.02 Medical Resonance Imaging (MRI)
30.03 Computerised Tomography (CT)
30.04 Nuclear Medicine
30.05 Pathology (Microbiology, Haematology, Biochemistry)
30.06 Positron Emission Tomography (PET)
30.07 Mammography Screening
30.08 Clinical Measurement
40.01 Aboriginal and Torres Strait Islander Health Clinic
40.03 Aids and Appliances
40.04 Clinical Pharmacy
40.05 Hydrotherapy
40.06 Occupational Therapy
40.07 Pre-Admission and Pre-Anaesthesia
40.09 Physiotherapy
40.10 Sexual Health
40.11 Social Work
40.12 Rehabilitation
40.13 Wound Management
40.14 Neuropsychology
40.15 Optometry
40.16 Orthoptics
40.17 Audiology
40.18 Speech Pathology

Box 2: Scope of Public Hospital Services and General List of Eligible Services (ctd)

Category A - In Scope Tier 2 Clinic List (ctd)

40.19 Asthma
40.20 Chronic Obstructive Pulmonary (Disease)
40.21 Cardiac Rehabilitation
40.22 Stomal Therapy
40.23 Nutrition/Dietetics
40.24 Orthotics
40.25 Podiatry
40.26 Diabetes
40.28 Midwifery
40.29 Psychology
40.30 Alcohol and Other Drugs
40.31 Burns
40.32 Continence
40.34 Specialist Mental Health

Box 3 Scope of Public Hospital Services and General List of Eligible Services

Category B – Examples of In scope services which are Other Non-admitted Patient Services

Lymphoedema services
Post acute care services
Mental health crisis assessment services
Mental health step down services
Mental health hospital avoidance programs
Chronic disease hospital avoidance programs
Early discharge program services
Falls services
Home Parenteral/Enteral Nutrition services
Community Palliative Care
Other hospital avoidance programs

3. The National Efficient Price for Activity Based Funded Public Hospital Services

3.1 Overview

Setting the National Efficient Price

The national introduction of activity based funding is intended to improve efficiency, as well as making transparent the funding contributions of the Commonwealth, State and Territory Governments for each Local Hospital Network across Australia. To achieve this, the IHPA is required to determine the national efficient price that will be used to calculate Commonwealth payments for in-scope public hospital services that are funded on an activity basis.

The determination of the national efficient price for public hospital services that are funded on an activity basis is the primary function of the IHPA. It is technically complex and has major financial and service delivery implications:

- The national efficient price will directly determine or shape annual expenditure of about \$35 billion, (and rising), by Commonwealth, State and Territory Governments on public hospital services. The Australian Institute of Health and Welfare reported that in 2009/10, the combined recurrent spending by Governments across Australia on public hospital services was \$33.4 billion.¹ Under Clause 8 of the Agreement, States and Territories retain responsibility for planning, funding and delivery of capital, so the national efficient price relates to operating, and not capital, costs.
- The level at which the national efficient price is set influences the ability of public hospitals (that will be funded on an activity basis) to provide accessible and high quality care, as well as impacting on the efficiency, effectiveness and financial sustainability of the public hospital system.

While there are about 750 public hospitals across Australia, many small hospitals in rural and remote areas will be funded on a block grant basis, rather than on an activity basis. Chapter 4 outlines how the IHPA will make decisions from 2013/14 onwards about: which public hospital services will be funded on an activity basis using the national efficient price; which services will be eligible for funding on a block grant basis; and which services will be eligible for funding through a mix of ABF and block grants.

This Chapter is about the public hospital services that will be funded on an activity basis using the national efficient price. It is organised to explain each of the steps, and the decisions taken by the IHPA, in setting the national efficient price, through answering the following questions:

1. What is the purpose of the national efficient price and how will it be used by Governments in funding public hospital services?
2. What are the classification, counting and costing inputs used in setting the national efficient price?
3. What factors are used in setting the level of the national efficient price for public patients?
4. Why does the national efficient price need to be indexed and how will this be done?
5. How is the introduction of new technology allowed for in setting the national efficient price?

¹ Australian Institute of Health and Welfare (2011), *Health expenditure Australia, 2009-10*, Cat. No. HWE 55, Canberra: AIHW. Data are from Table 4.8 for total funding by the Commonwealth, State and Territory Governments on public hospital services in 2009-10.

6. What factors are used in setting the level of the national efficient price for private patients in public hospitals?
7. How will the national efficient price be adjusted for legitimate and unavoidable variations in the costs of public hospital services?
8. How could quality, best practice pricing and normative pricing be considered in setting the national efficient price in the future?

This chapter begins by first providing some general background on: the legislative/intergovernmental agreement basis and the inputs to decision making that underpin the determination of the national efficient price. This is followed by examination and identification of the IHPA's decisions on each of the individual elements that make up the determination of the national efficient price. This incorporates background information on the policy drivers, and further detail on the legislative/intergovernmental basis and the decision-making process. This additional background information is included to support an understanding of the IHPA's decisions on some of the more complex elements of the national efficient price (such as indexation, price adjustments and pricing of private patients in public hospitals).

Provisions of the Act and/or the Agreement

The Act (Clause 131(1)) identifies several functions of the IHPA that are particularly relevant to determining the national efficient price including:

- "To develop and specify classification systems for health care and other services provided by public hospitals";
- To determine data requirements and data standards to support uniform provision of data, including standards relating "to patient demographic characteristics and other information relevant to classifying, costing and paying for public hospital functions"; and
- "To determine adjustments to the national efficient price to reflect legitimate and unavoidable variations in the costs of delivering health care services".

The Agreement provides further specification of the approach to be used by the IHPA in determining the national efficient price. In particular, the Agreement indicates that the IHPA will:

- Undertake "empirical analysis of data on actual activity and costs in public hospitals, taking account of any time lag and the cost weights to be applied to specific types of services" (Clause B3(d));
- 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" (Clause B12(a)) and "to the need for continuity and predictability in prices" (Clause B12(d));
- "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" (Clause B12(e));
- Determine "the national efficient price that will apply to eligible private patients receiving public hospital services (Clause B3(l)), with the methodology to be based on excluding or reducing the components of the service for private patients which are covered through other funding sources (Clause A41);
- Determine adjustments to the national efficient price that "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” (Clause B13); and

- Develop “projections of the national efficient price for a four year period, updated on an annual basis and providing confidential reports on these projections to the Commonwealth and States” (Clause B3(h)).

Approach used by the IHPA

There have been multiple streams of work undertaken by the IHPA (and prior to the IHPA’s establishment, by the Health Reform Transition Office in the Commonwealth Department of Health and Ageing) to assemble the ‘building blocks’ that are required to determine the national efficient price. This work has been undertaken in partnership with the Commonwealth, State and Territory Health Departments.

In summary, the major areas of work informing the determination of the national efficient price comprise:

- **Developing and refining classifications:** Building on the work carried out in prior National Partnership Agreements, this has included:
 - Refinements to AR-DRG Version 6.0 to address known issues introduced in moving from Version 5.2;
 - Undertaking a comprehensive review to update, expand and introduce enhanced specifications into the Tier 2 outpatient classification; and
 - Reviewing, refining and implementing the Urgency Related Groups classification for emergency departments, including review by the IHPA’s Clinical Advisory Committee.
- **Improving and verifying the robustness of costing data:** This has included:
 - The development of the Australian Hospital Patient Costing Standards;
 - The development of an associated Quality Framework, with particular emphasis on reconciliation of in scope expenditure in the first instance; and
 - Resubmission of 2009/10 cost data by States and Territories where necessary to ensure better national consistency.
- **Developing the funding model:** This has included:
 - Extensive consultation with Commonwealth, State and Territory Governments on the desired outcomes of the model, and the high level parameters (for example the outlier policy);
 - An iterative approach to developing cost weights, price adjustments and other outputs of the model;
 - Extensive peer review of the resulting outputs of the model; and
 - Independent verification of the veracity of the model.
- **Reviewing options to index cost data:** This has included:
 - Review of historical approaches and proposals for cost indexation under previous Australian Health Care Agreements;
 - Assessment of existing and potential new indices with the Australian Bureau of Statistics and the Australian Institute of Health and Welfare; and
 - Commissioning independent analysis of the options and financial impact of different approaches to indexation.
- **Analysing variations in the costs of public hospital services to identify the basis for adjustments to the national efficient price:** This has included:
 - Identification of cost variations in the provision of public hospital services for Indigenous patients, patients from rural and remote locations and patients accessing specialist paediatric services; and
 - Undertaking analyses to determine whether there are empirical differences in the costs of providing public hospital services related to other factors including location and hospital type.

- **Identifying and modelling options for adjusting the national efficient price for private patients:** This has included:
 - Analysis of the National Hospital Cost Data Collection to identify adjustments at the level of cost buckets based on the availability of revenue streams for private patients through the Commonwealth Medical Benefits Scheme and private health insurance;
 - Calculation of adjustments to the national efficient price for private patients at the DRG level that take into account different rates of utilisation of prostheses, length of stay and state-specific default benefits; and
 - Modelling of the impact of ABF pricing on private patient utilisation of public hospitals.

This technical work was undertaken in parallel with the consultations and submissions that provided feedback on approaches to setting the national efficient price.

3.2 Purpose and use of the national efficient price

The IHPA affirms that the national efficient price has two important purposes:

1. The national efficient price is one of the major determinants of the level of Commonwealth funding on public hospital services; the other factor determining Commonwealth expenditure is the volume of public hospital services provided.
2. The national efficient price provides a price signal or benchmark about the efficient cost of providing public hospital services. This price signal is an important driver of change:
 - It allows states in their capacity as system managers to determine the level of state funding provided and the approaches that will be implemented to support public hospitals in improving efficiency.
 - It encourages Local Hospital Networks and public hospitals to benchmark their cost structure against the efficient cost of providing public hospital services and so identify options for improvement.
 - It promotes transparency so that States and Territories, Local Hospital Networks and public hospitals can make choices (within the context of state health plans and service agreements) about the range of public hospital services they provide, the models of care and the settings in which care is provided that are consistent with accessible, equitable and high quality public hospital services provided on an efficient basis.
 - It promotes transparency so that all Governments and health service providers can make choices about the optimal level and relative mix of investment in public hospital services, primary health care services and other health services that is consistent with focussing on health outcomes and a balanced investment across the continuum of care including prevention and early intervention.

The first role of the national efficient price – determining Commonwealth funding for public hospital services – will operate differently in 2012/13 and 2013/14, compared to subsequent years. These funding arrangements are specified in the Agreement and are not a matter for interpretation by the IHPA; they are presented here for information purposes only. The national implementation of ABF will be staged as follows:

- In 2012/13 and 2013/14 the quantum of Commonwealth funding for public hospital services for each State and Territory will be fixed at the level specified in the National Healthcare specific purpose payment. This means that in 2012/13 and 2013/14:
 - Total Commonwealth funding for public hospital services will not vary according to the volume of services provided; but instead
 - The Commonwealth funding will be expressed as a share of the national efficient price.

- The Commonwealth's share of the national efficient price will vary across States and Territories (it will not be a fixed share such as 40%) because there are different rates of, and expenditure on, utilisation of public hospital services across Australia.
- From 2014/15 onwards, the Commonwealth funding for public hospital services funded on an activity basis moves from a 'capped' basis (a known quantum of funding) to an 'uncapped' basis (funding will vary in response to changes in activity and the cost of public hospital services as represented through the national efficient price). The approach and formulae used to calculate Commonwealth funding from 2014/15 onwards are specified in the Agreement (Clauses A3, A5, A34-A40, and A67-A79). In simple terms:
 - In 2014/15 to 2016/17 the Commonwealth will pay 45% of the national efficient price for 'growth' in the volume of services relative to the previous year.
 - In 2014/15 to 2016/17 the Commonwealth will also recognise changes in the national efficient price. It will pay a price adjustment calculated by multiplying the previous year's volume of services by the change in the national efficient price relative to the previous year multiplied by 45%.
 - From 2017/18 onwards, the growth in volume and price adjustments will use a rate of 50%, rather than 45%.

While the national efficient price determines Commonwealth funding for public hospital services, it does not require the States and Territories to fund at the national efficient price. Under the Agreement (Clauses A59-A66), States and Territories have autonomy as to the level of funding they choose to invest in public hospital services. States and Territories "meet the balance of the cost of delivering public hospital services and functions over and above the Commonwealth contribution". States and Territories may choose to provide a higher or lower share of the national efficient price.

The outcome of these different funding approaches by the Commonwealth, State and Territory Governments is that Local Hospital Networks will not necessarily be paid at the national efficient price. The 'price' or payment that Local Hospital Networks receive will be the sum of:

- The Commonwealth share of the national efficient price (fixed in 2012/13 and 2013/14, and varying in subsequent years depending upon whether activity is 'baseline' or 'growth' activity); and
- The State and Territory contribution towards funding public hospital services.

The IHPA's decision

Within this context of the important role of the national efficient price as a price signal, the IHPA has developed a definition of the national efficient price.

The IHPA has endorsed the following definition that sets out its expectations about the operation of the national efficient price:

A public hospital service operating at the national efficient price will:

- be able to provide episodes of patient care (on average, across all types of care, as measured using agreed classifications) and other services (including teaching, training and research) at or below the national benchmark price;
- be able to respond to evidence based initiatives to improve patient care including new technologies;
- be able to provide services at a quality level consistent with national standards, and to minimise negative consequences that fall on patients (including those attributable to poor quality and safety) or on other parts of the service system; and
- be able to make choices about how best to deliver services to ensure that people receive the 'right care at the right time in the right setting'.

In adopting this definition, the IHPA is seeking to convey that:

- The national efficient price is a benchmark of efficiency. It is not the price at which public hospital services can be provided most cheaply or the lowest price;
- The national efficient price is the price that allows for the provision of public hospital services at a quality level consistent with national standards. It is not the price at which public hospital services can be provided with no regard for the quality and safety with which those services are delivered;
- The national efficient price will move in response to changes in how care is delivered. The 'value' of the national efficient price will not be eroded over time; instead it will move in response to changes in the costs of delivering public hospital services.
- The national efficient price will provide a price signal that will allow choices to be made by Governments, by Local Hospital Networks, and by public hospitals about how best to provide public hospital services.

3.3 Classifications, counting and costing inputs

In determining the national efficient price for activity based funded services, the IHPA must first specify the classifications, counting rules, data and coding standards, and the methods and standards for costing data.

The IHPA undertakes the data functions delegated to it under the Agreement in accordance with nationally agreed standards for the collection and management of data. The IHPA will use existing data standards and definitions contained in METeOR (the repository for national metadata standards for the health, community services and housing assistance sectors that is maintained by the Australian Institute of Health and Welfare). To the extent that the IHPA develops new dataset specifications, these will be available through METeOR.

The IHPA's decision

The IHPA has determined that the following classifications, counting unit and costing data will be used in setting the national efficient price in 2012/13.

The classifications are:

- Admitted patient services: Australian Refined Diagnosis Related Groups Version 6.X;
- Emergency department services: Urgency Related Groups Version 1.2 (for recognised emergency departments at Levels 3B-6) and Urgency Disposition Groups Version 1.2 (for recognised emergency departments at Levels 1-3A); and
- Non-Admitted Patient Services: Tier 2 Outpatient Clinics Definitions Version 2.0.

The counting unit (that is used to express the price weights) is the National Weighted Activity Unit (Version 2012/13), described as NWAU (12).

The costing data used in setting the 2012/13 efficient price is the National Hospital Cost Data Collection Round 14 (2009/10 data). Public Hospital Expenditure Data is also used to give additional confidence in the NHCDC data where possible.

The costing of public hospital services that are delivered in 2012/13 (NHCDC Round 17) will use the Australian Hospital Patient Costing Standards Version 3.0.

Further information and explanation is provided on each of these three elements.

Classifications

- The IHPA has specified three classifications to take effect from 1 July 2012. This is in accordance with the agreement by Governments that the implementation of ABF would commence on 1 July 2012 with admitted acute services, emergency department services and non-admitted patient services (Clause 14(e)(i) of the Agreement).
- These classifications have been developed and/or refined in collaboration with the Commonwealth, State and Territory Health Departments.
- Further work will be undertaken (see below) to develop additional classifications for other public hospital services and functions that are scheduled to be funded on an activity basis in 2013/14 or later.

Counting unit (the National Weighted Activity Unit)

- The National Weighted Activity Unit (NWAU) is the 'currency' that is used to express the price weights for all services that are funded on an activity basis. It does not replace the classifications that are used to describe activity (such as AR-DRGs) and it serves a different purpose to these classifications. The classifications used in ABF provide groupings of services for which there is reasonable homogeneity of costs whilst maintaining clinical relevance.
- In contrast, the NWAU is a single measure that allows Local Hospital Networks to understand the price relativities of different types of public hospital services such as inpatients, emergency departments and non-admitted services. Box 4 provides further information on the construction of the NWAU.
- The NWAU is the tool that operationalises the last point of the definition of the national efficient price, namely, that Local Hospital Networks will "be able to make choices about how best to deliver

services to ensure that people receive the ‘right care at the right time in the right setting’”. It does this because it allows Local Hospital Networks to see the price that they will receive for providing similar services in different modes or settings (for example, an inpatient dialysis admission, a non-admitted dialysis service or a home-based dialysis service). The NWAU allows for models of care to evolve and for services to shift from hospitals to community-based settings.

Box 4.: Construction of the NWAU

1. The National Weighted Activity Unit (NWAU) is the unit that is used for setting the national efficient price.
2. The Reference Price for 1 NWAU is set on the basis of inpatient costs. The relativities for each of the AR-DRGs are determined from the pool of costs for all inpatient services.
3. The NWAU is also used to express the national efficient price of emergency department and non-admitted services. It is the same measure that is used for inpatient services, so that all public hospital services are arrayed along one continuous scale. For example:
 - The AR-DRG for amputation of a limb has an NWAU weight of 4.8387;
 - The Urgency Related Group for a non-admitted emergency department visit for a Triage 1 presentation has an NWAU weight of 0.2203; and
 - The Tier 2 clinic category for a general medical outpatient service has an NWAU weight of 0.0588.
4. While emergency department and non-admitted services are expressed using NWAU, the relativities for each of the emergency department services and the non-admitted services are determined within the respective pool of costs for each of these services. It ensures internal consistency of relativities within the respective pool of costs for each type of service.
5. The example illustrates that the NWAU is not a weighted aggregate or composite measure that puts different types of services together in one measure. Instead, the NWAU is a scale that expresses the relative weights of each public hospital service.
6. The NWAU will be used to express the national efficient price for all services funded on an activity basis.
7. This means that, in the future, the national efficient price of mental health services and subacute services will be expressed in terms of NWAU. These services will still have their own classifications, in the same way that acute inpatient services are classified using AR-DRGs. The calculation of the cost relativities for new services that are moved to funding on an ABF basis will be done within the pool of costs for each type of new service, such as subacute services or mental health services.
8. The NWAU will be updated annually. The NWAU will be named to reflect the year of its operation. This means that in 2012/13, the NWAU will be called NWAU (12). In 2013/14, the NWAU will be called NWAU (13), and so on.
9. The annual updating of the NWAU is required to set a new national efficient price each year that reflects annual changes in the costs of public hospital services.

Costing data

- The costing data that will be used to set the national efficient price are annual cost data from the National Hospital Cost Data Collection. The national efficient price will be set each year using the most recent available data. As there is currently a three-year time lag in the production of the NHCDC data, the 2012/13 national efficient price will be set using 2009/10 cost data that will be indexed to reflect estimated costs in 2012/13. The approach to indexation is outlined in Section 3.5.

Next steps and future work

In 2012/13 the IHPA will undertake further work on classifications as follows:

Subacute services

- In 2011 a review was undertaken of national and international approaches to the classification of subacute services. This work included an examination of cost drivers of subacute care and factors that might improve the predictive capacity of current subacute classifications. A draft Data Set Specification for subacute services has also been developed. Preliminary work has also commenced on approaches to counting and classification of non-admitted subacute services.
- In 2012/13 the IHPA will lead further work on subacute classifications, in partnership with States, Territories and the Commonwealth, in order to meet the 1 July 2013 target date for implementation of activity based funding for subacute services.
- Under the Agreement, the IHPA is required to implement the outcomes of bilateral agreements between the Commonwealth and the States and Territories over the proportion of Commonwealth funding that is provided on a block funding basis in 2012/13. The IHPA has been advised that these bilateral agreements have resulted in some States and Territories agreeing with the Commonwealth to utilise activity based funding for some components of subacute services in 2012/13. Given this outcome, the IHPA will price these components of subacute services that are to be funded on an activity based funding basis in 2012/13.

Mental health services

- In 2011 preliminary work was undertaken to identify the different mental health data collections operating in each State and Territory. Individual States and Territories also provided information on their different approaches to funding mental health services. There is not yet national consistency in the classification and funding of mental health services.
- Prior to the development of an agreed classification for mental health services, the existing AR-DRG (inpatients) and Tier 2 (non-admitted services) classifications were modified to allow counting, on an interim basis only, of some mental health services using these classifications.
- The Agreement states that the implementation of activity based funding for mental health services will commence from 1 July 2013.
- The IHPA will initiate discussions in the first half of 2012 with relevant groups (including the National Mental Health Commission, the Mental Health Council of Australia and other stakeholders) to identify a process and feasible timeframe for the development of a mental health classification that can be used as the basis of funding mental health services on an activity basis.
- Under the Agreement, the IHPA is required to implement the outcomes of bilateral agreements between the Commonwealth and the States and Territories over the proportion of Commonwealth funding that is provided on a block funding basis in 2012/13. The IHPA has been advised that these bilateral agreements have resulted in some States and Territories agreeing with the Commonwealth

to utilise activity based funding for some components (acute admissions, emergency attendances, outpatients) of mental health services in 2012/13. Given this outcome, the IHPA will price these components of mental health services that States and the Commonwealth have bilaterally agreed are to be funded on an activity based funding basis in 2012/13.

Teaching, training and research

- The IHPA will initiate discussions early in 2012/13 with relevant groups (including Health Workforce Australia, the National Health and Medical Research Council, Medical Deans Australia and New Zealand, the Committee of Presidents of Medical Colleges, the Royal College of Nursing Australia and other stakeholders) to develop a work program on approaches to the classification and costing of teaching, training and research activities undertaken within public hospitals. This work is required in order to provide advice to Health Ministers on the feasibility of transitioning funding for teaching, training and research from a block grant to activity based funding or another method that reflects activity volumes by no later than 30 June 2018 (Clause A49, Agreement).

3.4 Setting the level of the national efficient price for public patients

Having determined the classifications, counting and costing data, the critical question is the approach to setting the level of the national efficient price. The IHPA has to decide what degree of efficiency it wants to encourage in the provision of public hospital services through how it sets the benchmark for the national efficient price.

In making this decision, the IHPA has considered and balanced three of the Pricing Guidelines, namely:

- **Timely-quality care:** Funding should support timely access to quality health services. In other words, the national efficient price should support public hospital services being widely accessible, in a manner that allows care to be provided at the right time and at a quality level that meets national standards.
- **Fairness:** ABF payments should be fair and equitable. The Agreement indicates that the IHPA should “consider the actual cost of delivery of public hospital services in as wide a range of hospitals as practicable” (Clause B12(b)). A cost-based approach to pricing that recognises the actual costs incurred in the provision of public hospital services across a wide range of hospitals helps ensure fairness and equity of funding. However, there is considerable variation across hospitals in the cost of delivering public hospital services. Setting the national efficient price at about the middle of the distribution of costs (known as pricing at the ‘central tendency’) is fair: it values the efforts of hospitals that are able to provide public hospital services at lower than average costs and it creates an incentive for hospitals that are currently operating at higher than average costs.
- **Efficiency:** ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services. In setting the national efficient price, the IHPA needs to balance short-term improvements in efficiency with the need to ensure the ongoing provision of a network of hospital services. It has to ‘set the pace’ of how fast or how slowly efficiency improvements can reasonably be expected. The Agreement requires that in setting the national efficient price, the IHPA must consider “the financial sustainability of the public hospital system” and the “need for continuity and predictability in prices” (Clause B12). The IHPA also acknowledges that while considerable effort has been invested in improving and validating the NHCDC costing data, the costing data may not fully reflect the actual cost experience of all public hospitals. These factors suggest that, in the first instance, a conservative approach to price-setting is warranted in order to monitor the impact of the national implementation of ABF.

The IHPA's decision

The IHPA has decided to set the national efficient price using a measure of central tendency in 2012/13 and 2013/14.

The IHPA has determined that the national efficient price for 2012/13 will be set on the basis of the average cost per weighted separation (arithmetic mean).

The IHPA has determined that the national efficient price of an NWAU (12) is \$4,808.

The IHPA will review the impact of average pricing in 2012/13 and 2013/14, with a view to refining the benchmark used to set the national efficient price from 2014/15.

The decision to set the 2013/13 national efficient price on the basis of the average cost per weighted separation is underpinned by analysis of the distribution of public hospital costs. This analysis indicated that the median cost/weighted separation was ~80% of the mean cost per weighted separation. This wide variation between the median and the mean cost per weighted separation is a function of the skewed distribution of public hospital costs and, in particular, the very high costs associated with small numbers of patients. The costs of the patients are often not due to inefficiency, but reflect the cost of providing care to the sickest and most complex patients in the public hospital system. Due to this skewed distribution of public hospital costs, the mean is preferred over the median as it provides a fairer representation of the actual costs experienced by most hospitals.

Further technical information on the calculation of the national efficient price is available in The National Efficient Price Determination 2012-2013 on the IHPA website.

Next steps and future work

The decision to commence the national implementation of ABF with pricing at the central tendency is based on judgement about balancing several policy objectives outlined previously. It also reflects the following factors:

- The national implementation of ABF is the most significant reform to public hospital financing since the introduction of Medicare. There are major change management challenges for all levels of the health system including States and Territories, Local Hospital Networks, public hospitals, and clinical and management staff. Some states have extensive experience of ABF and well-developed hospital payment systems. Some do not. No State or Territory has experience in operating under a national ABF system.
- The capacity of activity based funding to generate efficiencies in the cost of providing public hospital services is contingent on an understanding by Local Hospital Networks of their cost structures relative to the benchmark set through the national efficient price. The important first step in ABF implementation is about introducing transparency of pricing and creating an incentive to better understand the factors driving the cost structure of providing public hospital services. That is why the Agreement incorporates an initial 'no change to existing funding' scenario at the aggregate level of each State and Territory. The first two years – 2012/13 and 2013/14 – are transition years, intended to provide an opportunity for all participants to learn how to operate under a national ABF framework.

- However, this ‘funding guarantee’ does not apply at the level of individual Local Hospital Networks. The experience of Local Hospital Networks in 2012/13 and 2013/14 will depend upon where their costs sit in regard to the benchmark of the national efficient price. Most importantly, it will depend upon the level at which each State and Territory chooses to set its funding contribution for public hospital services.

The situation changes in 2014/15 when Commonwealth funding is effectively uncapped and the national implementation of ABF goes ‘live’. The IHPA believes that it would be opportune to review the benchmark used to set the national efficient price at this time. Without being exhaustive, some of the factors that the IHPA will seek to assess and to understand through this review include:

- How the distribution and level of costs of public hospital services has changed following the national implementation of ABF;
- How States and Territories have intervened to mitigate, heighten or otherwise influence the payments received by Local Hospital Networks through setting the level of the State contribution for funding of public hospital services;
- Whether there have been, or are estimated to be, changes to the scope and volume of public hospital services funded on an activity basis; and
- Whether there is improved confidence in the robustness of the costing data that is used to set the national efficient price.

The IHPA is foreshadowing that it will review the approach to setting the level of the national efficient price in 2013/14, prior to setting the national efficient price for 2014/15. This review will need to consider how to factor in the existing 2.5 to 3 years time lag in accessing national cost data through the National Hospital Cost Data Collection, as well as options for evaluating each of the factors identified above. This review would incorporate consultations with Governments, other stakeholders and the public.

3.5 Indexation and projections of the national efficient price

In setting the national efficient price, the IHPA must deal with the inevitable delay in provision of the actual cost of public hospital services. Currently, the most recent available data on the actual costs of public hospital services are from the 2009/10 National Hospital Cost Data Collection. This means that to set the national efficient price, the IHPA has to index the 2009/10 cost data to reflect expected 2012/13 prices.

Approach used by the IHPA

The selection of a suitable index involved consultation with technical experts and review of historical and existing approaches to indexation including:

- Previous approaches to cost indexation under the Australian Health Care Agreements were examined. This included reviewing independent reports, as well as reports produced by Governments that compared different options for indexing the costs of public hospital services.
- Consultations were held with technical experts at the Australian Bureau of Statistics on index construction and at the Australian Institute of Health and Welfare (AIHW) on hospital expenditure data. Independent advice was also commissioned on approaches to the development of indices that were specific to public hospital costs, given that published indices combine cost data for public hospitals and nursing homes.
- In association with independent advice, the IHPA developed an index using cost data from the National Hospital Cost Data Collection. This was validated against a similar index able to be

constructed from the AIHW's health expenditure database and results were also compared against published indices including the Consumer Price Index.

The IHPA's decision

The IHPA has decided to use a hospital output cost index that is derived from the National Hospital Cost Data Collection to index 2009/10 costs to derive the 2012/13 national efficient price.

The cost index is based on a 5.1% annual growth in the cost/weighted separation of public hospital services.

There are some important issues involved in the selection and application of this index as follows.

Index selection

- The selection of an index involves weighing up the relative priority that should be given to features such as transparency, stability and the validity with which an index accurately represents cost increases.
 - The index developed by the IHPA is not as transparent as indices published by the Australian Bureau of Statistics (such as the Consumer Price Index). As it is a new index, the IHPA will be publishing details of its construction to foster transparency and understanding about this index.
 - An assessment of trends in cost data from the National Hospital Cost Data Collection indicates that these data are relatively stable, which is a desirable characteristic for an index.
 - The most important factor contributing to the IHPA's decision is that the index uses the same cost data that are being used to set the national efficient price. The reality is that if the NHCDC data had a shorter time lag in their production, the price would be set using exactly the same data that are now being used to construct the index. The use of the NHCDC cost data to develop the index, as well as the price, creates an internal consistency. It also has important implications, as will be discussed below, for reconciliation of the national efficient price to reflect actual, rather than estimated, costs.

Index application

- The 2012/13 national efficient price of \$4,808 for an NWAU (12) has been based on, and already includes, the application of a 5.1% annual growth in the cost/weighted separation, to index 2009/10 costs to 2012/13 prices.

Next steps and future work

The IHPA will provide, by 30 June 2012, confidential reports to the Commonwealth, State and Territory Governments on projections of the national efficient price for the next four years, as required under the Agreement (Clause B3(h)). This process is separate to the annual calculation of the index that is used to convert historical costs to current prices due to the delay in the availability of the NHCDC costing data.

3.6 Incorporating new technology in the national efficient price

One of the Pricing Guidelines adopted by the IHPA specified that the "pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the model of care that improve patient outcomes". However, there are several factors that might work against this outcome including:

- The time lag in the National Hospital Cost Data means that the national efficient price will be set based on the technology and model of care that were in operation two to three years ago.
- It may take some time for new technology and innovations in care delivery to be adopted more broadly, and for their costs to be routinely captured, in national costing data. Similar issues apply to the updating of ABF classifications such as AR-DRGs.

The implementation of activity based funding based on the NHCDC clearly creates a strong incentive for Local Hospital Networks to improve the recording, allocation and completeness of costing data, so that it accurately represents the real costs of providing public hospital services. It may also create an incentive for more timely submission and completion of the NHCDC data.

The IHPA recognises that there are parallel national and state-based processes for the evaluation of new technology. Some State and Territory Governments fund new technology outside existing activity based funding arrangements, as part of piloting and evaluating the more widespread introduction of new technology into their public hospitals. States have also used ‘rapid review’ type processes, with clinical feedback on new technology and changing models of care feeding into updates to activity based funding models.

The IHPA expects that these existing technology evaluation and supplementary funding mechanisms will continue. The IHPA’s core function is the pricing of public hospital services and it was not established to take on a major technology evaluation role.

However, the IHPA’s Clinical Advisory Committee has an important ‘watching brief’ on new technology. The Clinical Advisory Committee is established under the Act to “advise the Pricing Authority in relation to developing and specifying classification systems for health care and other services provided by public hospitals”. Hence, the IHPA has access to clinical expertise and can consider the extent to which classifications and costing are reflective of new technology and changing models of care.

The IHPA’s decision

The IHPA, through its Clinical Advisory Committee, will monitor the potential impact of new technology and innovations in the model of care that have not yet been incorporated in the costing of public hospital services. This will be informed by existing national and state-based approaches for technology evaluation.

Next steps and future work

The IHPA, with the input of its Clinical Advisory Committee, will identify the best approach to monitoring and reviewing new technology and changes in models of care that might materially impact on the national efficient price.

3.7 Setting the level of the national efficient price for private patients in public hospitals

Provisions of the Act and/or the Agreement

The Agreement recognises that the IHPA will set a separate price for private patients in public hospitals, in acknowledgement of the fact that some of the costs of these patients are funded through other sources including private health insurance and Commonwealth programs such as the Medicare Benefits Schedule. The concept embodied in the Agreement is that of a ‘discounted’ national efficient price for private patients in public hospitals, based on adjusting the national efficient price for public patients to remove funding received via these other funding sources (Clause A41).

It is important to be clear that what is being discussed in this section is the national efficient price (and hence the level of the Commonwealth funding contribution) for private patients in public hospitals. The methodology outlined below has no bearing on the ‘price’ or daily charges paid by patients, nor does it impact on the ‘price’ paid by private health insurers (the so-called ‘default benefit’) when their members use public hospitals as private patients. The national efficient price for private patients in public hospitals will only determine the level of Commonwealth Government funding for private patients.

Clauses A6 and A7 in the Agreement are also relevant to decisions about the pricing of public hospital services for private patients. Clause A6 outlines the ways in which the Commonwealth Government supports private health services through the MBS, the PBS and the private health insurance rebate. Clause A6 then goes on to state that “Subject to any exceptions specifically made in this Agreement or through variation to this Agreement, the Commonwealth will not fund patient services through this Agreement if the same service, or any part of the same service, is funded through any of these benefit programs or any other Commonwealth programs”. In lay terms, the policy intent of this clause is that the Commonwealth Government will not pay twice for the same service through different funding streams.

Clause A7 then lists the specific payments that constitute legitimate exceptions to the operation of Clause A6 as follows:

- Two of the exceptions are for Commonwealth payments that specifically relate to private inpatients, namely, MBS payments for services “provided to eligible admitted private patients in public hospitals” and the default bed day rate supported through the private health insurance rebate.
- One of the exceptions is for MBS payments made by the Commonwealth in relation to non-admitted services in small rural hospitals. Under Section 19(2) of the *Health Insurance Act 1973*, the Commonwealth makes MBS payments for primary care services provided in small rural hospitals.
- The fourth exception is for PBS benefits dispensed under “Pharmaceutical Reform Arrangements agreed between the Commonwealth and the relevant State”. Pharmaceutical Reform refers to bilateral agreements in place between some States and the Commonwealth Government which extends access to the PBS to admitted public and private patients on discharge from hospital, non-admitted patients and certain chemotherapy pharmaceuticals.

The intent of Clause A7 is that the Commonwealth may make multiple payments through different programs (i.e. the Agreement and the MBS/PBS/private health insurance rebate) for the same service, or any part of the same service only in the context of the listed exceptions. The interpretation of these clauses is discussed later. For now, it is worth noting that there are no specific exceptions listed in Clause A6 that relate to MBS payments made for private non-admitted services in public hospitals.

Finally, in setting the national efficient price for private patients in public hospitals, the IHPA is required under the Agreement (Clause B3(l)(i)) to consider any advice from Heads of Treasuries.

Policy drivers underpinning the IHPA's decision

The policy context in which the IHPA is setting the national efficient price for private patients in public hospitals is a 'no change', or 'business as usual' scenario regarding private patients. In other words, the key parameters that influence the use of public hospitals by private patients remain unchanged including:

- Under the Medicare principles, patients can choose to be treated as public or private patients in public hospitals, irrespective of their health insurance status.
- States and Territories set the level of fees payable by private patients in public hospitals, while the Commonwealth Government sets the default benefit payable by private health insurers.
- Commonwealth, State and Territory Governments continue to meet some of the costs of private patients in public hospitals (through the mechanism of the national efficient price from 2012/13), while some costs are met by private health insurers and through the MBS.

However, the national implementation of ABF is expected to change the incentives faced by Local Hospital Networks, particularly from 2014/15 when Commonwealth funding is uncapped. It is important to note that the national implementation of ABF applies equally to public and private patients in public hospitals. This means that:

- States and Territories and Local Hospital Networks will jointly make decisions through service agreements about the range and volume of public hospital services to be provided including the share of public and private patients.
- States and Territories have autonomy under the Agreement (Clause A65) to determine the level of the payment they make towards the costs of public hospital services for public and private patients. This means that States and Territories remain free to use funding initiatives to either encourage or discourage the provision of services to private patients in public hospitals.

Approach used by the IHPA

The IHPA used the following approach to determine the national efficient price for private patients in public hospitals:

- Following the release of a Discussion Paper, consultations were held with, and submissions received from, major stakeholders including private health insurers, private and public hospitals and Governments. This feedback was assessed and considered in the development of the pricing methodology.
- The IHPA commissioned a study to assess the potential impact on private patient utilisation of public hospitals under the national implementation of ABF. This study was not able to definitively rule in or out changes to the utilisation of public hospitals by private patients. The outcome will depend upon the behaviour of the many different agents – State Governments, Local Hospital Networks, doctors and patients – who will be involved in, or impacted by, the national implementation of activity based funding.
- The IHPA undertook extensive analysis of the NHCDC cost data to understand the robustness with which it captured costs for private patients, including alternative funding sources. The Australian Hospital Patient Costing Standards require that costing data submitted to the NHCDC should represent the total cost to the hospital of the treatment of patients, regardless of their election status as private or public patients.

The IHPA's decision

The IHPA will calculate the national efficient price for private patients in public hospitals so that the total revenue (including activity based funding, MBS and private health insurance payments) available to a hospital is equivalent to the national efficient price for public patients.

The IHPA has decided that the determination of the national efficient price for private patients in public hospitals will incorporate state-specific default benefits.

The IHPA does not consider private non-admitted services (privately referred clinics) to be eligible for activity based funding as public hospital services, when there is a payment under the MBS, the PBS, private health insurance or any other Commonwealth program. However, the IHPA has decided that other services for these patients (that constitute separate service events such as allied health services) are public hospital services that will be funded under activity based funding as these services are not able to be funded privately.

Further explanation of these decisions is provided below.

Pricing of private patients

- Further technical information on the calculation of the national efficient price for private patients in public hospitals is available on the IHPA website.
- The calculation is based on the NHCDC. There are three major categories of private patient revenue that are factored into the calculation of the national efficient price for private patients in public hospitals:
 - Prostheses, pathology and imaging costs: the actual costs of these services are removed.
 - Medical costs: some of the costs of medical services are retained in the calculation of the national efficient price for private patients. This recognises that the costs of junior medical staff are not funded through the MBS and therefore need to be included in the activity based funding payments.
 - Default benefits payable by private health insurers: the national efficient price is calculated through deducting state-specific default benefits. This recognises that there is considerable variation across States and Territories in the level of default benefit payable by private health insurers. The deduction is undertaken on the basis of actual length of stay for each patient. A deduction based on the average length of stay would penalise Local Hospital Networks that had a lower than average length of stay.
- The outcome of these steps is a set of private patient adjustments to the price weights that then determines the national efficient price for private patients in public hospitals. These price weights are included in the National Efficient Price Determination 2012-2013.
- In developing this methodology, the IHPA is aware of arguments about whether the price should be calculated based on deducting 'actual costs' or 'theoretical revenue'. For example, it has been suggested that public hospitals may incur lower costs for prostheses through bulk purchasing arrangements than the benefits payable by private health insurers for prostheses. The IHPA has adopted a pragmatic approach that is grounded in using the available data to determine the price for private patients as follows. The deductions for prostheses, imaging, pathology and medical costs are based on the actual costs of these services as reported through the NHCDC. The adjustment for default benefits is based on published state-specific default benefits. This approach assumes that Local Hospital Networks charge and receive the full revenue available through default benefits. The IHPA recognises that some Local Hospital Networks may currently waive some revenue attributable to

private patients. This is a matter for Local Hospital Networks. It is neither possible, nor desirable, for the IHPA to attempt to incorporate these local factors into the determination of the national efficient price for private patients in public hospitals.

- The same principle applies to MBS revenue. The IHPA is aware of arguments that MBS revenue should not be deducted off the national efficient price as it is not 'available' to Local Hospital Networks. The nature of private practice arrangements, including the extent of any facility fees, is a matter for States and Territories, Local Hospital Networks and clinicians. It is not the intent of the IHPA to incorporate these local arrangements into the determination of the national efficient price for private patients in public hospitals.

Non-admitted private patients

- In responding to the consultation and submission feedback, the IHPA has been required to reach a decision on whether there will be any payments through activity based funding for private non-admitted services. In practical terms, this discussion is about private 'outpatient' services, where States and Territories and Local Hospital Networks have taken decisions to bill medical (and sometimes pathology and imaging) services against the MBS. It is not generally an issue about private 'emergency department' services.
- In reaching this decision, the IHPA has considered the wording and the intent of Clauses A6, A7 and A41 of the Agreement. The IHPA recognises that Clauses A6 and A7 provide specific directions for the IHPA to exclude privately referred non-admitted services that receive a Commonwealth payment from eligibility for Commonwealth funding under the Agreement. The IHPA has also carefully taken into account Clause A41 which is less specific than Clauses A6 and A7 prior to reaching its conclusion as to the interpretation of Clauses A6 and A7.
- The IHPA supports the principle implicit in Clause A6 that the Commonwealth should not have to pay twice through different funding streams for the same service. The IHPA also notes that Clause A41 lays out a process for calculating ABF payments based on mixed funding streams that comprise ABF and funding from other sources including the Commonwealth and private health insurers. Clause A41 applies to 'eligible private patients'. The IHPA notes that the Agreement defines 'eligible admitted private patients', but not 'eligible private patients'. Clause A41 could be interpreted to mean both 'admitted' and 'non-admitted' private patients.
- The IHPA notes that patients attending privately referred clinics may also receive other services. A patient recovering from a hip fracture may attend a privately referred clinic that bills against the MBS, but is then referred to receive physiotherapy and other allied health services provided by the Local Hospital Network. These allied health services are not covered under the MBS fee charged by the private orthopaedic surgeon. They are also not claimable under private health insurance as they are provided by salaried public hospital staff. Effectively, these additional services form part of the public hospital services that have historically been funded by the Commonwealth and States and Territory Governments under the former Australian Health Care Agreements.
- The IHPA believes that these services are separate from any services billed against the MBS for private patients. As they do not form part 'of the same service', the IHPA has decided that the cost of these services should be met through activity based funded payments by the Commonwealth and States and Territories Governments. The IHPA further notes that the Tier 2 Outpatient Clinic classification, on which activity based funding payments will be made includes provision for a range of allied health services. The IHPA has set prices for these services and expects that they will be funded under activity based funding by the Commonwealth and States and Territory Governments, regardless of whether the patient receiving these services is a public or a private patient for the medical component of their care.

- The IHPA further notes that its interpretation of Clauses A6, A7 and A41 does not extend to the situation where the MBS fee does not fully cover the costs of medical services provided to private non-admitted patients. This is the 'same service' and the IHPA will not set a price to cover any gap between the medical costs incurred and the fee revenue payable under the MBS. The IHPA recognises that the 'not paying twice' policy intent would not be breached through creating such a gap price between Commonwealth ABF and other sources of funding. However, the IHPA's determination is bound by the more specific provisions of Clause A6 and A7.

Next steps and future work

The IHPA will regularly review the utilisation of public hospitals by private patients in order to detect any emerging trends. This will form part of its evaluation of its price determination function for private patients in public hospitals. However, the IHPA is not authorised to intervene in decisions taken by States and/or Local Hospital Networks about State funding of public hospitals or the use of other incentives that may influence the share of public and private patients in public hospitals.

3.8 Adjustments to the national efficient price

Provisions of the Act and/or the Agreement

The Act gives the IHPA the role of determining "adjustments to the national efficient price to reflect legitimate and unavoidable variations in the costs of delivering health care services" (Clause A131(d)).

The Agreement provides additional specification indicating that 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" (Clause B13).

The Agreement further states that these adjustments "should provide a relevant price signal to States and Local Hospital Networks", but that the IHPA "should not seek to duplicate the work of the Commonwealth Grants Commission in determining relativities" (Clause B14).

The Agreement also describes, at some length, the interplay involving the national efficient price and the autonomy of States and Territories to make payments to Local Hospital Networks. While the Commonwealth funding contribution is determined as a share of the national efficient price, "states will determine the amount they pay for public hospital services and functions" and they "will meet the balance of the cost of delivering public hospital services and functions over and above the Commonwealth contribution" (Clause A60). The Agreement also makes clear that this autonomy of States and Territories with regard to payment arrangements includes capacity for "variations in the State funding contribution in respect of individual Local Hospital Networks" to "enable States to play their role of system managers of the public hospital system".

Policy drivers underpinning the IHPA's decision

As the Agreement indicates, the policy context in which the national efficient price (including any adjustments to the national efficient price) operates is quite complex. The Agreement states that the IHPA must consider "the actual cost of delivery of public hospital services in as wide a range of hospitals as practicable" but it also identifies an important role of the national efficient price as a "relevant price signal to States and Local Hospital Networks". The core concept in the Agreement is of a 'national efficient price', with autonomy for States to plan and manage public hospital services.

The policy drivers underpinning price adjustments mirror the policy goals that the IHPA must balance in setting the national efficient price. Once again, the three Pricing Guidelines relevant to making decisions about adjustments to the national efficient price are:

- **Timely-quality care:** This Pricing Guideline requires that funding support timely access to quality health services. The IHPA has to weigh the dual purposes of the national efficient price (being to determine the Commonwealth funding contribution and to act as a price signal) with the role of States and Territories as system managers. Under the Agreement, States and Territories determine the mix of public hospital services and functions that will be provided through service agreements with Local Hospital Networks. States and Territories can also use funding “to adjust service levels across the State” (Clause A61). On balance, this Pricing Guideline and the Agreement suggest that a national efficient price is set to enable national levels of access and quality, with States having autonomy to make local decisions on access and quality.
- **Fairness:** This Pricing Guideline is about ensuring fairness and equity of activity based payments. One of the tests that the IHPA has used in considering ‘fairness’ is whether there is empirical evidence of demonstrated national differences in the cost of providing public hospital services. The IHPA also has to balance different aspects of equity. This includes, for example, considering whether it is equitable to pay different prices for the same service, as well as considering the equity aspects of variations between the cost and price of public hospital services.
- **Efficiency:** As noted in the previous discussion on setting the level of the national efficient price, the IHPA must consider ‘how much’ efficiency it wants to encourage in the provision of public hospital services. Where there are differences in the cost of provision of public hospital services, the IHPA has to consider the extent to which this variation in costs is attributable to efficiency differences, to legitimate and unavoidable variations in costs, or to some other factors.

Approach used by the IHPA

The IHPA undertook the following tasks to inform its decision-making on adjustments to the national efficient price.

- Preliminary analysis on potential adjustments to the national efficient price was released in January 2012 in the Discussion Paper that formed the basis of consultations. Submissions received in response to the Discussion Paper were analysed, including identifying views on other potential pricing adjustments and the criteria that could inform decision-making on adjustments to the national efficient price.
- The IHPA held discussions with the Commonwealth Grants Commission to understand the interaction between the CGC’s fiscal equalisation methodology and the inclusion by the IHPA of any adjustments to the national efficient price for public hospital services.
- The IHPA undertook a series of increasingly granular analyses (moving from examination of hospital-level variations in the cost of public hospital services to patient-level variations in costs) to systematically identify variables that were associated with differences in the cost per weighted separation. Analysis of these variables was undertaken in an hierarchical manner as follows:
 - The higher costs associated with the provision of specialist paediatric services were first isolated.
 - The higher costs associated with the provision of public hospital services to Indigenous patients were next identified.
 - Analyses were then undertaken to identify whether there were higher costs based on location, using all potential combinations of ‘hospital location’ and ‘patient location’.

- The IHPA provided these analyses on an iterative basis to the Commonwealth, States and Territories and sought feedback on other variables that could be examined to identify if there were empirical differences in the cost of provision of public hospital services.

The IHPA's decision

The IHPA used the test of whether there are empirical differences in the cost of providing public hospital services as a measure of whether there are legitimate and unavoidable variations in the costs of service delivery that may warrant an adjustment to the national efficient price. Decisions are based on national data sources, but were informed by data held by States and Territories.

The IHPA first examined patient-based characteristics in the cost of providing public hospital services, before considering hospital or provider-based characteristics.

The IHPA has determined that in 2012/13, there will be:

- An adjustment for patients who are treated in an Intensive Care Unit. This applies only to patients in DRGs that do not normally have ICU treatment AND are admitted to a level 3 ICU;
- A specialist paediatric services adjustment that will take the form of DRG-specific adjustments to the price weights in relevant hospitals;
- An adjustment of +5.0% to the national efficient price for Indigenous patients;
- An adjustment of +8.7% to the national efficient price for public hospital services provided to patients from outer regional locations, payable wherever these patients are treated;
- An adjustment of +15.3% to the national efficient price for public hospital services provided to patients from remote locations, payable wherever these patients are treated; and
- An adjustment of +19.4% to the national efficient price for public hospital services provided to patients from very remote locations, payable wherever these patients are treated.

The IHPA has determined that these adjustments to the national efficient price will apply across relevant in-scope public hospital services in all settings.

The IHPA is committed to an ongoing process of review of existing and potential adjustments to the national efficient price. The IHPA will undertake further work:

- To determine whether there is an empirical basis for other patient-based adjustments to the national efficient price such as socio-economic status and patient severity; and
- To identify more accurately the real costs of the provision of public hospital services to Indigenous patients.

Further explanation of these decisions is provided below.

- **Empirical evidence:** In order to evaluate whether there are legitimate and unavoidable variations in the cost of public hospital services, the IHPA is indicating that it will first need to establish whether there is empirical evidence as to the existence of such variation in costs. In effect, the demonstration of an empirical difference in costs is a pre-condition to subsequent decision-making by the IHPA as to whether there will be an adjustment to the national efficient price. The requirement that cost variation needs to be empirically demonstrated means that:
 - Any variation in the costs of public hospital services will need to be statistically significant; and

- The IHPA has relied on national data sources to empirically demonstrate cost variation. However, this has been informed by data sources held by States and Territories. The IHPA has decided to use national data sources in considering price adjustments, consistent with its approach to setting the national efficient price based on the national costs of public hospital services reported through the National Hospital Cost Data Collection.
- **Order of assessing adjustments:** The IHPA gave priority to assessment of adjustments to the national efficient price that are related to patient-based characteristics, consistent with its Pricing Guideline on this matter. The rationale for first assessing patient-based characteristics is that these characteristics are more likely to reflect inherent, underlying differences in the cost of providing public hospital services that are legitimate and unavoidable. After considering patient-based characteristics, the IHPA then assessed hospital or provider based characteristics that may lead to differences in the costs of public hospital services. The IHPA needed to establish whether these variations in costs are legitimate and genuinely unavoidable, or whether they represent policy choices by States and Territories and Local Hospital Networks that fall within the responsibility of States and Territories as system managers.
- **Adjustments for 2012/13:** These adjustments are additive so, for example, the provision of public hospital services to an Indigenous patient from an outer regional location results in two adjustments to the national efficient price. While detailed information on each of the 2012/13 adjustments is provided in the National Efficient Price Determination 2012-2013, some background on the operation of these adjustments is provided here:
 - **The ICU adjustment** is an adjustment that applies to patients who are treated in a specified Intensive Care Unit. It only applies to patients who are within a DRG where most patients do not normally receive treatment in an ICU. In 2012/13, eligible ICUs are those listed as Level 3 or above by ANZICS, or are considered to meet that level by jurisdictions. From 2014/15, this loading will only be applicable to ICUs that are recognised as level 3 or equivalent by an independent external body.
 - The **specialist paediatric services adjustment** is an adjustment that is calculated on a DRG-specific basis (the adjustment may be upwards or downwards) to recognise differences in the average cost of paediatric and non-paediatric patients. The adjustment is applied for public hospital services provided to patients up to and including the age of 16 years in specified hospitals. The specified hospitals are the seven specialist children's hospitals and two general hospitals that have a Level 3 intensive care unit or paediatric intensive care unit and provide a minimum specified volume of mechanical ventilations on paediatric patients.
 - The **Indigenous patient** adjustment is for public hospital services provided to persons who identify as being of Aboriginal or Torres Strait Islander descent.
 - The **outer regional, remote and very remote location** adjustments apply based on the location of the patient's residence. That is, there will be a price adjustment for patients who reside in outer regional, remote or very remote locations if they are treated in these locations, but there will also be a price adjustment when these patients receive public hospital services in other locations. This adjustment is based on the residential status of the patient (on their post code where available), not the location of the Local Hospital Network. Analysis of the costing data indicated patients from outer regional or remote locations incurred higher costs, irrespective of where they were treated. This confirmed anecdotal feedback from consultations and submissions that suggested higher costs for rural and remote patients treated in metropolitan hospitals. IHPA has constructed a post code to remoteness area mapping file. Where post codes straddle multiple remoteness areas, the post code is mapped to the remoteness area where the majority of residents live. Where

jurisdictions believe that an alternate approach should be taken, they will be able to submit a request for change to the mapping file to the IHPA.

- For the purposes of illustration, the adjustments to be applied on the basis of area and Indigenous status are shown below:

	Indigenous	Non Indigenous
Major Cities of Australia	5.0%	-
Inner Regional Australia	5.0%	-
Outer Regional Australia	13.7%	8.7%
Remote Australia	20.3%	15.3%
Very Remote Australia	24.4%	19.4%

- The IHPA undertook analyses of **a range of other factors** to determine whether there was an empirical basis for adjustments to the national efficient price. Two hospital—related factors that **did not warrant an adjustment to the national efficient price in 2012/13** were: the remoteness of hospitals; and the specialist, tertiary status of hospitals.
 - **Location of hospitals:** The strongest evidence for an adjustment to the national efficient price was for the remoteness of the residence of the patient, rather than the remoteness of the hospital. The use of a price adjustment for patients living in remote areas means that this higher price will be available when remote patients use their local, remote hospital; it will also be available when remote patients travel to receive treatment in a regional or metropolitan hospital.
 - **Specialist tertiary hospitals:** The empirical evidence did not support the inclusion of an adjustment to the national efficient price for specialist tertiary hospitals. In large part, this is because the expected higher costs of specialist tertiary hospitals have already been accounted for by three other adjustments to the funding model. First, the costs associated with teaching, training and research have been excluded from the cost database, as teaching, training and research is being funded on a block grant basis in 2012/13. Second, an intensive care unit copayment is already included in the funding model. Third, there is a separate adjustment for specialist paediatric services. The analysis undertaken by the IHPA found that when these three adjustments had been built into the funding model, there was not a significantly higher cost distribution for specialist tertiary hospitals.
- **Adjustments in all settings:** The IHPA notes that the empirical evidence on which it has based its decision-making on price adjustments relates to the national costs of inpatient services. As inpatient costing data are the most robust costing data available, they will be used in determining the quantum of any price adjustments. However, consistent with its Pricing Guideline of encouraging “best practice provision of appropriate site of care”, adjustments to the national efficient price will apply across all relevant in-scope public hospital services and all settings. This means, for example, that a 5% adjustment to the national efficient price would also apply for non-admitted services provided to Indigenous patients, including the provision of these services in the community or in the patient’s home. In the case of specialist paediatric services, the adjustment has been calculated on a DRG-

specific basis; this means that the adjustment will only apply to inpatient services and not non-admitted or emergency department services. However, these inpatient services could be provided in other settings (such as hospital-in-the home) and still be eligible for the specialist paediatric services adjustment.

Next steps and future work

As identified in the decisions, the IHPA is committed to a program of ongoing work to establish the factors resulting in legitimate and unavoidable variations in the costs of providing public hospital services. This work will be focused on the empirical demonstration of differences in the costs of public hospital services.

The IHPA wants to make clear that its review of price adjustments will include both existing adjustments and potential adjustments. That is, the adjustments to the national efficient price that have been approved in 2012/13 are not adjustments that will automatically be included on an ongoing basis at the same quantum. Instead, the IHPA will undertake a program of ongoing validation, testing and refinement of any price adjustments that it introduces.

In addition, the IHPA received advice during the consultations and submissions about other patient-based factors that may result in variations in the cost of providing public hospital services. The IHPA is committed to examining the available data to test whether there are empirical cost differences for any patient-based factors.

Finally, the IHPA is committed to undertaking further work to more accurately measure the real costs of providing public hospital services to Indigenous patients.

3.9 Approaches to quality, best practice pricing and normative pricing

To date, this Chapter has identified the determination of the national efficient price and its basis in costing data that reflects the actual costs of delivering public hospital services. This is a cost-based approach to price setting.

However, the IHPA has adopted a definition of the national efficient price (see Section 3.2) that states, in part, that a public hospital service operating at the national efficient price will “be able to provide services at a quality level consistent with national standards, and to minimise negative consequences that fall on patients (including those attributable to poor quality and safety) or on other parts of the service system”. Accordingly, this section begins to explore how the IHPA might incorporate quality considerations in its setting of the national efficient price in the future. It also considers the related concepts of best practice pricing and normative pricing.

Provisions of the Act and/or the Agreement

The Agreement says that in setting the national efficient price, the IHPA must “consider the actual cost of delivery of public hospital services in as wide a range of hospitals as practicable” (Clause B12(b)). However, this does not preclude taking quality into account in price-setting.

In the same clause, the Agreement also requires the IHPA in setting the national efficient price to “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” (Clause B12(a)). The Agreement does not specify, nor does it constrain, how the IHPA might seek to give effect to this broad set of responsibilities. Clause B12(a) indicates that the IHPA should not only be guided by the efficiency of the public hospital system, but it must also have regard to other important policy objectives such as quality and access as it undertakes its price-setting role.

Approach used by the IHPA

The IHPA's views have been informed as follows:

- The IHPA commissioned and released a Literature Review in November 2011. This Literature Review examined international best practice in activity based funding and future payment reform. In particular, it identified:
 - Current initiatives in the United Kingdom to introduce best practice weights for certain procedures and medical conditions, as part of the English ABF payment system; and
 - The use by the United States Medicare payment system of a payment approach that excludes the costs of certain hospital acquired conditions in the price of hospital services.
- Through the consultations and submissions process in early 2012, the IHPA received feedback on its initial proposal to adopt the US Medicare approach of not paying for the costs for certain hospital-acquired conditions. The IHPA also received advice on alternative approaches to building quality into the national efficient price, together with specific proposals for piloting best practice and normative pricing.
- The IHPA held discussions with the Australian Commission on Safety and Quality in Health Care (ACSQHC) to understand its views on the potential to link, or in some manner to incorporate, quality into pricing. The IHPA also discussed with the ACSQHC the potential for future collaborative work.

The potential confluence of quality and pricing represents a relatively new frontier in the Australian health landscape. In this context, it is important to include some definitions of the potential approaches, or indicative examples, for the purpose of promoting further debate on these issues. The following points provide background information and some working definitions only; they do not indicate a commitment by the IHPA to implementation of these approaches.

- **Best practice pricing:** Best practice pricing involves forming a view as to what constitutes best practice, through consultative processes with clinicians and consumers, review of the literature including clinical guidelines and service improvement frameworks etc. It then involves putting a price on the resulting best practice 'package' or 'model of care'. Best practice pricing essentially means that there is clearer specification as to what services are expected to be delivered for a particular product and price. In England the National Health Service has introduced best practice weights for cholecystectomy, hip fractures, cataracts and stroke.
- **Normative pricing:** Normative pricing usually involves using price to influence the way in which care is delivered. For example, it might involve using pricing to encourage the delivery of more community-based care (such as providing palliative care in people's homes). As with best practice pricing, normative pricing would draw upon the experience of clinicians and consumers.
- **Quality and pricing:** There are many other options for incorporating quality into pricing. Payment systems can include bonuses or penalties related to the delivery or non-delivery of expected quality standards of care.

The IHPA is aware that the public hospital system is participating in many significant reforms, over and above the national implementation of activity based funding. The Australian health system is also being transformed with the establishment of the National Health Performance Authority, and the creation of Local Hospital Networks and Medicare Locals. In this context, the IHPA recognises the need to set a manageable pace in any changes pricing public hospital services that factors in consideration of quality, best practice or normative pricing. However, the IHPA believes it is important to signal future work and potential development of these approaches.

The IHPA's decision

Recognising the leadership role of the Australian Commission on Safety and Quality in Health Care on quality and safety, the IHPA has decided to work in partnership with the ACSQHC to explore options for the inclusion of quality and safety considerations in determining the national efficient price to commence in 2013/14. The IHPA believes that this work should also involve the National Health Performance Agency and the Commonwealth, State and Territory Governments.

The IHPA supports, in principle, the consideration of positive funding mechanisms to support the implementation of national safety and quality initiatives.

The IHPA will include research and development on approaches to best practice pricing and normative pricing in its work program, so that these approaches can be evaluated for potential implementation in the future.

Next steps and future work

Further work will proceed as outlined in the above decisions.

4. Block Funding of Public Hospital Services

Understanding this element of the Pricing Framework

The major element of public hospital funding reform is the implementation of activity based funding. However, it was always recognised by Governments that activity based funding will not be practicable for all public hospitals, especially those hospitals which see a low volume of patients but must remain open to provide essential access. In addition, there are some public hospital services or functions that are not yet able to be described in terms of activity or 'outputs', including teaching, training and research. The intention is that these public hospitals and public hospital services will be eligible for funding on a block grant basis. Alternatively, some of these hospitals and services may operate with a mix of block grant and activity based funding.

Local Hospital Networks will still be required to ensure that block funded hospitals and services operate on an efficient basis. Local Hospital Networks will be accountable for the provision of services specified in service agreements with State and Territory Governments including hospitals and services funded on a block grant basis.

Provisions of the Act and/or the Agreement

The Act requires that the IHPA "determine the efficient cost for health care services provided by public hospitals where the services are block funded" (Clause 131(1)(b)).

The Agreement requires that activity based funding be used wherever practicable. It then sets out two pathways for determining block grant funding:

- In 2012/13 the services and the level of block grant funding are to be specified through bilateral agreements between the Commonwealth and each State or Territory (Clause A32);
- From 2013/14 onwards, the IHPA will assume responsibility for determining eligibility of public hospitals and public hospital services for block grant funding and the "discrete amounts for block funding" (Clause A27).

The Agreement sets out a detailed six-stage process that the IHPA will use in determining block funding for 2013/14 and onwards as follows:

1. The IHPA, in consultation with the Commonwealth, State and Territory Governments, will develop Block Funding Criteria and identify whether hospital services and functions are eligible for block funding only or mixed ABF and block funding.
2. During the consultation period, States and Territories will assess their hospital functions and services against the Block Funding Criteria and, if necessary, provide advice to the IHPA on the potential impact of the criteria.
3. The IHPA will provide the Block Funding Criteria to the Council of Australian Governments (COAG) for endorsement.
4. COAG will consider the Block Funding Criteria proposed by the IHPA and either:
 - a. Endorse the recommendation; or
 - b. Request the IHPA to refine the Block Funding Criteria and bring it back to COAG.

5. States and Territories provide annual advice to the IHPA on how their hospital services and functions meet the Block Funding Criteria (this advice may be provided every six years for small rural and small regional hospitals, or more frequently at the discretion of the State).
6. On the basis of this advice, the IHPA will determine which hospital services and functions are eligible for Commonwealth funding on a block grant basis.

The Agreement also identifies how the Commonwealth funding contribution for block grant funded services will increase over time (Clauses A50-A51), in a similar manner to the Commonwealth's funding of activity based funded services.

Finally, the Agreement indicates that the IHPA will annually determine the efficient cost of block grant funded services "taking account of changes in utilisation, the scope of services provided and the cost of those services to ensure the Local Hospital Network has the appropriate capacity to deliver the relevant block funded services and functions" (Clause A4).

Policy drivers underpinning the IHPA's decision

The implementation of block grant funding will have different impacts depending upon how it is applied.

- At one end of the spectrum, it can provide a robust alternative funding mechanism in situations when ABF is not practicable, including providing a short-term or transitional pathway for some public hospital services to move towards being funded on an activity basis.
- At the opposite end of the spectrum, it can operate as an undesirable 'escape hatch' that takes the pressure off Local Hospital Networks to examine the costs of all their services and to identify any changes required to improve the efficiency of service delivery.

These scenarios reflect the policy tension between ensuring equitable access to public hospital services and creating an environment that promotes incentives for efficiency in the delivery of public hospital services.

Hence, it will be important for the IHPA in using block grant funding to be explicit about the policy goal that is being sought in exchange for a move away from activity based funding. In the case of small rural and remote hospitals, the policy goal is likely to be one of guaranteeing access to an essential service; albeit sometimes, this may be about having the capability to provide urgent care and organise retrieval to another hospital that can provide more specialised care. However, it is not always straightforward to determine what an 'essential service' is, with the argument sometimes being made that all public hospitals provide a community service obligation. This policy dilemma is sharpened in the context of different patterns of provision of public hospital services across Australia.

The IHPA will also need to consider trade-offs in funding design about whether to use a block grant or to incorporate an adjustment to activity based payments to recognise the higher costs associated with some types of public hospital services. Such trade-offs depend, in part, upon whether the proposed block grant funding is intended to be available on a short-term basis only (pending, for example, the development of a suitable ABF classification) or available on a long-term basis (if it is considered that funding via ABF is never likely to be feasible). The use of block grant funding on an ongoing basis is likely to involve the payment of a 'funding premium' or subsidy. In other words, the Local Hospital Network is receiving a higher payment to provide a specific public hospital service than would otherwise have been payable through activity based funding. In this situation, the IHPA will need to consider the size of any funding premium and its relationship with the policy goal that is being sought through the use of block grant funding. This is effectively what is specified in the Agreement when it is stipulated that the IHPA must determine the 'efficient cost' of block funded services, rather than simply assuming that the existing cost is efficient.

Approach used by the IHPA

The IHPA used the same approach to developing the draft Block Funding Criteria as some other key elements of the Pricing Framework.

- A literature review, released in November 2011, examined the mix of ABF and block grant payments in other countries, together with identifying the services that were likely to be funded outside activity based funding in these countries.
- The Discussion Paper, released in January 2012, included a set of Draft Block Funding Criteria for public consultation.

The IHPA's decision

In 2012/13 the IHPA will implement ABF and block grant funding in accordance with the outcome for each State and Territory of its bilateral agreement with the Commonwealth.

The IHPA is releasing the draft Block Funding Criteria (see Box 5), as the first stage of the development and consultation process that will occur in 2012/13, prior to their finalisation and use by the IHPA in 2013/14.

The IHPA is also releasing some indicative guidelines on 'low volume' thresholds that might form part of draft Block Funding Criteria for use in 2013/14. Under these thresholds, hospitals may be eligible for block funding if:

- They are in a metropolitan area (defined as 'major city' in the Australian Standard Geographical Classification) and they provide $\leq 1,800$ inpatient NWAU per annum; or
- They are in a rural area (defined as all remaining areas, including 'inner regional', 'outer regional', 'remote' and 'very remote' in the Australian Standard Geographical Classification) and they provide $\leq 3,500$ inpatient NWAU per annum.

Box 5: Draft Block Funding Criteria

These Draft Block Funding Criteria are released for further development and consultation in 2012/13, prior to submission to the Council of Australian Governments for endorsement.

The Draft Block Funding Criteria are that public hospitals, or public hospital services, will be eligible for block grant funding if:

1. The technical requirements for applying activity based funding are not able to be satisfied.
2. There is an absence of economies of scale that mean some services would not be financially viable under activity based funding.

Further explanation on these decisions is provided below.

Block grant funding in 2012/13

- The IHPA has no determinative role in 2012/13 in regard to which services will be block grant funded. Instead, the IHPA is required to implement the outcomes of the bilateral agreements on block grant funding negotiated between the Commonwealth and each State or Territory.

As a result of these bilateral agreements, it is anticipated that there will be differences across States and Territories in whether the same service (such as mental health services) will be funded through block grants or on an activity basis. This means that the same service may be priced by the IHPA on an activity basis in one State, while in another State this service will be funded on a block grant basis at a level specified in a bilateral agreement.

Draft Block Funding Criteria

The development of the Draft Block Funding Criteria is likely to require further specification and, in the case of the economies of scale criterion, an assessment of the measurement of economies of scale. Factors that may be included by the IHPA in the further specification of these criteria are outlined below for illustrative purposes.

- **Technical requirements:** Activity based funding may be impractical in situations where there is:
 - No or poor product specification/classification, meaning that there is no basis for differentiating/describing the 'product' that is to be priced; and/or
 - No or poor costs associated with any product classification, or where there is no cost homogeneity of the product classification; and/or
 - No suitable 'unit of output' for counting and funding the product, such as a well defined occasion of service, episode of care, or bed-day, amongst others.
- **Absence of economies of scale/Financial viability:** Activity based funding may be impractical in situations where there is:
 - A low volume of services, with an outcome being that the costs of keeping the health service open and 'available' exceed the funding that would be able to be achieved under ABF payments;
 - Instability or unpredictability in service volumes, accompanied by an inability to manage input costs in accordance with changing service patterns; and
 - A skewed profile of services and/or costs.
- **Volume of services:** The IHPA has also undertaken some preliminary work on the volume of inpatient services that could indicate a potential absence of economies of scale, meaning that hospitals should be eligible for funding on a block grant basis. The preliminary decision has been informed by analysis and the consensus position of States and Territories as to low-volume thresholds, in particular, for small rural hospitals. The proposed low-volume threshold of 3,500 inpatient NWAU per annum for non-metro hospitals or 1,800 inpatient NWAU per annum for metro hospitals represents a small volume of inpatient services and it is considered that such hospitals should be eligible for block grant funding. There will be a flexible and dynamic approach to implementation of these low-volume thresholds. This will consider historical trends in, and projections of, hospital utilisation.

Next steps and future work

As outlined above, the IHPA will undertake further development of, and consultation on, the Draft Block Funding Criteria in order to be able to use them for the determination of block grants in 2013/14.