Towards a Pricing Framework: Summary Report

21 December 2011

1. Introduction

The Independent Hospital Pricing Authority (IHPA) has commissioned the development of a comprehensive Pricing Framework for use in the implementation of activity based funding (ABF) for Australian public hospitals.

This report is a short summary of the implementation options, together with selected consultation questions. The complete Discussion Paper, *Activity based funding for Australian public hospitals: Towards a Pricing Framework,* includes data analysis and other consultation questions and is available at: http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/publications. **The IHPA welcomes submissions in response to the issues and consultation questions included in these reports. The closing date for submissions is Tuesday 21 February 2012.**

2. Principles

A set of principles has been developed to help guide decisions about how best to price public hospital services. These principles draw on the National Health Reform Agreement, as well as international and Australian experience about reforming health care payments. The proposed principles are:

- **Timely–quality care:** ABF 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 hospital services.
- **Fairness:** ABF payments should be fair and equitable.
- **Maintaining agreed roles and responsibilities of governments:** ABF design should recognise the complementary responsibilities of each level of government in funding health services.
- **Transparency:** all steps in the ABF process should be clear and transparent.
- **Administrative ease:** ABF should not unduly increase the administrative burden on hospitals.
- **Stability:** the payment relativities are consistent over time.
- **Evidence based:** ABF should be based on best available information.
- **Supporting innovation:** ABF pricing should respond in a timely-way to introduction of evidence-based, effective new technology and innovation.
- **Price harmonisation:** Pricing should facilitate best practice provision of appropriate site of care.
- **Minimising undesirable and inadvertent consequences:** ABF design should minimise susceptibility to gaming, inappropriate rewards and perverse incentives.
- **ABF pre-eminence:** ABF should be used for funding 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.

Consultation question:

- *Do you agree with the proposed principles to guide the development and operation of the Pricing Framework? Are there other important principles that should be included?*

3. What public hospital services should be included in new funding arrangements?

Making decisions about what is, or is not, a public hospital service for the purposes of Commonwealth funding is the first task in implementing new funding arrangements.

Unfortunately, this task is not as simple as funding everything that a public hospital provides. There is some blurring between a *service provided by a public hospital* and *public hospital services*. Many public hospitals provide some services, such as aged care services, that are not public hospital services. In addition, other organisations such as charitable groups provide 'public hospital services' with funding provided by public hospitals and state health authorities.

The National Health Reform Agreement says that all care provided to inpatients and to people treated in emergency departments is included as public hospital services and will be eligible to receive Commonwealth funding. But, it also says that the Independent Hospital Pricing Authority has to make decisions about whether other services (including outpatient clinics, mental health services, rehabilitation services and community programs to help people manage chronic disease) should be counted as public hospital services in order to get Commonwealth funding.

To help define what a public hospital service is, a set of draft criteria has been developed (see Appendix 1). These criteria would be used by the Independent Hospital Pricing Authority in reviewing recommendations by states for services to be included as eligible to receive Commonwealth funding.

It is also important to note that the way in which public hospital services are delivered continues to evolve, which means that funding of these services also needs to evolve. That is why the National Health Reform Agreement provides a guarantee 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 establish incentives to admit more patients, rather than treat them in the community when it is safe to do so.

.***Consultation questions:***

- *Do the draft criteria (including the Guidance Notes) provide sufficient clarity for the Independent Hospital Pricing Authority to make transparent and consistency decisions about eligibility of services for Commonwealth funding?*
- *Are there public hospital services that should be considered eligible for Commonwealth funding that would not be positively identified under these draft criteria?*
- *Are there services that should not be considered eligible for Commonwealth funding that would be incorrectly assessed as eligible under these draft criteria?*
- *Is the concept of services being 'funded by a public hospital' useful and able to be measured? Is this a better approach than 'hospital-auspiced' or 'hospital managed?*

4. When should public hospital services be funded on an activity basis or a block grant basis?

The National Health Reform Agreement makes it clear that, whenever practicable, activity based funding is the preferred approach to funding public hospital services. But, it also acknowledges that some services may be better funded through block grants.

From July 2013, the Independent Hospital Pricing Authority has the job of deciding which public hospital services will be funded through block grants, which will be funded on an activity basis, and which will be funded through a combination of ABF and block grant funding. (Prior to July 2013, this will be decided between governments). To do this, the IHPA is required to publish Block Funding Criteria that can be used to assess how public hospital services will be funded.

Two Block Funding Criteria are proposed to identify which services should be funded through block grants:

- The **technical requirements** for applying ABF are not able to be satisfied.
- There is an **absence of economies of scale** that mean some services would not be financially viable under ABF.

Technical barriers to applying ABF may include inadequate classification systems, poor costing data and difficulties in counting certain types of health services. **In the short-term, some mental health and subacute services** (such as rehabilitation and palliative care) **provided in the community may need to be funded under block grants due to these technical barriers**. However, the plan is to undertake further work so that these services can be funded on an activity basis in the future. Governments are also still considering whether to count and fund some subacute and mental health services using existing ABF classifications in July 2012, pending the development of more suitable patient classification systems for these services. **Teaching, training and research will also be funded using block grants**, until classification and costing data support a transition to funding on an activity basis.

Some small rural and small regional hospitals are likely to be funded under block grants (or a mix of block grants and ABF), as they do not have sufficient economies of scale. There will need to be a decision on how to set thresholds for when block grant funding might apply to these services. Funding under the National Health Reform Agreement is intended to cover public hospital services, but many hospitals provide a range of other services including aged care, and primary and community health services that may also be important in considering economies of scale and viability.

For all services funded under block grants (including relevant small rural and small regional hospitals), **the Independent Hospital Pricing Authority is required to determine the efficient cost of block funded services. It will also need to consider the factors or circumstances where a mix of block grant and activity based funding should be used.**

Consultation questions:

- *When is ABF 'impracticable' to apply? Are the proposed criteria for block grant funding suitable?*
- *What are your views on how to determine the efficient cost of block grant funded services (including those provided by small rural and small regional hospitals)?*
- *What factors might warrant the mixed use of ABF and block grant funding?*
- *For each of mental health and subacute services, what are the most important priorities in service classification and costing to support a transition to ABF?*

- *What priority should be given to implementing ABF for teaching, training and research in public hospitals?*
- *What factors should be considered in determining which small rural and small regional hospitals are best funded through block grants?*

5. How should the national efficient price be set?

The introduction of activity based funding across most Australian public hospitals is intended to improve efficiency, as well as make transparent the funding provided by the Commonwealth and state governments.

To achieve this, the Independent Hospital Pricing Authority is required to determine the (single) national efficient price that will be used for Commonwealth activity based payments to public hospitals across Australia. As there are many different understandings of efficiency, a definition has been developed to help inform price-setting.

The proposed definition is that:

A hospital operating at the national efficient price will

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

Governments have made decisions about the classifications that will be used in July 2012 for activity based funding. Inpatient services will be classified using AR-DRGs Version 6.0x, emergency department services using Urgency Related Groups or Urgency and Disposition Groups, and outpatient services using a modified Tier 2 clinic classification. However, separate counting and funding for each type of service can result in funding being 'locked in' for specific services. Instead, it is preferable for payment systems to support changes in how care is delivered, based on best clinical practice. **To achieve this, it is proposed that all service types be described using a single measure of activity, the National Weighted Activity Unit.**

The next step is deciding the approach to price-setting. The National Health Reform Agreement says that the Independent Hospital Pricing Authority should consider the 'actual cost of delivery' of public hospital services: this is known as 'cost-based' pricing. But, pricing can also include elements of 'best practice' or 'normative pricing': this is when price is set to achieve certain goals, such as reducing waiting times or improving the quality of care. These two pricing strategies – 'cost-based' and 'best-practice' – are not mutually exclusive and price-setting can take both into account. Best practice pricing has been slow to be introduced, as it needs clinicians to agree on what constitutes best practice care for particular types of patients (e.g. care for patients after a stroke). **For 2012/13, it is proposed that weights and pricing of public hospital services should be based on observed costs, not best practice pathways**. (One exception is proposed in the next section to consider pricing adjustments for quality-related complications that occur during a hospital stay).

The level at which the price is set involves balancing different policy objectives. Larger efficiency gains will be achieved with lower prices. But, the principle of fairness suggests that low prices can only be set if there is a high degree of confidence that all states and public hospitals are counting and costing public hospital services in the same way. This is not likely to be true at the moment. **It is therefore proposed that in the short-term,**

the national efficient price is set using a measure of 'central tendency' such as the median or the mean. The median price is preferred over the mean price as it results in better stability and predictability of prices over time. **In the medium and long term, it is proposed that lower than average or normative pricing could be adopted.**

A final issue in price-setting is the need to include estimates of inflation. In practical terms, the 2009/10 public hospital cost data (the most recent available) will need to be indexed to set the national efficient price that will apply from July 2012. Output cost indices are preferred over input cost indices: an output cost index reflects changes in the cost of inputs as well as capturing changes in the efficiency with which services are delivered. **It is proposed that an output cost index called the Government Final Consumption Expenditure hospitals and nursing home deflator be used as the measure of price indexation.**

Consultation questions:

- *Do you agree with the proposed definition for a hospital operating at the national efficient price?*
- *Is a single unified measure the right approach at this stage of development of ABF?*
- *Do you agree that it is too early in the development path of activity based funding in Australia to adopt best practice pricing as the standard approach?*
- *Do you support a pricing strategy based around the middle of the cost distribution? If so, should it be mean or median?*
- *Do you agree that the Independent Hospital Pricing Authority should use an output cost index to adjust cost data in setting the national efficient price?*

6. Should there be any adjustments to the national efficient price?

The introduction of activity based funding using a national efficient price is underpinned by the concept that **hospitals should get paid the same price for providing the same service**. Another way of expressing this is that payment should generally be based on the characteristics of the patient or the service provided, rather than the setting in which care is provided – payment is 'patient-based rather than 'provider-based'. This concept is also about fairness: the same payment is made for the same hip operation wherever it is provided. And, of course, the national efficient price is intended to improve efficiency as high-cost hospitals reduce their costs.

However, the National Health Reform Agreement also recognises that **some of the variation across public hospitals in the costs of care may be due to legitimate and unavoidable factors**. In order words, not all the differences in costs across public hospitals may be about differences in their efficiency. So, governments may need to make extra payments through adjustments to the national efficient price in certain circumstances. This can be done through adjustments to weights or to prices. In general, **adjustments to prices are preferred over adjustments to weights** as it makes more transparent the 'premium' paid.

When should such adjustments be considered**? It is proposed that adjustments only be approved if there is demonstrable evidence to support them**; that **the cost differences cannot be said to be created by affected providers**; and that, when assessing the data for identification of cost differences, **all patient-related factors are first considered and addressed**.

Two potential adjustments for **patient-related characteristics** are examined: Indigenous status and specialist services for children. Several states pay a price loading for the higher costs associated with treating Aboriginal and Torres Strait Islander people. Price loadings are also commonly applied for specialist children's hospitals. In both cases, there is need for better data to demonstrate the real cost differences. In the case of specialist

services for children, price loadings have to also take into consideration the adequacy of DRGs to incorporate differences in the costs of care.

Hospital location is another factor that might be considered 'unavoidable'. There may be higher costs for hospitals in rural and remote locations due to an absence of economies of scale. These hospitals might face increased costs to recruit health professionals, as well as providing a low volume of services, leading to viability problems under activity based funding. Analysis of cost data confirms higher costs for public hospitals in remote locations, although further analysis is required to separate out the higher costs of treating Aboriginal and Torres Strait Islander people. It is also likely that some of these remote hospitals will be funded under block grants.

The '**teaching status**' of hospitals is often argued as justifying a price loading. However, most public hospitals now provide clinical education, so it is not clear cut to identify 'teaching' and 'non-teaching' hospitals. From July 2012, teaching, training and research undertaken in public hospitals will be funded through block grants. Governments have agreed to consider funding teaching, training and research on an activity basis in the future.

Another potential adjustment relates to **paying for quality, or not paying for poor quality**. The United States Medicare system has defined a list of hospital acquired conditions, or specific problems arising during a hospital admission (See Appendix 2). These hospital-acquired conditions lead to longer lengths of stay for the patient; previously hospitals were paid more for these patients and less for patients that did not develop complications during their hospital stay. On the basis that US Medicare believes that these hospital-acquired conditions are preventable, it now does not pay hospitals extra if patients develop any of these complications. **It is proposed that in 2013/14 the IHPA adopt the United States Medicare list of Hospital Acquired Conditions and exclude these from consideration in Diagnosis Related Group assignment.**

Consultation questions:

- *Do you agree that patient-related factors should always have pre-eminence?*
- *Do you think there is a case for a loading for the additional costs of treating Aboriginal and Torres Strait Islander people? If so, what should be the evidence used for the loading?*
- *Do you think there is a case for a loading for the additional costs in specialist children's hospitals and units? If so, what should be the evidence used for the loading?*
- *Do you think there is a case for a loading for the differences in costs for hospitals in different locations? If so, what should be the evidence used for the loading?*
- *Do you think there is a case for a loading for the potential differences in costs for 'teaching hospitals'? If so, what should be the evidence used for the loading?*
- *Do you think that some form of pay for performance incentives should be introduced with national implementation of ABF?*
- *If so, do you think the United States approach (and listing of hospital acquired conditions) is a reasonable place to start?*

7. How should the national efficient price be set for private patients in public hospitals?

All patients who are admitted to a public hospital can choose to be treated as a public or a private patient, regardless of their health insurance status. However, there are different sources of funding for public and private patients in public hospitals. Funding for privately insured patients includes benefits paid by private health insurers towards the cost of their accommodation and payments for surgically implanted prostheses.

The medical costs of privately insured patients are also funded jointly under the Medicare Benefits Schedule, private health insurers and by patients (if there are other gap payments).

In recognition of this difference, the National Health Reform Agreement specifies that ABF payments for private patients should be adjusted or discounted to reflect these other payments. This impacts on the national efficient price, and, particularly, on the price paid by the Commonwealth Government. It does not affect the benefits paid by private health insurers or the charges set by public hospitals for these patients.

The proposal to adjust the national efficient price for private patients in public hospitals is as follows:

- Exclude the costs of prostheses, pathology and diagnostic imaging from the cost weights;
- Exclude the costs of medical specialist services from the cost weights, but retain the costs of other medical services in the cost weights;
- Reduce the national efficient price to deduct revenue for accommodation services, equivalent to the private health insurance default benefits, calculated on a national average default benefit rate.

This proposal is intended to maintain public-private neutrality, so that all patients remain retain the right to choose to be admitted as a public or a private patient in a public hospital. In addition, **it is also proposed that work commence on changing private health insurance default benefits from a per diem basis to an activity basis**, using the same classification as applies for public patients.

Consultation questions:

- *Is there support for the proposed approach to adjusting the costs of various components in calculating the national efficient price for private patients in public hospitals?*
- *Will the proposed approach achieve the aim of ensuring public-private neutrality?*
- *Are alternative approaches preferred? If so, what specific alternative is preferred and what are the criteria or principles driving support for this alternative approach?*
- *Is there support for future work on harmonising default benefits to achieve consistency across classification systems used for public and private patients in public hospitals?*

Appendix 1: Draft criteria for determining scope of public hospital services eligible for Commonwealth funding

Criterion	Service Analysis Factors	Guidance Notes	Examples
1	Is the service currently provided (or was it provided in 2010) on an admitted patient basis?	1. This criterion is based on Clause A10 and A15 in the NHRA. 2. In specifying that the service may have been provided on an admitted patient basis in 2010, it captures services that may have shifted from an admitted basis to another delivery model in most states. 3. The criterion uses the term 'admitted', meaning that services can be any of the care types specified in the National Health Data Dictionary and do not have to be 'acute' services.	Surgery Obstetrics Specialist medicine Dialysis Chemotherapy Hospital in the home
2	Is the service currently provided (or was it provided in 2010) as an emergency department service through recognised emergency departments?	1. This criterion is based on Clause A10 and A15 in the NHRA.	Emergency department attendances at recognised emergency departments
3	Was the service provided in 2010 through outpatient clinics on the campus of public hospitals?	1. This criterion results in all outpatient services that were provided in at least 2010 being considered as eligible public hospital services. 2. Assessment of whether services were provided in 2010 will be determined on the basis of these services having been included in national reporting.	Outpatient clinics at public hospitals
4	Was the service a non-admitted specialised service that was: a. Causally and proximately related to an inpatient admission? AND b. Funded by a public hospital?	1. The concept of causality implies that the service was 'planned' as part of an episode of care that included an inpatient admission. 2. The concept of 'proximately' implies that the service is provided within a specified time period, before or after the hospital admission. This is intended to exclude the ongoing provision of services for an indefinite period.	Pre-admission clinics Early discharge programs Medical review or after-care services Post-acute care services
5	Was the service a non-admitted specialised service that was: a. Causally and proximately related to an emergency department visit? AND b. Provided via a referral from an emergency department? AND c. Funded by a public hospital?	1. The concept of causality implies that the service was directly related to an emergency department visit. 2. The concept of 'proximately' implies that the service is provided within a clinically appropriate time of attendance at the emergency department.	Fracture clinics Cardiology diagnostic testing Specialist consultation-liaison services Specialist outreach services

Criterion	Service Analysis Factors	Guidance Notes	Examples
6	Was the service a non-admitted subacute service (rehabilitation or palliative care) that: a. Was provided through a 'designated subacute services' facility/unit/program? AND b. Was provided to the patient at a public hospital, in a community-based setting or at home? AND c. Was funded by a public hospital?	1. There are different approaches to 'designation' of subacute services across states (as to whether this occurs at the facility, unit or program level). This criterion is intended to identify subacute services that are specifically recognised by each state as designated services. Although the approach to designation will occur through separate processes, the intended concept is to identify the provision of multidisciplinary, time-limited and goal-oriented programs.	Specialist community based palliative care services Rehabilitation clinics Cognitive, dementia & memory services Pain management service Continence services
7	Was the service a non-admitted specialised mental health service that: a. Was delivered by a designated specialist mental health team? AND b. Provides a response primarily designed to manage high risk/crisis situations where there is high probability of admission? AND c. Was funded by a public hospital or an area mental health service (or state equivalent)?	1. This criterion is intended to distinguish short-term, acute specialised mental health services from other mental health services that provide long-term support for people with chronic mental illness. 2. The specialist mental health services need to be 'designated' or recognised. Although the approach to designation will occur through separate processes, the intended concept is to identify the provision of comprehensive, multidisciplinary specialist mental health services.	Mental health crisis assessment services Emergency department mental health services
8	Was the service a non-admitted specialised service that was funded by a public hospital AND: a. Was designed to directly substitute for, or avoid, an imminent admission or emergency department visit? OR b. Was delivered as part of a planned program for a defined population with a history of high hospital utilisation to provide an alternative care delivery model for this population through the provision of a planned schedule of care over a time-limited period?	1. This criterion is intended to capture specialised services that substitute for hospital care on either an emergency or a planned basis. The services involve patients with either a high risk of imminent hospital admission or patients with previous high utilisation of hospitals.	Outreach programs from public hospitals to residential care that manage people at imminent risk of hospitalisation Emergency department diversion programs Programs for active management of groups with high hospitalisation (such as CHF and COAD)

Criterion	Service Analysis Factors	Guidance Notes	Examples
9	If the service does **not** otherwise meet any of criteria 1-8, was it a service that: a. Was included in the listing of 'GP and primary health care services currently funded by State governments' specified in Clause B10 of the 2010 National Health and Hospitals Network Agreement? OR b. Was included in the listing of state services 'excluded from transfer to the Commonwealth' specified in Clause B9 of the 2010 National Health and Hospitals Network Agreement? OR c. Was included in the listing of state services for future 'transfer to the Commonwealth or for strong national reform' specified in Clause B34 of the 2010 National Health and Hospitals Network Agreement?	1. This criterion is intended to define 'non public hospital services'. Its application means that unless a service specifically meets one of Criteria 1-8, it would be considered not eligible for Commonwealth funding as a public hospital service. The interaction between Criteria 1-8 and Criteria 9 (and the relevant clauses of the 2010 National Health and Hospitals Network Agreement) would result in the following services being assessed as not eligible for Commonwealth funding as a public hospital service: **Clause B10**: • Community health centre primary health care services such as generalist counselling, integrated care, GP and primary care coordination programs including Indigenous and rural and remote primary health care services • Primary mental health care services which target the more common mild to moderate illnesses • Hospital avoidance programs that do not relate specifically to patients who are predominantly being treated in acute care • Primary and secondary prevention programs for early intervention and care coordination that focus on the management of patients with chronic disease in the community • Screening programs for cancer delivered in a primary health care setting • Immunisation **Clause B9:** • Ambulance services • Public dental services • Health care for prisoners • School and workplace primary care programs **Clause B34** • Community health promotion and population health programs including preventive health • Drug and alcohol treatment services • Child and maternal health services	The following services would be assessed as included or eligible for Commonwealth funding through satisfying any of Criteria 1-8 (even though they would otherwise be ruled out under Criterion 9): • Hospital avoidance programs that relate more specifically to patients who are predominantly being treated in acute care • Community palliative care • Specialist community mental health services for people with severe mental illness

Appendix 2: United States' Medicare List of Hospital Acquired Conditions

The US Medicare system has adopted a list of hospital acquired conditions which it believes are preventable with contemporary knowledge. The list is updated annually following extensive consultation.

If a condition is included in the list, and it was not present on admission, then that code is not taken into account in the Diagnosis Related Group (DRG) assignment algorithm. Essentially that means that a hospital will be paid for the relevant case as if that condition had not occurred i.e. if the presence of the code would have meant that the case would otherwise have been assigned to a higher weighted DRG, then the case won't be so assigned and it will be assigned to a lower weighted DRG.

The 2012 list is:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcer Stages III & IV
- Specific Falls and Trauma (Fracture; Dislocation; Intracranial Injury; Crushing Injury; Burn)
- Catheter-Associated Urinary Tract Infection
- Vascular Catheter-Associated Infection
- Manifestations of Poor Glycemic Control
- Surgical Site Infection following Coronary Artery Bypass Graft
- Surgical Site Infection Following Certain Orthopedic Procedures
- Surgical Site Infection Following Bariatric Surgery for Obesity
- Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures