

Submission to the Independent Hospital and Aged Care Pricing Authority

Towards an Aged Care Pricing Framework Consultation Paper — August 2022

by

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Introduction

This submission is in response to the IHACPA consultation paper: Towards an Aged Care Pricing Framework Consultation Paper – August 2022. The submission discusses design issues in relation to principles of activity based funding (ABF) and incentive effects of ABF on quality of care. It also covers specific issues in relation to the AN-ACC classification system and outlines some considerations about size and cream skimming.

Design of activity based funding for aged care

By design, ABF ought to improve efficiency. Where markets are absent, such as in public hospitals, ABF creates competition to promote efficiency. At its core is a costing and classification system so that output is classified into standard units, e.g., NWAU in the case of hospitals, and a single price per standard unit is set for all providers based on costs. Providers whose costs are above average will face a deficit and have an incentive to lower their costs, while providers with below average costs will enjoy a surplus which incentivises them to maintain or lower their costs even further. Over time, the overall efficiency of the system will improve.

The application of ABF to aged care follows the same principle. However, for aged care, a long standing community concerns have been about quality of care and safety. These concerns have been comprehensively documented in the Royal Commission Report and widely reported in the media. A key issue is whether the emphasis of ABF on efficiency would compromise quality of care even further. Indeed, in the case of public hospitals, the tradeoff between quality and efficiency has been a concern. The systematic review by Palmer et al. (2014) of 65 articles covering 10 countries showed a mixed picture but the authors suggested that readmission rates may have increased and an apparent increase in severity of illness may have followed after the introduction of ABF. Specific to Australia, there is some recent evidence that ABF improves public hospital efficiency in Queensland (Bao et al., 2022), but to our knowledge there has yet been any evaluation of how ABF affects quality of hospital care.

We recommend that IHACPA incorporate quality of care into the pricing framework as a core design element. For example, a standardised metric could be developed based not

only on costs but also quality of care, such that each standardised quantity unit can be thought of as a quality-adjusted unit. The next section outlines how quality could be incentivised under ABF. We further recommend that IHACPA investigates whether a tradeoff exists between efficiency and quality following the implementation of ABF for aged care.

Will ABF pricing influence provider behaviour?

The price of residential aged care generally consists of two broad components: fees for providing care (daily care fees) and charges in relation to the accommodation provided. Government subsidies for both components are means tested. In addition, nursing homes can also provide additional services for additional fees, known as additional and extra service fees. These additional and extra service fees are not means tested. The accommodation charges may also include additional government subsidies known as supplements (e.g., enteral feeding supplement) that are designed to cover the additional cost of providing care to residents with special care needs. There are various caps imposed on these fees and accommodation-related charges. However, providers can vary their charges as long as they stay below the caps, which can vary by providers.

Note that the price received by providers consists of two parts: the portion paid by consumers and the portion from the government in the form of subsidies. It appears that the ‘price’ IHACPA recommends to the government only concerns the portion covered by government subsidies. For consumers who are fully subsidised, this price would cover most if not all payments for their care. However, for other consumers who are not fully subsidised, they will face additional out-of-pocket payments that are unregulated, except for the caps mentioned above. A substantial portion of this will be payments in relation to accommodation. More importantly, the share of this latter group of consumers will rise over time, as more wealthy baby boomers enter aged care. With the increasing fiscal pressure faced by the government, consumers will increasingly be required to contribute more to the cost of aged care. Hence, both the proportion of consumers facing out-of-pocket payments and the quantum of such payments will likely be increasing over time.

The implication is that, for non-fully-subsidised consumers, the price they face will have

little resemblance to the price recommended by IHACPA. Providers will be able to charge the price they command since, if the IHACPA recommended price is below what they think the market will bear, they can always adjust the out-of-pocket portion of the total price for non-fully subsidised consumers. In this way, the intended signals of ABF pricing framework could be compromised.

Another implication is that pricing complexity and non-transparency will remain in residential aged care. This has, along with the limited availability of quality information, contributed to market failures. Previous reforms promoting consumer choice and competition have delivered neither lower prices nor higher quality. Higher prices were not associated with higher quality, as shown in our research (Yong et. al, 2021), which found that, among for-profit, not-for-profit and government-owned providers, for-profit providers charged the highest prices on average, but were providing the lowest quality of care.

We recommend that IHACPA investigates the pricing decision of providers, with a view to ensure that the price recommended by IHACPA will be a key factor influencing providers' decision making in relation to efficiency and quality of care. There maybe a need, for example, to link pricing adjustments to quality in order to encourage good quality care. This is discussed next.

Pricing adjustments to incentivise quality care

Quality of care has been a concern in all ABF schemes. In the case of hospital funding, countries that implemented ABF have also experimented with various incentive schemes to encourage quality care. Our review suggested that the effectiveness of schemes varies and is highly context specific (Scott et al., 2018; Zaresani and Scott, 2021). In implementing ABF for public hospitals in Australia, IHACPA has also incorporated a number of quality-based adjustments in its pricing framework. For various reasons, IHACPA has opted for a design that imposes penalties by patient episodes rather than by hospital, i.e., a hospital is penalised by reduced payments for the number of low-quality episodes it produced regardless of whether it provides more or fewer low-quality episodes overall than comparable hospitals. This clearly provides very weak incentives for improving quality of care. *We strongly recommend against adopting such a design for aged care.*

To understand the incentive issue, it pays to conceptualise aged care provision in the context of production theory—providers choose inputs (number of worker hours, equipment, materials, buildings, etc.) to produce outputs in the form of aged care services. Providers are to a large extent able to influence the quality of services to provide. All else equal, higher quality services will require higher costs and higher worker efforts. This difference in costs is likely reflected in both the cost of each additional unit of services (i.e., marginal cost) and the average cost of a unit. The two can differ due to the presence of fixed costs such as setup costs and lump sum costs that have to be incurred regardless of service volume. For example, to reduce infections, providers can implement resident-specific measures that prevent the transmission from carriers to others, as well as facility-wide measures that promote good hygiene such as improving environmental cleaning and increasing distancing between all residents to reduce the risk of infections. The former type of measures raise the cost of care for specific residents (i.e., marginal cost) while the latter measures could incur large fixed costs.

Recognising that producing higher quality outputs incur both higher marginal and fixed costs has implications on the design of incentive schemes. Incentives should be provided so that providers are able to cover the costs of implementing measures for quality improvement. That is, incentive payments should be directed toward marginal as well as fixed costs associated with quality improvements. This means a good design should have a lump-sum component in addition to a per-unit component. The lump-sum component could be structured to encourage providers to improve their performance over time (i.e., improved quality over previous years should be rewarded), as well as to perform above their peers (i.e., above average performance should be rewarded).

The presence of fixed costs also implies economies of scale, which suggest small providers will be at a disadvantage compared to larger providers. Thus providers should be compared with their peers of comparable size on risk adjusted outcomes, or the risk adjustment process should account for volume. We discuss the issue of whether volume is related to efficiency and quality in a separate section below.

We recommend that IHACPA adopts an approach that incentivises good quality care that operates at both the episodic and facility levels, such that facilities that improves over time or provide above-average quality care be rewarded.

The AN-ACC model

A key infrastructure for ABF is a classification system of activity volume into homogeneous units so that activity can be standardised into a common metric for which a single price can be set. For in-patient care, the DRG classification system has been developed using a large volume of data over many years. Its robustness and consistency have been validated over many years and across countries.

The AN-ACC classification is the equivalent of DRG for residential aged care. However, AN-ACC is based on a single study—the Resource Utilisation and Costing Studies (RUCS)—undertaken by the University of Wollongong (UOW) in 2017–18. The RUCS classification of aged care residents into 13 categories has been based on a relatively small sample from 30 facilities in 3 regions, with less than 2,000 residents (Eagar et al., 2019). It is unknown whether it captures the variation of costs over the entire residential aged care sector, which contains about 3,000 facilities and more than 200,000 residents. Its robustness and consistency over time remains to be verified.

More importantly, it is questionable whether the AN-ACC classification remains appropriate for the post-pandemic. It is conceivable that the relativity of costs may have changed in significant ways due to additional care requirements brought about by the SAR-COV2 virus. This can have differential cost impacts on different resident groups.

We recommend that IHACPA conducts further studies to establish the robustness of the classification over broader samples of facilities. This is particularly important for the post-pandemic setting, where cost relativities may have changed and some of these changes could be long-term in nature.

Pricing adjustments for size

Economies of scale may exist in residential aged care operation, such that larger providers enjoy a cost advantage over smaller providers. Put differently, smaller providers suffer from efficiency disadvantages that could require pricing adjustments under ABF. This could be the basis for providing pricing adjustments for rural and remote providers, which tend to be small in size compared to providers in cities.

An important issue that arises is whether size is related to quality of care. On this, there is limited evidence. Our research suggested a mixed picture. On some quality metrics (e.g., assaults per resident), worse quality is associated with larger size whereas for others (e.g., complaints per resident) the reverse association holds (Yang et al., 2021: Appendix B). Another indirect piece of evidence came from our research showing that for-profit providers, which tend to be larger in size, provided the lowest quality on average than other types of providers (Yong et al, 2021). We caution that these results show association, not causation. Further research is needed to establish the causal link between size and quality of care.

In the context of hospital care, the effect of size on quality has been documented in numerous studies (e.g., Kumbhani et al., 2018; Hentschker and Mennicken, 2018). However, by the nature of hospital care, volume may reflect learning and experience effects. It is less clear whether volume plays a similar role in aged care provision.

We recommend that IHACPA conduct further studies to understand the tradeoff between efficiency and quality. The evidence will inform decisions on whether there should be pricing adjustments for, e.g., supporting smaller, hence less efficient but higher quality providers. It will also inform the proposed adjustments of a one-off payment for residents first entering care to offset the high initial costs. It is conceivable that such costs may vary by size, e.g., larger providers may have a cost advantage over smaller providers.

Unintended consequences: Can cream skimming arise under AN-ACC?

The selective admission of profitable patients, i.e., cream skimming, by private hospitals under the hospital DRG system is a concern in hospital care where private and public hospitals co-exist. Our study found evidence of cream skimming in Australia's mixed public-private system (Yang et al., 2020) , where private hospitals select profitable and easy-to-treat patients while transferring complex and high cost patients to the public system.

The same phenomenon of cream skimming could arise under the AN-ACC classification. The number of classes is small compares to the DRG classification, which classifies in-

patient care into of more than 800 DRG groups. No classification system can capture all variation in costs. Some variation would inevitably remain in each class, even in the case of the DRG system. Private providers cream skim in two ways: by selecting patients in a DRG class that are less complex, and by selecting DRGs with lower complexity and hence patients that are easier to treat and can generate greater profits.

The same pattern of cream skimming may arise in residential aged care with higher prevalence due to the much coarser AN-ACC classification. The costing relativity could also give rise to private operators targeting certain high-profit segment of the resident population, e.g., those who pay out-of-pocket payments and with less complex care requirements, leaving less profitable or loss making resident to others, which will typically end up in government-owned and not-for-profit facilities.

We recommend that IHACPA investigates the costing variation within each group under AN-ACC with a view to further refine the classification to minimise cream skimming. We further recommend that IHACPA develops a monitoring system that keeps track of the phenomenon of cream skimming and examines the costing relativity of different provider types, i.e., for-profit, not-for-profit, and government-owned providers.

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