Centre for Health Service Development

Comments on the document "Activity based funding for Australian Public Hospitals: Towards a Pricing Framework"

This is a submission from the Centre for Health Service Development (CHSD). The CHSD is a research centre within the Australian Health Services Research Institute (AHSRI), University of Wollongong. During the last 18 years, the CHSD has undertaken casemix classification and funding model research and development projects in a wide range of settings including acute care, emergency departments, subacute care, mental health, outpatients and community care. These projects have given us a detailed understanding of the issues that will need to be addressed in the development of an appropriate activity based funding model.

The CHSD has particular expertise in subacute casemix. In 1997 we developed Version 1 of the Australian National Subacute and Non-Acute Patient (AN-SNAP) classification. We have subsequently developed versions 2 and 3 of the classification, a subacute activity based payment model and a range of related information tools.

Our overall view is that, given the short time frame, the consultants have produced a draft framework that is very helpful both in identifying areas where progress can be made in the short term and in identifying areas where significantly more longer term work is required.

It is important that the framework is developed in the context of contemporary healthcare. It is for this reason that we are very disappointed to see that the focus of the framework is very much on inpatient acute care. It is true that acute inpatient care represents the significant majority of activity in public hospitals. However, it is equally true that acute care is declining as a proportion of total hospital activity. As one example, subacute inpatient services now represent about 15% of hospital bed days. Non bed-based services (outpatients and community) are also growing at a faster rate than acute inpatient care. We do not believe that the framework pays adequate attention to these other streams of care and recommend that the consultants correct this in the final version of the paper.

Our comments below are based on our 18 years of experience in the development of casemix classification and funding models. As will be seen below, we have not attempted to comment on every issue. Instead, we have restricted our comments to those areas we consider most critical.

Chapter 4 Principles

We agree that funding models should not create perverse incentives. Our health system should aim to provide best practice affordable care and this goal should be supported by the funding model. The IHPA funding model, while promoting efficient care, should also explicitly support best practice care as a goal. Examples of how this is a potential problem under the proposed framework and a possible way of addressing this in some cases are provided in our comments on chapters 5 and 9.

We believe that one further principle is required. This further principle is equity in the distribution of resources across different geographic and different population groups. Governments at all levels should be committed to equity in health care and this should be enshrined as a principle in a national funding model.

Chapter 5 The scope of public hospitals and services included under new funding arrangements

We understand that the IHPA is required to define the scope of public hospitals in a way that is consistent with the national health reform agreement. However, we are very concerned about the artificial distinction that is being drawn between hospital and other public health care. Models of health care are rapidly changing and, in our view, this was not adequately recognised in the national health reform agreement. In some specialties such as mental health and palliative care, services are provided across all treatment settings and there is national consensus that where care is delivered, it should be based on patient need and not driven by the funding model. There is also national consensus about the need to support and integrate early intervention services into routine models of care. By including some, but not other, components of care within a specialty, incentives may be created to provide care in a particular way and the aim of providing clinically best practice care may be jeopardised.

We appreciate that the existing agreement may act to constrain the IHPA in the way that it defines the scope of the ABF model. However, we recommend that the IHPA adopts the broadest definition possible. If the final list of services is based on an artificial barrier between public hospital and public non-hospital care, it will inevitably disrupt current patient/service provision and work against best practice.

Just one small point of clarification. Under Criterion 6 in Table 5.1, subacute care is defined as rehabilitation and palliative care. This is not technically correct. There are four nationally agreed

subacute care types, the others being Geriatric Evaluation and Management and Psychogeriatric care.

Chapter 6 Setting the national efficient price

Section 6.1.1 of the paper refers to ‘episodes of care’. We believe that the paper needs more work (either in this section or elsewhere) on a classification framework that can underpin ABF. The absence of a classification framework in the current draft is a significant omission in our view.

Our recommended classification framework is depicted in the following diagram. One axis shows the setting of care (inpatient, outpatient and community). The other shows the type of care (acute, subacute, mental health). In our view casemix classifications should be determined for each type rather than setting of care (that is, vertical rather than horizontal classification).

For example, we believe that subacute outpatient care should be classified for ABF purposes as ‘subacute’ rather than ‘outpatient’. Likewise, mental health requires one classification that has classes for all settings of care. In contrast, the draft framework assumes that subacute outpatients will be classified as outpatient rather than subacute and that inpatient mental health should be classified by DRG rather than a mental health classification. We do not support the approach that is currently in the draft framework.

Figure 1 Recommended casemix classification matrix

<table>
<tr><th rowspan="2">Setting of care</th><th colspan="5">Type of care</th></tr>
<tr><th colspan="3">Acute Care</th><th>Subacute Care</th><th>Mental Health</th></tr>
<tr><td>Inpatient</td><td rowspan="2">Emergency Department</td><td>AR-DRG</td><td>ICU</td><td rowspan="3">AN-SNAP</td><td rowspan="3">Specialist mental health classification</td></tr>
<tr><td>Outpatient</td><td colspan="2">Clinic classification</td></tr>
<tr><td>Community</td><td>NA</td><td colspan="2">TBD</td></tr>
</table>

Once a classification framework is in place, it forms the logical structure for both defining the nationally efficient price and for determining how it is calculated.

We understand the concept of a single unit of measure and price equivalents and we support models that drive dynamic efficiency. However, we do not agree that the single unit of measurement and relative weights across all services will drive dynamic efficiency. Instead, the use of a single unit of measure and relative weights across all services will lead to a lack of transparency. As just one example, the relationship between the cost and the price of subacute care will not be transparent. Dynamic efficiency can only be increased when both costs and prices are transparent.

The obvious point to make about pricing is that it needs to take account of the legitimate costs of delivering different types of care in different healthcare settings. Unavoidable additional costs (whether due to factors such as location, patient mix, size or any other factor) need to be built into the price. This implies an ongoing research and development agenda to better understand cost drivers in health care.

We agree that it is too early to adopt best practice pricing as the standard approach. However, this is the right time to adopt a research and development strategy that would create the evidence base for such an approach to be adopted in future.

In relation to the measure of central tendency to be adopted, while cost weights continue to be calculated using averages, the mean is the most appropriate measure. Consideration should also be given to trimming of the data and outlier policies.

Other technical issues relating to the use of cost data include:

1. There are no national collections of reliable costs for sub-acute and many other types of care.
2. Calculation of cost, be it mean or median, should exclude cost components that are funded from other buckets.

The suggestion that lower-than-average pricing be adopted in the future is of concern. While it is possible that technical efficiency might increase, this could be at the expense of quality and safety. This would not be a dynamically efficient change. Our very strong view is that pricing and other aspects of ABF policy should be based on evidence. There is a significant risk to the integrity of the model if it is based on ideology rather than evidence.

Chapter 7 Adjusting the national efficient price

Teaching

The paper asks how 'teachingness' should be defined. The national health reform agreement is much broader than simply teaching and, reflecting this, "teachingness" should incorporate teaching, learning and research. These three activities are carried out at all hospitals, not just "teaching hospitals" and each should be separately recognised in the funding model. NSW has implemented the results of a study we undertook on this issue in its Resource Distribution Formula and we recommend that the consultants seek a copy of this report from New South Wales. We would also draw the consultants' attention to a summary of the issues to be addressed in relation to teaching, training and research that can be found at Eagar (2010) http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/documents/doc/uow082639.pdf

Adjusting for quality

The submission from our sister centre, the National Casemix and Classification Centre, discusses the technical issues around this at some length.

CHSD wishes to make two more general points. The first is that this section of the report deals only with adverse events in acute inpatient care and not with either quality more generally or with other types or settings of care.

The second point we wish to make is that adjusting for hospital-acquired complications in a payment model should only be considered when it can be reliably identified that the complication was the result of inappropriate care and has had an adverse impact on the patient. For example, a malnourished patient has a higher chance of complications arising during their admission than a patient who is well-nourished. Such an adjustment should never be considered for the classification itself (see NCCC submission for further detail).

Chapter 9 Block grant funding

For reasons that are not apparent to us, both subacute care and mental health care are dealt with in the chapter called Block Grant Funding.

Mental health

As illustrated in Figure 1 above, mental health services are provided in all settings. All mental health should be incorporated into one ABF model. Apart from the technical weaknesses that are outlined in the NCCC submission, paying for acute admitted inpatients on an activity basis while block funding or excluding other care settings risks creating perverse incentives. CHSD strongly supports the development of an all-setting casemix classification for mental health. This classification could build on the work undertaken in the MH-CASC study that was undertaken in the mid-1990s.

On that note we would point out that MH-CASC was a one off study and, contrary to what is written in the consultation paper, there has been no significant investment in mental health classification development in the 15 years since that study was undertaken. This minor error of fact needs to be corrected in the final version of the paper.

Subacute care

The AN-SNAP classification was developed to classify patients in designated subacute facilities. It includes classes for ambulatory patients as well as admitted inpatients (see Figure 1) and applies to all four subacute case types as well as non-acute patients. The classification is comprehensive, but outdated. Patient complexity is incorporated using functional measures rather than diagnoses. This is because functional status is the main cost driver in this type of care.

As we noted above, since developing Version 1 of AN-SNAP in 1997, we have subsequently developed versions 2 and 3 of the classification, a subacute activity based payment model and a range of related information tools. AN-SNAP is currently used routinely for both classification and funding purposes in several Australian jurisdictions and has recently been adopted as a payment model for parts of the private rehabilitation sector in Victoria.

The intellectual property associated with the AN-SNAP classification continues to be owned by the University of Wollongong. However, given the University's release of the classification into the public domain, the University is happy for others to use the classification without modification or development. If the IHPA or any other party wishes to modify or develop the classification, it is necessary to consult with and seek the consent of the University.

Our recommendation is that, having negotiated these issues with the University, work proceed as soon as possible to develop version 4 of the AN-SNAP classification and the associated cost weights

and service weights. We further recommend that, once it is developed, it be used to classify subacute care in all settings (see Figure 1).

Chapter 10 Phasing: a sustainable implementation of ABF

We note that, in reality, 2012/13 will be a shadow year for ABF funding. Genuine funding of hospitals on the basis of their activity will not commence until 2013/14. Based on our previous experience, there is a huge amount of development that will need to be undertaken before 2013/14 if the changes in payment arrangements are to successfully go live that year. Classification systems will need to be reviewed and updated and this work needs to be done thoroughly. In many instances, jurisdictions still have to start collecting the necessary data to enable the classifications to be implemented. This is true for a number of classifications including AN-SNAP and the classification adopted for emergency departments (URGs).

While the focus of the next year will necessarily be on developments required for 2013/14, we urge the IHPA to also take a longer term view. It is imperative that the IHPA develop and implement a long-term research and development agenda. Piecemeal investment in short term consultancies will not be sufficient for the development of a high-quality ABF model. Strategic and longer term R&D investments are also required. The draft pricing framework is a good start. However, there is much more work to be done.

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The CHSD is happy to provide any further information that may be required. Please contact either Associate Professor Rob Gordon (CHSD Director) or Prof Kathy Eagar (CHSD Executive Director) in the first instance.