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Abstract
Activity-Based Funding (ABF) is a central feature of the Rudd hospital reform plan ('A National Health and Hospitals Network for Australia's Future'). ABF is not a new idea, either to the health sector or to other industries. Indeed, the Council of Australian Governments (COAG) agreed in November 2008 to introduce a nationally consistent ABF approach as part of its National Partnership Agreement on Hospital and Health Workforce Reform. The Rudd hospital reform plan proposes to accelerate the ABF work program that has already been agreed with the States and Territories.

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ABF Information Series No. 1

What is activity-based funding?

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March 2010

Activity-Based Funding (ABF) is a central feature of the Rudd hospital reform plan ('*A National Health and Hospitals Network for Australia's Future*'). ABF is not a new idea, either to the health sector or to other industries. Indeed, the Council of Australian Governments (COAG) agreed in November 2008 to introduce a nationally consistent ABF approach as part of its *National Partnership Agreement on Hospital and Health Workforce Reform*. The Rudd hospital reform plan proposes to accelerate the ABF work program that has already been agreed with the States and Territories.

ABF means exactly what it says – providers are funded based on the activity they undertake. Because most hospital activity involves treating patients – or cases – the term 'casemix funding' is also used. 'Casemix' literally means the 'mix of cases' that a health service treats.

However, the term casemix funding is not quite correct. The health system produces more than treated cases, and includes maintaining the health of people at home, prevention, teaching and research. For this reason, no hospital system in the world is funded solely on the basis of its 'casemix'.

ABF models have been used in the funding of Australian hospitals since the early 1990s. By 2003, most States and Territories had some type of ABF model in place, using casemix classifications to count activity. In some States and Territories, such as Victoria and South Australia, ABF is already the dominant funding model. However, even in these States, a considerable amount of hospital work is not funded on activity and many small hospitals are not activity based funded at all. In other States such as New South Wales, activity based funding is but one element of a broader funding model.

ABF is already used at the national level as well. Residential aged care, which is funded by the Commonwealth, is based on a form of ABF in which providers are paid more for caring for frailer and sicker residents and less for caring for residents who are more independent. That idea makes sense and the same idea underpins hospital ABF.

However, there is one important difference. In residential care, the activity is counted per day. In most hospital models, activity is counted by 'episode of care', which refers to the whole time a patient is in hospital from admission to discharge. In ABF models, the financial incentive is to minimise the cost of each episode of care, which inevitably rewards the shortest length of stay in a hospital bed and raises concerns that patients will be discharged too soon. These concerns can be overcome if patient outcomes are measured at discharge and if there is continuity of patient care between the hospital and home.

What activities can be funded under ABF?

A critical element of ABF is that you need to be able to define, classify, count, cost and pay for each activity in a consistent manner. If you cannot do all of these, you cannot use ABF.

The COAG agreement recognises five different types of activities to be funded under ABF:

- Acute inpatient admissions such as surgery, medical admissions, maternity and paediatrics
- Emergency department services
- Sub-acute care (both inpatient and outpatient) such as rehabilitation and palliative care
- Outpatient services

- Hospital-auspiced community health services such as home nursing and post acute care.

Of these five types, only one – acute inpatient care – has a nationally adopted classification that can currently be used to define the 'activity' to be counted in an ABF model. This classification is the Australian-Refined Diagnosis Related Group (AR-DRG) classification. It consists of about 670 patient classes with each patient being classified based on their diagnoses, surgical procedures and other routinely collected data. In ABF, a different price is paid for each class and that price depends on what each class typically costs. There are also special rules to provide extra funding for patients who are very atypical in terms of their length of stay in hospital or their cost. The Rudd proposal is that an 'independent umpire' will set the 'efficient price' for each patient class.

The DRG system is only suitable for acute inpatient care and cannot be used to classify all of the other activities that hospitals undertake. Acute inpatient care costs about $16 billion per year and represents about 60% of the costs of Australian public hospitals. The other 40% of public hospital costs cannot be funded under the DRG classification model. This 40% is discussed below.

The existing COAG agreement also recognises that there will be a need for a separate approach for small hospitals with community service obligations. This is because ABF works on the idea of standard prices for each activity. Remote hospitals, for example, cost more than the standard price and so need special arrangements.

What activities can't currently be funded under ABF?

Some hospital activity cannot currently be classified and counted and therefore cannot be funded under ABF:

- Teaching (eg, medical, nursing, allied health)
- Learning (eg, intern, resident and registrar medical training, student nurses)
- Research
- Services for boarders (eg, a mother staying at the hospital while her child is an inpatient)
- Patient travel (eg, isolated patient travel schemes) and medical retrieval services (eg, air ambulance)
- Support for affiliated agencies (eg, hospitals that prepare food for Meals on Wheels)
- Public health and health promotion services (eg, healthy lifestyle programs, parent education for new mothers)
- Interpreter services
- Aboriginal liaison and support.

Further, and as noted above, while it is theoretically possible to use an ABF approach, other services require a nationally agreed classification before an ABF model could be developed:

- Emergency department services
- Sub-acute care (both inpatient and outpatient) such as rehabilitation and palliative care
- Outpatient services
- Hospital outreach and post-acute care services
- Mental health.

Implementation of ABF

The Rudd plan proposes that, from 1 July 2012, the Commonwealth will progressively introduce ABF starting with admitted patient services and progressing to emergency department and outpatient services. In practice, it will only be possible to start with **acute** inpatient care as the DRG classification is not suitable for use in a funding model for sub-acute or mental health care.

Adopting or developing nationally agreed classifications for these types of care will not be a trivial exercise and, even after a national classification is agreed, it will take several years to implement the required information systems and design the ABF model. The existing COAG Agreement proposes that use of a nationally agreed ABF funding model will begin from 2014-15. While it is technically feasible for the acute inpatient care stream to begin earlier, 2014-2015 is optimistic for most of the other care streams.