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A national perspective on activity based funding and palliative care

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Abstract

[extract] A quick reminder of recent history

Core design features of the National Health Reform Agreement (NHRA)

Signed by COAG 31 July 2011

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A National Perspective on Activity Based Funding and Palliative Care

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A quick reminder of recent history

Core design features of the National Health Reform Agreement (NHRA)

Signed by COAG 31 July 2011

Brave new world

- ◆ Health system splits into 5
 - Hospitals - State responsibility
 - ◆ Commonwealth to contribute its share on an activity basis
 - Private sector primary care - Commonwealth responsibility
 - “Aged care” including Home and Community Care (HACC) for people 65 years and over - Commonwealth
 - ◆ except Victoria and Western Australia
 - Disability services - State responsibility
 - ◆ All disability, HACC and residential care for people less than 65 years
 - Community health, population health and public health - State responsibility

◆ National

- Independent Hospital Pricing Authority (IHPA)
- National Health Performance Authority (NHPA)
- National Health Funding Pool
 - ◆ Reserve bank accounts (one for each state and territory) with an independent administrator

◆ State

- Ongoing reorganisations of most departments

◆ Local

- Local Hospital Networks (LHN)
 - ◆ Local Health Districts in NSW, Hospitals and Health Services in Qld etc
- 'Medicare Locals'

- ◆ Hospitals - big white buildings surrounded by a fence
- ◆ Everything outside the fence is either 'primary care' or 'aged care' or a 'disability service'
 - no terms defined
- ◆ Specialist services outside the fence (public and private) not adequately recognised in original agreement
 - but IHPA has gone a long way to addressing this since

Hospitals

The centre of the health reform
- creating perverse incentives for some
very regressive thinking!

Commonwealth and State joint responsibilities

- ◆ Funding public hospital services
 - using Activity Based Funding (ABF) where practicable and block funding in other cases
- ◆ Nationally consistent standards for healthcare and performance reporting
- ◆ Collecting and providing comparable and transparent data

Commonwealth role from 2012

- ◆ Pay a 'national efficient price' for every public hospital service
 - Funding at current levels (around 38%) until 2014
 - 2014-2017 - fund 45% of **efficient growth** in public hospitals
 - 2017 on - fund 50% of **efficient growth** in public hospitals
 - ◆ Commonwealth will never get back to 50% of total hospital funding
 - ◆ Current estimate is that Cw contribution will be about 44% in 2030
- ◆ Fund States (and through them LHNs) a contribution for:
 - teaching, training and research
 - block funding for small public hospitals
- ◆ Agreement has detailed arrangements for defining a 'hospital' service that the Commonwealth will partly fund

Scope of Commonwealth funding

- ◆ **Hospital services** provided to both public and private patients in a range of settings (including at home) and funded either:
 - on an activity basis or
 - through block grants, including in rural and regional communities;
- ◆ teaching and training undertaken in public hospitals or other organisations (such as universities and training providers)
- ◆ research funded by States undertaken in public hospitals and
- ◆ public health activities managed by States

- ◆ From 1 July 2012 funding to be "provided on an ABF basis wherever possible"

- ◆ Management of public hospitals, including:
 - hospital service planning
 - purchasing services from LHNs
 - planning, funding and delivering capital
 - planning, funding (with the Commonwealth) and delivering teaching, training and research
 - managing Local Hospital Network performance
- ◆ Lead role in public health
- ◆ Management and 100% funding of community health and public sector primary care



Activity Based Funding

Also known as 'casemix' funding

IHPA role

- ◆ Define activity units and set the price that the Commonwealth will pay for a unit of activity (National Weighted Activity Unit - NWAU)
- ◆ IHPA determines the price paid to States (via LHNs)
- ◆ IHPA does not determine the price paid by a state or territory to an LHN or hospital
 - Although states and territories are free to adopt the IHPA price if they want
- ◆ IHPA does not determine the funding for individual palliative care services

“National efficient price”

- ◆ Five different classifications for different streams of activity:
 - acute admitted
 - emergency department
 - subacute (including palliative care)
 - outpatient services
 - mental health
- ◆ One ‘national efficient price’ for a ‘national weighted activity unit’ (cost weight)
- ◆ Cost weights equalised across classifications

National ABF activity classifications

- ◆ Acute - AR-DRG
- ◆ Subacute and non-acute - AN-SNAP
- ◆ ED - Urgency Related Groups - URGs or Urgency Disposition Groups - UDGs
- ◆ Outpatients and community care - Tier 2 outpatient clinic list of Service Events
- ◆ Mental health – new classification to be developed
- ◆ Teaching and research – block funded for now

Calculation of Efficient Price

- ◆ Based on the “cost of the efficient delivery of public hospital services”
- ◆ Adjusted for ‘legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery, including:
 - hospital type and size
 - hospital location, including regional and remote status and
 - patient complexity, including Indigenous status’



AN-SNAP

Australian National Subacute and Non-Acute Patient classification

- ◆ Care in which diagnosis is not the main cost driver
- ◆ Subacute Care
 - enhancement of quality of life and/or functional status
- ◆ Non-Acute Care
 - supportive care where goal is maintenance of current health status if possible

AN-SNAP

- ◆ Current version is V3, developed 2012
- ◆ Work to develop V4 is just beginning
 - Plan is to complete in 2014 and implement nationally on 1 July 2015
 - V4 being developed by Centre for Health Service Development (UoW) led by A/Prof Rob Gordon and A/Prof Janette Green with A/Prof Richard Chye participating as a member of the team
 - Multiple consultations in planning seeking ideas for incorporation in V4

Key Cost Drivers - 1

- *Case Type* - characteristics of the person and the goal of treatment
- *function* (motor and cognition) - all Case Types
- *phase* (stage of illness) - palliative care
- *impairment* - rehabilitation
- *behaviour* - psychogeriatric
- *age* - palliative care, rehab, GEM and maintenance

Key Cost Drivers - 2

There are additional cost drivers in ambulatory care:

- *problem severity* - palliative care
- *phase* - psychogeriatric
- *usage of other health and community services*

and probably:

- availability of Carer
- instrumental ADLs (eg. medication management, food preparation)

AN-SNAP

- ◆ Version 1 developed in 1996, Version 2 in 2007, Version 3 in 2012
- ◆ Based on a study of 30,057 episodes in 104 services in Australia and New Zealand
- ◆ 150 classes in the current version:

Care Type	Ambulatory	Inpatient	Total
GEM	8	7	15
Maintenance	16	11	27
Palliative Care	22	12	34
Psychogeriatric	7	7	14
Rehabilitation	15	45	60
Grand Total	68	82	150

AN-SNAP v2 & v3

palliative care inpatient classes

ClassNo	Description
S2-101	Assessment only
S2-102	Stable, RUG-ADL 4
S2-103	Stable, RUG-ADL 5-17
S2-104	Stable, RUG-ADL 18
S2-105	Unstable, RUG-ADL 4-17
S2-106	Unstable, RUG-ADL 18
S2-107	Deteriorating, RUG-ADL 4-14
S2-108	Deteriorating, RUG-ADL 15-18, age <=52
S2-109	Deteriorating, RUG-ADL 15-18, age >=53
S2-110	Terminal, RUG-ADL 4-16
S2-111	Terminal, RUG-ADL 17-18
S2-112	Bereavement

Ambulatory classes v1-v3

151	Medical only
152	Therapies only
153	Stable, Multidisciplinary
154	Stable, Nursing only, severity <10, RUG 4, age 66+
155	Stable, Nursing only, severity <10, RUG 4, age <=65
156	Stable, Nursing only, severity <10, RUG 5-18
157	Stable, Nursing only, severity 11+
158	Unstable, Multidisciplinary, RUG 4, severity=<11
159	Unstable, Multidisciplinary, RUG 4, severity 12+
160	Unstable, Multidisciplinary, RUG 5-18
161	Unstable, Nursing only, RUG<=14, age 60+
162	Unstable, Nursing only, RUG<=14, age <=59
163	Unstable, Nursing only, RUG 15+
164	Deteriorating, Multidisciplinary, severity <10
165	Deteriorating, Multidisciplinary, severity 11+, RUG<=10
166	Deteriorating, Multidisciplinary, severity 11+, RUG 11+
167	Deteriorating, Nursing only, RUG 4
168	Deteriorating, Nursing only, RUG 5-18
169	Terminal, Multidisciplinary
170	Terminal, Nursing only
171	Bereavement, age >45
172	Bereavement, age <44



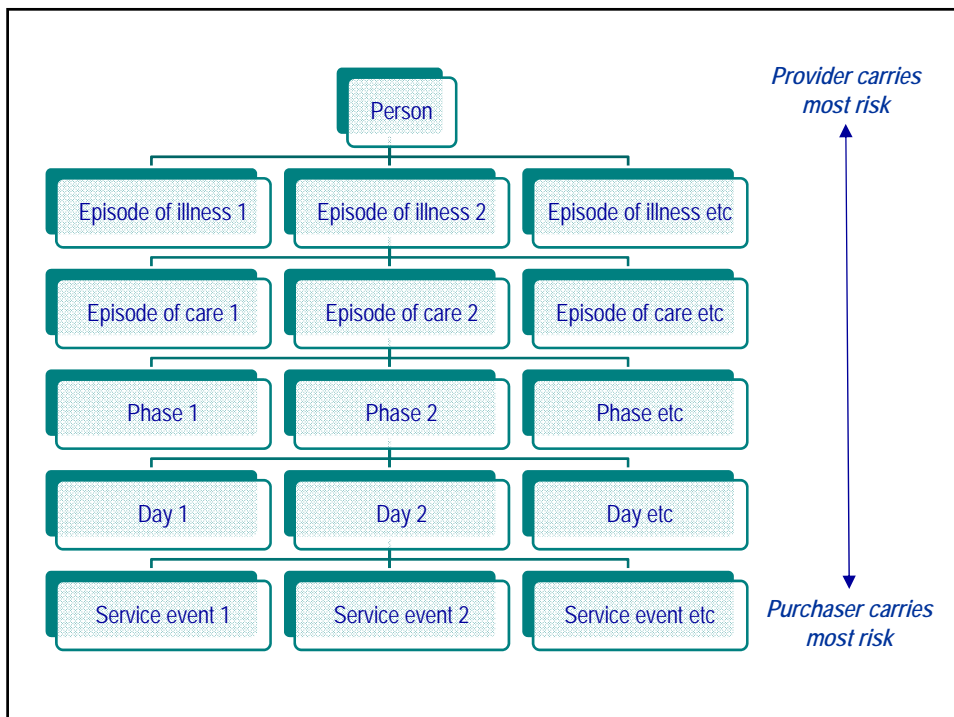
Future possibilities

Cost drivers

- ◆ Need to distinguish between the **classification**, the **funding model** and the **price**
- ◆ Are additional **classification** variables required to better explain differences between **patients**?
- ◆ How to classify paediatric palliative care?
- ◆ Does the IHPA need to take account of any additional factors to better explain legitimate **cost** differences between **providers** and use this information in **pricing**?

Non-admitted palliative care

- ◆ IHPA is 'agnostic' about both setting and provider:
 - No distinction between palliative care provided at home, in an outpatient clinic or in a day hospital
- ◆ How to classify 'same day admitted' care?
 - IHPA classifies as inpatient, AN-SNAP as ambulatory
- ◆ What unit of counting?
 - AN-SNAP is by palliative care phase
 - Tier 2 is by Service Event



Other future developments?

- ◆ New models of care?
 - Consultation liaison?
- ◆ Price for quality and outcomes, not based on current average cost?
 - Pay for Performance (P4P)?
- ◆ How to deal with gaming?
 - Manipulating your data so patients are assigned to higher-paying classes
 - This is not in the interests of quality care
 - How do we get the message through?

Want to know more?

- ◆ <http://ahsri.uow.edu.au/chsd/abf/index.html>
 - ABF Information Series No. 1. What is activity-based funding?
 - ABF Information Series No. 2. The special case of smaller and regional hospitals
 - ABF Information Series No. 3. Lessons from the USA
 - ABF Information Series No. 4. The cost of public hospitals - which State or Territory is the most efficient?
 - ABF Information Series No. 5. Counting acute inpatient care
 - ABF Information Series No. 6. Subacute care.
 - ABF Information Series No. 7. Research and training
 - ABF Information Series No. 8. Mental health
- ◆ <http://www.ihsa.gov.au>