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Meeting emerging challenges: Activity Based Funding and Casemix

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Abstract
Outline

- Summarise key aspects of the national health reform, with a particular focus on Activity Based Funding (ABF)

- Three key challenges for health information management that arise from the reforms

Keywords
challenges, casemix, activity, emerging, funding, meeting

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Meeting Emerging Challenges: Activity Based Funding and Casemix

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Outline

- Summarise key aspects of the national health reform, with a particular focus on Activity Based Funding (ABF)
- Three key challenges for health information management that arise from the reforms
The National Health and Hospitals Network Agreement

Key aspects
Brave new world

Health system splits into 5

- Hospitals - State responsibility
  - Funded 60:40 by Commonwealth and State
- “Primary health care” - Commonwealth responsibility
- “Aged care” including Home and Community Care (HACC) for people 65 years and over - Commonwealth
  - except Victoria
- Disability services - State responsibility
  - All disability, HACC and residential care for people less than 65 years
- Other population health - State responsibility
New entities

National
- Independent Hospital Pricing Authority (IHPA)
- National Performance Authority (NPA)

State
- National Health and Hospital Network Funding Authority in each state
  - Each with a board of 3 supervisors - one State, one Commonwealth and an independent chair

Local
- Local Hospital Networks (LHN)
  - Local ‘Health’ Networks in NSW
Premise

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 not adequately recognised or addressed

– Despite the fact that these are major growth areas and key hospital demand management strategies
  † eg, around 30 public Diabetes Centres in NSW alone (part of the LHN, the PHCO or something else?)
Hospitals
Commonwealth responsibilities

pay 60% of the ‘national efficient price’ of every public hospital service provided to public patients under agreed LHN Service Agreements

pay States (not LHNs):

- 60% contribution for research, training, block funding for small public hospitals and capital funding paid on a user cost of capital basis
- 100% for any Commonwealth-funded primary health care services that are provided by the states and territories

“The Commonwealth will not intervene in matters concerning governance of LHNs or the negotiation and implementation of LHN Service Agreements”
Based on this planning, States enter into a Local Hospital Network (LHNs) Service Agreement with each LCN that specifies services to be provided.

Commonwealth contribution based on ‘efficient price’ as determined by Independent Hospital Pricing Authority.

State contribution determined by each State.

Quarterly financial adjustments for activity and performance.

LHN receives Commonwealth and State funds from National Health and Hospital Network Funding Authority in each State.

State and Commonwealth transfer funding for these services to the National Health and Hospital Network Funding Authority in each State.

LHN reports to State (and through to Commonwealth) on activity and performance.
Activity Based Funding (AKA ‘casemix’ or ‘episode’ funding)
ABF - 2 national agreements

2008 National Partnership Agreement (NPA) on Hospital and Health Workforce Reform

- Schedule A - nationally consistent ABF
- 5 streams - acute admitted, ED, subacute, outpatient services & “hospital-auspiced community health services”
  ◆ nationally consistent classifications and data collections for each of these streams
  ◆ mental health not mentioned but inevitably requires a separate approach

2010 National Health and Hospitals Network Agreement

- Acceleration of the 2008 NPA
“Nationally efficient price”

As per the existing NPA, 4 streams - acute admitted, ED, subacute & outpatient services

Plus

- 'primary health care equivalent' outpatient services
- training and research
- block funding for small hospitals
- capital, on the basis of user cost of capital where possible

Mental health not mentioned
Calculation of Efficient Price

Based on the cost of the efficient delivery of public hospital services

Adjusted ‘for a small number of loadings, to reflect variations in wage costs and other legitimate and unavoidable 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’
Not one size fits all - lots of wriggle room!

‘The IHPA will provide advice to COAG on the definition and typology of public hospitals eligible for:

i. block funding only;

ii. mixed ABF and block funding; and

iii. ABF only;

COAG will make a decision on the definition and typology of public hospitals’
ABF 2011-2012

HPA becomes responsible for classification development

HPA to commence:
- development of national efficient price and relevant cost weights for admitted acute patient services
- calculation of block funding levels for small hospitals
- calculation of funding for training and research activities

HPA will ‘develop advice on the process of transition to the national efficient price’ - & the timetable

HPA's classification of outpatient services to be
ABF - from July 2012

Admitted acute patient services
- payments on ABF basis with state-specific prices from 1 July 2012
- transitioning over time to national efficient price

Emergency department, subacute and outpatient services
- each service funded using nationally consistent activity 'proxies' and state-specific prices from 1 July 2012
- moving over time to ABF payments with state-specific prices and transitioning to payment against a national
Health Information Management
Challenges
Defining activity for ABF purposes

Nationally consistent classifications and data collections required for each stream:

- Acute admitted - AR-DRG
- Emergency Department
- Subacute
- Outpatients &
- “Hospital-auspiced community health services”
Defining ‘activity’ for ABF purposes

Only acute inpatient activity will be defined by diagnosis and procedures (using AR-DRG)
- Because diagnosis is not a major cost-driver for the other 4 activity streams

What role for Health Information Managers and medical record departments in collecting, coding and classifying cost-drivers beyond DRGs?
- Focus remains on acute care, ICD, ACHI OR
- Focus expands to include the information required for the
Workforce

Where is the national workforce strategy to underpin ABF reforms?
– given the increasing importance of health information for funding purposes?
E-Health

National ABF and national E-health initiatives being introduced in parallel.

They have to come together so that the information required for ABF purposes is captured in electronic medical records.

How do we get from clinical (input) terminologies like SNOMED to output-based classifications like DRGs?
“In God we trust, all others bring data”

Anonymous treasury official (2013)