A National Perspective on Activity Based Funding and Palliative Care

Professor Kathy Eagar
Director, Australian Health Services Research Institute
Palliative Care Services and ABF: From National Perspectives to Local Implementation,
NSW Agency for Clinical Innovation and Palliative Care NSW Forum, ACI, Sydney 5 February 2014

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
New entities

◆ 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’

Commonwealth 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 (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”
State responsibilities

◆ 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

Scope

- 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

- Based on a study of 30,057 episodes in 104 services in Australia and New Zealand
- 150 classes in the current version:

<table>
<thead>
<tr>
<th>Care Type</th>
<th>Ambulatory</th>
<th>Inpatient</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>GEM</td>
<td>8</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Maintenance</td>
<td>16</td>
<td>11</td>
<td>27</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>22</td>
<td>12</td>
<td>34</td>
</tr>
<tr>
<td>Psychogeriatric</td>
<td>7</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>15</td>
<td>45</td>
<td>60</td>
</tr>
<tr>
<td>Grand Total</td>
<td>68</td>
<td>82</td>
<td>150</td>
</tr>
</tbody>
</table>
### Palliative Care Inpatient Classes

<table>
<thead>
<tr>
<th>ClassNo</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S2-101</td>
<td>Assessment only</td>
</tr>
<tr>
<td>S2-102</td>
<td>Stable, RUG-ADL 4</td>
</tr>
<tr>
<td>S2-103</td>
<td>Stable, RUG-ADL 5-17</td>
</tr>
<tr>
<td>S2-104</td>
<td>Stable, RUG-ADL 18</td>
</tr>
<tr>
<td>S2-105</td>
<td>Unstable, RUG-ADL 4-17</td>
</tr>
<tr>
<td>S2-106</td>
<td>Unstable, RUG-ADL 18</td>
</tr>
<tr>
<td>S2-107</td>
<td>Deteriorating, RUG-ADL 4-14</td>
</tr>
<tr>
<td>S2-108</td>
<td>Deteriorating, RUG-ADL 15-18, age &lt;=52</td>
</tr>
<tr>
<td>S2-109</td>
<td>Deteriorating, RUG-ADL 15-18, age &gt;=53</td>
</tr>
<tr>
<td>S2-110</td>
<td>Terminal, RUG-ADL 4-16</td>
</tr>
<tr>
<td>S2-111</td>
<td>Terminal, RUG-ADL 17-18</td>
</tr>
<tr>
<td>S2-112</td>
<td>Bereavement</td>
</tr>
</tbody>
</table>

### Ambulatory Classes

<table>
<thead>
<tr>
<th>ClassNo</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>151</td>
<td>Medical only</td>
</tr>
<tr>
<td>152</td>
<td>Therapies only</td>
</tr>
<tr>
<td>153</td>
<td>Stable, Multidisciplinary</td>
</tr>
<tr>
<td>154</td>
<td>Stable, Nursing only, severity &lt;10, RUG 4, age 66+</td>
</tr>
<tr>
<td>155</td>
<td>Stable, Nursing only, severity &lt;10, RUG 4, age &lt;=65</td>
</tr>
<tr>
<td>156</td>
<td>Stable, Nursing only, severity &lt;10, RUG 5-18</td>
</tr>
<tr>
<td>157</td>
<td>Stable, Nursing only, severity 11+</td>
</tr>
<tr>
<td>158</td>
<td>Unstable, Multidisciplinary, RUG 4, severity&lt;=11</td>
</tr>
<tr>
<td>159</td>
<td>Unstable, Multidisciplinary, RUG 4, severity 12+</td>
</tr>
<tr>
<td>160</td>
<td>Unstable, Multidisciplinary, RUG 5-18</td>
</tr>
<tr>
<td>161</td>
<td>Unstable, Nursing only, RUG&lt;=14, age 60+</td>
</tr>
<tr>
<td>162</td>
<td>Unstable, Nursing only, RUG&lt;=14, age &lt;=59</td>
</tr>
<tr>
<td>163</td>
<td>Unstable, Nursing only, RUG 15+</td>
</tr>
<tr>
<td>164</td>
<td>Deteriorating, Multidisciplinary, severity &lt;10</td>
</tr>
<tr>
<td>165</td>
<td>Deteriorating, Multidisciplinary, severity 11+, RUG&lt;=10</td>
</tr>
<tr>
<td>166</td>
<td>Deteriorating, Multidisciplinary, severity 11+, RUG 11+</td>
</tr>
<tr>
<td>167</td>
<td>Deteriorating, Nursing only, RUG 4</td>
</tr>
<tr>
<td>168</td>
<td>Deteriorating, Nursing only, RUG 5-18</td>
</tr>
<tr>
<td>169</td>
<td>Terminal, Multidisciplinary</td>
</tr>
<tr>
<td>170</td>
<td>Terminal, Nursing only</td>
</tr>
<tr>
<td>171</td>
<td>Bereavement, age &gt;45</td>
</tr>
<tr>
<td>172</td>
<td>Bereavement, age &lt;=44</td>
</tr>
</tbody>
</table>
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?

  – 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. 7. Research and training
  – ABF Information Series No. 8. Mental health

◆ http://www.ihpa.gov.au