The National Efficient Price for Public Hospital Services
– what is it, and what is its impact on the delivery of health services?

INTRODUCTION
On 28 February 2014, the Independent Hospital Pricing Authority released the third round of the National Efficient Price (NEP) and associated pricing relativities. The NEP, as part of an overall national Activity Based Funding (ABF) model, determines the allocation of Commonwealth funds to States and their Local Hospital Networks for public hospital services that will be delivered in the financial year 2014/15. The NEP for 2014–15 is $5,007, which compares to $4,993 for 2013–14, and $4,808 for 2012–13. The NEP represents the price per National Weighted Activity Unit (NWAU).
WHAT IS ACTIVITY BASED FUNDING?

ABF is a method of funding healthcare based on the volume and mix of services delivered. Each service is allocated a complexity weighting which reflects the relative cost of delivering that service. The complexity weighting is multiplied by the price per weighted unit to calculate the total price of a hospital service. For example, using the 2014-15 NEP parameters:

- A tonsillectomy has a weight of 0.7058 NWAU which equates to $3,534 per admission.
- A hip replacement has a weight of 4.1855 NWAU which equates to $20,957 per admission.

Total funding over a defined period is calculated as the sum of the weighted units of the services delivered in that year, multiplied by the price per weighted unit to calculate the total relative cost of delivering that service. The complexity weighting that IS a Complexity Weighting which reflects the volume and mix of services delivered. Each service is allocated a complexity weighting which reflects the relative cost of delivering that service. The complexity weighting is multiplied by the price per weighted unit to calculate the total price of a hospital service. For example, using the 2014-15 NEP parameters:

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WHY WAS A NATIONAL ABF MODEL INTRODUCED?

In 2009 the National Health and Hospitals Reform Commission (NHHRC) recommended that activity based funding should be the principal mode of funding for public and private hospitals. This was adopted as part of the 2011 National Health Reform Agreement, and implemented on 1 July 2012.

The two largest funders of health services are the Commonwealth and State and Territory governments. In 2011/12 State governments were the largest funders of public hospital services (53%), with the Commonwealth funding approximately 35% of public hospital services. The relationship between the funder and the type of services is illustrated in the following chart.

Figure 1: Australian Health Expenditure in 2011/12 by area of expenditure and source of funds

The national ABF model provides a mechanism by which the growth of hospital funding is proportionately shared between the Commonwealth and the States. As the population ages, demand for services will grow more quickly than the currently available financial and workforce resources. Various studies have shown that hospitals will be one of the fastest growing areas of health spending over the next few decades' placing considerable pressure on State and Territory budgets.

Prior to the implementation of the Agreement on 1 July 2012, Commonwealth funding to States for public hospital services comprised block grants based on historic funding levels, adjusted for inflation, population growth, and ageing. This historical funding approach carries forward funding inequities from year to year. The risks of increased demand and utilisation for hospital services are carried by the States and Territories, who have limited revenue-raising capacity compared to the Commonwealth. As a result, over time the Commonwealth proportion of funding for public hospitals has reduced. The implementation of ABF means that, for the first time, Commonwealth funding will be linked directly to the utilisation of hospital services. This reduces the pressure on States to raise revenue through their less efficient sources of taxes.

The funding formula specified in the Agreement leads to cost sharing between the States and the Commonwealth, such that Commonwealth funding will increase from current levels of 35% of actual expenditure to 50% of ‘efficient’ costs in the longer term. For services that are funded on an activity basis, efficient costs are derived from the ABF model as the NEP times the number of national weighted activity units. For services that are funded on an activity basis, differences in volume and complexity between States and Local Hospital Networks (LHNs) are directly recognised in the funding model. An illustration of the potential change in the relative share of Commonwealth/State funding of hospital expenditure is below.

Figure 2: Commonwealth / State contribution to hospital expenditure for a given State, assuming cost of service grows at the same rate as NEP growth


Note: Other consists of patient transport services ($3b), Other health practitioners ($4.5b), Public health ($2.2b), Aids & appliances ($3.7b), Admin ($2.4b), Research ($5.0b).
The national ABF model provides a mechanism by which the allocation of hospital funding to Local Hospital Networks is equitable and transparent. Prior to the implementation of the Agreement on 1 July 2012, there was little transparency on the distribution of Commonwealth and State funds to Local Hospital Networks. With an ABF formula now published by the Pricing Authority each year, there is complete transparency on how Commonwealth funds are allocated to States and Local Hospital Networks. The transparency principle is supported by compulsory monthly reporting of the amount of Commonwealth funds paid to each Local Hospital Network. For services that are funded through ABF, the allocation of funds to all Local Hospital Networks around the country is based on the national ABF model, thereby being significantly more equitable than funding models based on historic budgets.

The national ABF model encourages greater uniformity between State funding models. It is important to remember that State funding models will still be the key determinant of total funding paid to a Local Hospital Network. The national ABF model is used to determine the allocation of Commonwealth funds to States and Local Hospital Networks, however there is no requirement for States to adopt the national model. The State funding model will determine what contribution the State must make over and above the Commonwealth amount, as illustrated below:

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\text{State contribution to each Local Hospital Network} = (\text{State funding model}) \text{ less } (\text{Commonwealth funding}),
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\text{where Commonwealth funding} = \text{Commonwealth} \times \text{share of National ABF model based on the NEP}
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A number of the States have chosen to base their funding models on the price weights published through the national model: the national price weights are based on the national data sets, which are more robust than weights derived from local state datasets. Furthermore, there is administrative efficiency to be gained from using a pricing structure that compliments the national model.

**WHAT DATA ARE USED TO SET THE NEP AND THE PRICE WEIGHTS?**

As with most actuarial pricing exercises, a base price must be set (this is represented by the NEP) for the costs that are covered by the Commonwealth, and pricing relativities must be set. The NEP and the pricing relativities are developed from ‘activity’ data and from ‘cost’ data. The cost data comes from the National Hospital Cost Data Collection (NHCDC), which is collected annually by the Pricing Authority from jurisdictions. In the NHCDC, each hospital allocates all patient-related costs from its general ledger accounts down to an individual patient episode, or to groups of patient episodes. The NHCDC is a sample, with over 90% coverage of hospital activity. The NHCDC is the primary data source that is used to set the pricing relativities. Because the NHCDC is a sample, a weighting process is used to weight up the cost data to the population of activity that is in-scope for the ABF model before the base price can be determined. The activity data is either at patient episode level, or at summarised level, and represents the volume and mix of services that are delivered within a given year.

**WHAT ARE THE RISKS OF AN ABF MODEL?**

For the first time, Commonwealth funding of public hospital services will be ‘uncapped’. This presents risks of public hospital expenditure growth that the Commonwealth has not previously been exposed to. However, with the States still needing to fund approximately half of public hospital expenditure growth, there are strong incentives for the States to manage the growth in total public hospital expenditure. A further risk that has been identified by various stakeholders is that ABF for public hospitals could incentivise the shift of services that could otherwise be delivered outside the hospital, back into the hospital. While this could be so in some instances, workforce, financial, and bed capacity constraints mean that Local Hospital Networks and Hospitals must make decisions regarding the optimal use of their limited resources. These resource constraints incentivise decisions around which services are best delivered in a hospital setting compared to an out of hospital setting.

An ABF model, as with any funding model, comes with the risks of gaming and up-coding. Gaming risks exist when two different prices exist for a similar service, providing an incentive to code and service the activity in the setting that provides the highest price. Perfect pricing harmony can be difficult to achieve if the systems that are used to classify and fund health services are different. The Pricing Authority is aware of this risk and seeks to minimise these differences where possible. A number of health providers will now place greater focus on coding accuracy and it is likely that the average complexity of patients will increase, relative to that recorded in prior periods, in order to maximise revenue. Over time, these coding changes should eventually be reflected in the price weights. The Pricing Authority is also aware of the up-coding / gaming risk and has stated that monitoring is being performed to identify this.

Another risk that has been identified is the impact of shortcuts that could be taken to cut costs, leading to adverse patient outcomes. However, additional new Commonwealth agencies have been established as part of the implementation of National Health Reform: the National Health Performance Authority (NHPA), and the Australian Commission on Safety and Quality in Healthcare (ACSQHC). NHPA must report on the
performance of every Local Hospital Network and other health organisations, and it maintains the MyHospitals and MyHealthyCommunities websites. The ACSQHC must formulate and monitor safety and quality standards and work with clinicians.

**SO WHAT ARE THE IMPACTS AND CHALLENGES FOR STATES, LOCAL HOSPITAL NETWORKS, HOSPITALS AND CLINICIANS?**

The impact of the introduction of a national ABF system has been significant. There has been a significant level of activity relating to data collection, budget setting and accountability, governance processes, reporting, and the establishment of national and state working groups:

- **Data collection and reporting**: first, new national data collections have been specified by the Pricing Authority. These new data collections have been developed from those that have already been in existence for many years, however refinements and additions to the existing datasets have been necessary. A simple example is the reporting of the number of hours spent by a patient in an Intensive Care Unit – this has not been reported to the national data collections previously, but is now necessary because it is a direct input to the calculation of the National Weighted Activity Unit.

- **Coding of activity**: there will be increased focus on more accurate coding of activity to ensure that funding is maximised for the services delivered. This will affect clinicians, where some clinicians have been requested to record information more accurately and frequently than they have been used to in the past. ABF has also led to an increase in demand for skilled coders.

- **Working groups**: in order to arrive at a national approach, a large number of working groups have been established. These groups meet at regular intervals to bring together the views of all jurisdictions and the Commonwealth.

The National Health Reform Agreement provides incentives for public hospitals to deliver quality health care for the lowest cost, thereby providing a relative ‘surplus’ if they can outperform the NEP.

- **Local Hospital Network Governance**: LHNs are separate legal entities under State legislation who will have a Governing Council and Chief Executive Officer. Their clinical, financial and operational responsibilities are specified in the Agreement and include service and budget management.

The National Health Reform Agreement provides incentives for public hospitals to deliver quality health care for the lowest cost, thereby providing a relative ‘surplus’ if they can outperform the NEP. The extent to which ABF will influence decision making at the hospital and clinician levels will depend on the extent to which budgets are devolved, and accountability and KPIs are established around budget setting and management. ABF provides a tremendous resource in that a benchmark is available against which actual costs can be compared. To make the most of this benchmark, reporting and analysis systems must be made available to Local Hospital Networks, hospital managers, and clinicians, so that they can better understand their costs, how they compare to the ABF prices, how they compare to each other, and what they can do to improve efficiency while maintaining or improving patient outcomes.

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