Victorian Healthcare Association

SUBMISSION

Australian Senate Standing Committee on Finance and Public Administration Legislation Committee Inquiry into the National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011

31 August 2011

1. Introduction

This submission outlines the Victorian Healthcare Association's response to the Australian Senate Standing Committee on Finance and Public Administration Legislation Committee Inquiry into the *National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011*.

The Victorian Healthcare Association (VHA) agrees to this submission being treated as a public document and to the information being cited in the Committee's Report.

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The Victorian Healthcare Association

The VHA is the major peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health services and aged care facilities. Established since 1938, the VHA promotes improvement of health outcomes for all Victorians, from the perspective of its members.

Context

The National Health Reform Amendment (Independent Hospital Pricing Authority) Bill will introduce activity based funding (ABF) to all of the public health service agencies in Australia with the aim to "promote improved efficiency in, and access to, public hospital services".

ABF is not new to Victoria. It was introduced in Victoria 18 years ago as Casemix funding and established on the premise of improvement in the health policy objectives of equity, technical and allocative efficiency, and consumer choice. What is new is the proposed re-introduction of ABF in sub-acute and outpatient services.

The National Health Reform Amendment (National Health Performance Authority) Bill 2011 was introduced to Parliament in March this year to establish the National Performance Authority (NPA). This followed the National Health and Hospital Network Bill 2011 (later renamed the National Health Reform Act), which introduced the Australian Commission on Safety and Quality in Health Care.

2. The VHA's Response

The VHA supports the general premise of the National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011 and the national standardisation of ABF across Australia. However, the effect of the Bill on the health service agencies in Victoria will be determined by how well the ABF is implemented. The Independent Hospital Pricing Authority (IHPA) can learn from the 18 years of experience in Victoria.

The essence behind Casemix funding was that it would allow for a more transparent and equitable distribution of funds. When introduced in Victoria a health service agency's budget for hospital activity at the time of introduction was simply divided into whatever was the price at the time. This became your Casemix target. Thus issues of allocative efficiency remained unaddressed through the introductory methodology applied to ABF in Victoria.

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However, what casemix did do was highlight a lot of variables. An inconsistency became obvious in agencies with a high level of activity that did not align with the community being serviced. This has led to the idea that Casemix funding endorses *standardisation*, but it is merely an expression of technical efficiency. It avoids the other health objectives of distributive or allocative efficiency. There is a need to understand that there are variances in cost and variances in performance that result in the underlying cost driver for an individual agency. For example, if the average cost weight for hospital A is at .8, and at hospital B it is .9, and they both do the same amount of separations, hospital B may cost more because they have a higher level of complexity than hospital A.

The funding model applying to bed activity in Victoria acknowledges that the cost of business varies according to scale and location. The Weighted Inlier Equivalent Separation (WIES) funding model incorporates six different price points relative to scale. Bed day rates in mental health and aged care also reflect variable pricing. However, the rate range in mental health reflects a .54% rural premium, compared to a 13.8% price spread for acute activity. Neither primary care nor dental unit rates reflect scale or geographical consideration.

Unfortunately, the conceptual acknowledgement of scalable input costs has been lost over time as the gap between the various rural WIES prices and the WIES price for major providers has remained a relatively constant proportion over time (with some marginal upward adjustment). It is not clear if these price gaps are reviewed in detail annually.The WIES funding model is underpinned through an extensive input cost modelling exercise but when cost weights are based upon out-of-date cost data, the result is a lag effect.

Indeed, the growing uncertainty about the viability and sustainability of current service levels within the Victorian health system has been caused by a failure to maintain the relative input-costs variance between agencies of differing scale. This is compounded by a failure of funding models to reflect increasing input costs, such as burgeoning utilities costs and the cost of expanding information and communication technologies (ICT) platforms. Significantly, the annual indexation applied for hospital activity is below that received by the private health insurance (PHI) industry (see table). This is causing more agencies across all Victorian health settings to experience significant fiscal pressure. It has also significantly diminished the capacity of boards to effectively govern and create financial reserves that can be used to improve infrastructure and foster innovation.

Price point/year on year change	05-06 %	06-07 %	07-08 %	08-09 %	09-10 %	10-11 %
WIES (Major)	3.97	3.89	4.00	5.76	3.81	3.47
WIES (>14,000)	3.99	4.03	3.99	5.76	3.80	3.47
WIES (>7,500)	3.98	4.10	4.00	5.76	3.79	3.47
WIES (>5,000)	3.98	4.22	4.02	5.77	3.81	3.47
WIES (<5,000)	3.99	4.40	4.01	5.78	3.80	3.47
WIES (C Hosp)	12.93	4.54	4.01	5.76	3.80	3.47
PHI	7.96	5.68	4.52	4.99	6.02	5.78

Table 1: Annual indexation applied for hospital activity

This exacerbates the relative input-costs variance between agencies of differing depreciation. There is a cost associated with inefficient capital, whether it results from to higher maintenance costs or technical inefficiencies due to the physical layout of the

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facilities. Not all environments are the same, yet there is a failure of the ABF model to reflect these increased costs.

To demonstrate the inefficiencies of ABF, VHA has long advocated that maternity should be funded as a strategy rather than on the basis of an activity. Maternity services are mostly funded through Victoria's activity-based funding model. Whilst there are places where it is equitable for funding to be provided on the basis of an activity, there are a small number of service providers who skew the cost input weights for some particular diagnostic categories that it becomes a challenge for everyone else.

The cost weight applying to maternity services is heavily influenced by high-volume activity in major metropolitan hospitals. Monash Medical Centre, Mercy Women's Hospital and the Royal Woman's Hospital probably have the lion's share of maternity in the state. If you include Barwon Health in this equation, this covers a huge portion of the state and the analysis of cost weights associated with the provision of maternity services and therefore price. However, this makes low-volume maternity services in rural areas less viable, threatening the sustainability of services in rural areas.

Health services agencies' sustainability is further challenged by the dwindling supply of qualified practitioners. An example that the VHA has previously articulated is a comparison involving Swan Hill, which has about 260 births a year, and Bairnsdale, which has about 340 births a year. The infrastructure and fixed costs associated with maintaining maternity in those two regional centres is very similar except they will pay a specialist obstetrician on the basis of visits, rather than as an employed obstetrician. Fundamentally, most of their costs will be fixed and the ABF model does not allow for this.

Another issue that the VHA has identified as impacting on ABF, through diagnosis related group (DRG) weight fluctuations, is changes in technology. A systemic problem exists with the fact that as newer procedures are added to DRGs, particularly those that employ expensive technology and are highly resourced, the weights of these DRGs are going to increase significantly.

The effect of new technology relates to the fact that the overall pool of WIES available to health services grows only minimally over time in accordance with particular growth indexations, but demand for many existing services escalates in excess of this growth. Demand for new services creates an additional burden on the system as WIES are not added in alignment with the addition of new activities. This creates a scenario that means the weight of some DRGs increases and the weight of others must proportionally decrease in response to new activities occurring. These fluctuations are unlikely to happen in proportion to changes in the real costs of providing particular DRGs.

Ultimately, this means that some health agencies are going to lose out, particularly those that focus their work in a smaller range of less complex DRGs, where proportional changes will affect them most as they are least likely to use the DRGs with escalating weights. Over time, they will be expected to perform more work for the same amount of money if they are to retain existing levels of service to their communities. If a service, such as obstetrics, loses enough DRG weighting so as to become unviable, it is not necessarily in the interests of the agency, and certainly not in the interests of the community, to cease providing it.

A risk associated with differential pricing can be characterised from the Victorian experience whereby, in order to prevent health service agencies from having to operate in deficit, a series of grants has been created to cover various shortfalls. Some grants are directed towards covering the costs of particular procedures such as prostheses or dialysis, while others are about contributing to the costs of teaching and professional development that happens in hospitals. The most telling use of grants, however, has been

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the introduction of what are called 'transition' or 'compensation' grants. The application of these particular grants is not transparent as not all agencies receive them.

These grants are designed to eliminate the negative effects of budget shortfalls, which can be exacerbated by DRG weight changes or inadequate indexations of funding in relation to costs of service provision. There is acknowledgement built into the casemix system that it is not appropriately funding particular health service agencies, so that they have to be 'bailed out' on a regular basis.

To overcome the deficiencies of current cost modelling, the VHA recommends;

- price reflect scale and geography for all unitised pricing approaches, with differential pricing being consistently applied across the various service domains
- bi-annual reviews of the relativity between price points
- that prospective provision for the cost of ICT initiatives be incorporated into the price setting methodology
- The IHPA must ensure the price it determines for services fairly represents the cost of providing those services

3. Conclusions

Whilst VHA supports the introduction of the Independent Hospital Pricing Authority as highlighted in the National Health Reform Amendment Bill 2011 and the standardisation of ABF across Australia, there is a need to consider the lessons of Casemix funding over the past 18 years to ensure effective implementation. As highlighted in this submission, there is imbalance in the application of cost weights as evident in maternity services and inconsistencies in WIES which vary depending on location, scale and type of health service. It is imperative to both understand and acknowledge these inefficiencies to develop a sustainable approach in its implementation to better meet the health objectives of the Victorian healthcare system.

The VHA welcomes the opportunity to provide further information to the Senate Standing Committee on Finance and Public Administration on this or any other issues relating to health in Victoria.

Please contact me on (03) 9094 7777 to clarify any information in this submission.

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