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Impact of ABF on equitable access to public hospital allied health service in Australia

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BACKGROUND - ACTIVITY BASED FUNDING

Implementation of Activity Based Funding (ABF) in Australia

- ABF for Australian public hospitals was introduced from 1 July 2012;
- The overarching principles that govern the implementation of ABF in Australia are that:
 - Funding should support timely access to quality health services;
 - ABF should improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services;
 - ABF payments should be fair and equitable; and
 - Funding design should recognise the complementary responsibilities of each level of government in funding health services.
- **This paper examines the impact of ABF on access to public hospital non-admitted allied health services;**
 - Specifically, to investigate whether the implementation of ABF will create incentives that impact on the timely access to quality allied health services in public hospitals.

BACKGROUND - ACTIVITY BASED FUNDING

Implementation of ABF, maintenance of effort and hospital growth funding:

- The development and implementation of ABF in Australia is governed by a National Health Reform Agreement (NHRA) between the Australian Federal, State and Territory governments (nine governments);
- Under the NHRA, ABF will be phased-in for all public hospital service streams, i.e. acute admitted, sub-acute, emergency department, non-admitted and mental health patients;
- After the ‘maintenance of effort’ period (2012/13 and 2013/14), public hospital-provided services will attract Commonwealth growth funds (at 45% of the NEP) from 1st July 2014 rising to 50% from 1st July 2017;
- Commonwealth/State proportions of funding may still not be the same, due to:
 - Hospital grants from the Commonwealth to State governments (block funding) have previously been calculated (largely) on a population per capita basis; and
 - Historical differences in hospital utilisation between states;
 - State decisions regarding the share of funding allocated to block grant funding.

THE INDEPENDENT HOSPITAL PRICING AUTHORITY

The Australian Independent Hospital Pricing Authority

- As part of the implementation of ABF, an Independent Hospital Pricing Authority (IHPA) was established by the Australian Government in December 2011;
 - The principal role of the IHPA is to determine the National Efficient Prices (NEP) for (in 2012/13) acute admitted, non-admitted (outpatient) and emergency department services in public hospitals;
- In June 2012, the IHPA determined that the NEP for a single unit of activity in an Australian public hospital is AUD\$4,808;
 - Under Australian ABF, units of hospital activity are termed 'National Weighted Activity Units' (NWAUs);
 - NWAU values are uniquely calculated for each individual service, then multiplied by the NEP to determine the funding for each admitted, non-admitted and emergency department service delivered in public hospitals.

NATIONAL WEIGHTED ACTIVITY UNITS

Development of NWAU values

- To develop NWAU, and to determine the NEP, IHPA collated activity and cost data for each of the service streams to be funded on an activity basis in 2012-13, principally using the National Hospital Costs Data Collection (NHCDC) provided by states;
- Using these data, ‘base’ NWAU (or price weights) have been developed for each public hospital service stream, according to agreed classification schemes;
 - Price weights are set at the average (arithmetic) costs for each category in the product classification system (i.e. AR-DRGs for admitted patients, NHCDC Tier 2 Clinics for non-admitted patients and Urgency Related Groups (URGs) for emergency department patients);
 - These price weights are modified by adjustments based on patient characteristics, such as the Indigenous status, remoteness classification of the patient’s usual residence, private patient election, pediatric status, length of stay and time spent in ICU to produce the NWAU for an individual service.

METHOD

Comparison of service volumes by discipline across and jurisdictions to establish current level of access to public hospital allied health services

- Using historical data, the number of non-admitted allied health services provided and the per capita rate of service provision are calculated, for each discipline; and
- The level of variation in per-capita service volumes is compared across jurisdictions.

Comparison of pricing of allied health services by discipline and payer to determine any impact on access

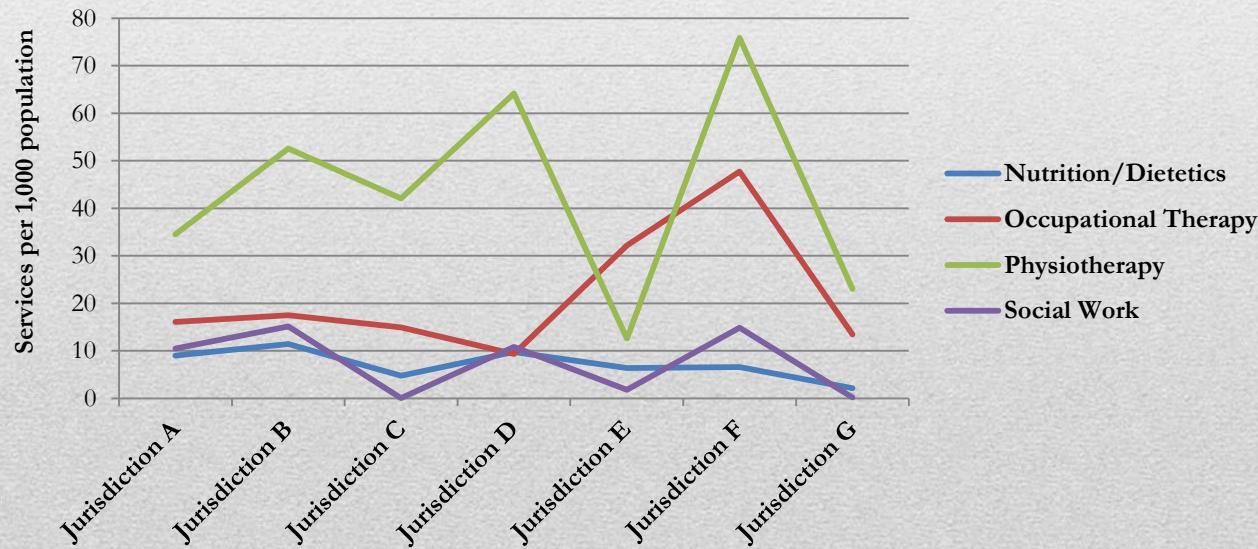
- The published public patient NEP for selected allied health services is compared across the payers selected for the study;
- Average rates paid for the same set of allied health services were determined based on desktop research and some primary data collection;
- The raw rate of payment for allied health services was compared across payers; and
- The variation (range) in pricing of services was compared across payers.

ANALYSIS – SERVICE VOLUMES

Historically, per-capita service volumes for allied health services vary across States

- Reported per-capita service volumes of hospital-provided allied health services vary significantly between both services and jurisdictions;
- The level of variation in high-volume services (particularly physiotherapy and occupational therapy) is established by Figure 1;

Figure 1: Per-capita service volumes for selected high-volume allied health services, 2009-10



IMPLICATIONS OF VARIATION IN SERVICE VOLUMES ACROSS JURISDICTIONS

Per-capita service volumes for allied health services vary across States

- Some of the variation may be accounted for by:
 - the use of different counting rules to report data;
 - different service models (i.e. some states provide more public services through community health services, while others provide more through hospitals); and
 - real differences in access to public allied health services.
- **Each of these potential variations has significance in the ABF context.**
- Variations in the per-capita provision of public hospital allied health services were relatively unimportant in an environment where all services were block funded so low rates of service provision in hospitals could be offset by high rates in the non-hospital sector.
- However, under ABF public hospital provided services attract Commonwealth growth funds, whereas non-hospital-provided services do not;
- **As a result, those States/Territories that have higher hospital provision rates will benefit, at the expense of states with lower rates of hospital provision.**

ANALYSIS – PRICING VARIATION

NEPs vary significantly across the allied health disciplines

- NEPs vary considerably across the allied health disciplines selected for the study, from \$96 to \$556 per service event;
- For high volume services (physiotherapy, occupational therapy, social work and nutrition / dietetics), the NEP varies from \$103 to \$175;

Table 1: Service volumes and NEPs for selected allied health services

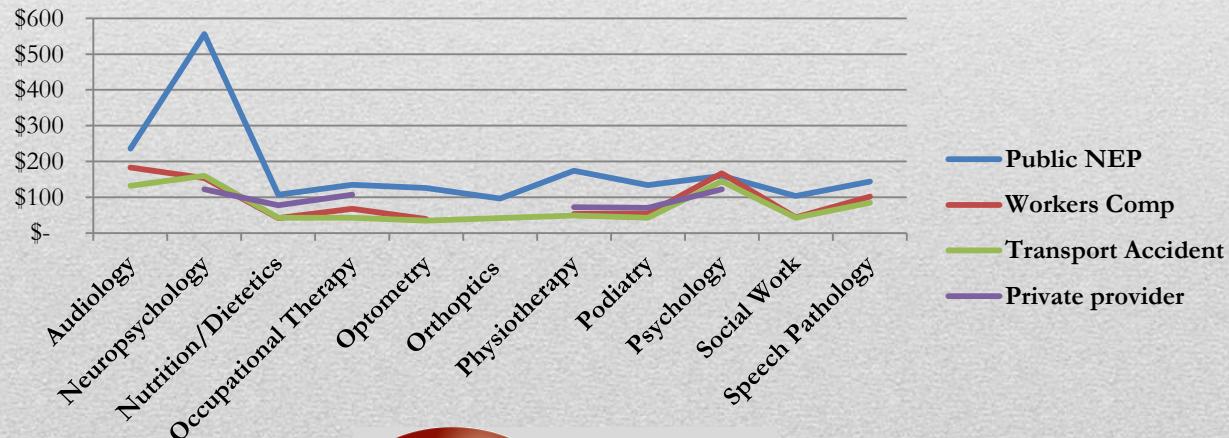
Allied Health Service	Total 2009-10 service volume	2012-13 Public NEP
Audiology	27,466	\$236
Neuropsychology	867	\$556
Nutrition/Dietetics	85,302	\$107
Occupational Therapy	166,242	\$135
Optometry	1,577	\$126
Orthoptics	5,350	\$96
Physiotherapy	481,515	\$175
Podiatry	62,028	\$134
Psychology	27,106	\$160
Social Work	93,295	\$103
Speech Pathology	53,622	\$144

ANALYSIS – PRICING VARIATION

Public NEP versus private market rates

- Published NEPs for 2012-13 allied health services were compared to average prices paid for:
 - Services provided by private practitioners (at market rates);
 - Worker's compensation schemes operating across Australia; and
 - One transport accident insurance scheme.
- Figure 2 shows that the public NEP is significantly higher for almost all services, except psychology.

Figure 2: Prices paid for allied health services, by payer type



ANALYSIS – PRICING VARIATION

Level of pricing variation across payers

- Table 2 examines variations in prices paid by the type of payer;
- Variation in the NEP is greater than for all other types of payer;
- NEP variation is in the ratio of 1.7 to 1 whereas other providers range between 1.1 to 1.6.

Table 2: Variation in pricing of allied health services, by type of payer

Allied Health Service	Public NEP	Workers Comp	Transport Accident	Private provider
Audiology	\$236	\$183	\$132	not available
Neuropsychology	\$556	\$153	\$159	\$122
Nutrition/Dietetics	\$107	\$42	\$42	\$78
Occupational Therapy	\$135	\$68	\$42	\$107
Optometry	\$126	\$39	\$35	not available
Orthoptics	\$96	not available	\$41	not available
Physiotherapy	\$175	\$53	\$49	\$72
Podiatry	\$134	\$55	\$42	\$70
Psychology	\$160	\$167	\$145	\$122
Social Work	\$103	\$44	\$42	not available
Speech Pathology	\$144	\$102	\$84	\$73
Variation factor - all services	5.8	4.6	4.6	1.7
Variation factor - high volume services	1.7	1.6	1.1	1.5

IMPLICATIONS OF PRICING VARIATIONS

Variations in pricing using the NEP relative to prevailing market may create unintended incentives for hospitals to ‘game’ the system

- Variation in rates paid for allied health services under the public NEP are greater than other types of payer, as are the absolute levels of prices;
- The higher absolute prices, even relative to other government payers, creates the potential for increasing or decreasing the provision of services in a sector, thereby impacting on patient access to public hospital allied health services
- The variation in prices calculated using the NEP relative to variation in the market may result in inequitable funding for the allied health disciplines in the public sector (e.g. prices paid by workers compensation insurers and charged by private providers for occupational therapy are noticeably higher than for physiotherapy, but the reverse is true for the NEP).
- **Again, these variations may not matter much in the current environment where block funding is effectively in force until 30th June 2014, but they will create significant issues from 1 July 2014 and beyond.**

REVISED APPROACH TO PRICING

A revised approach to price setting is required to manage the risk of unintended impacts of ABF on access to public hospital services.

- It is known that costing of non-admitted services is relatively underdeveloped compared to costing of admitted patient services in Australia, thus it is hypothesised that much of the variation in the published NEPs for the allied health disciplines are due to inaccuracies in the costing processes used to support, and/or poor quality data reported to, the NHCDC.
- Costs data for non-admitted services need to improve rapidly; the reliance on heavily dated service weights linking clinician costs (the largest component of allied health costs) to categories in the NHCDC Tier 2 classification system needs to be removed.
- More detailed costing studies, probably prospective, to enable the development of more accurate relative value units, and subsequently more accurate costs are urgently required.
- Even when more accurate costs are available, IHPA should have regard to prevailing market prices when setting the NEP; consideration of market prices may not be appropriate for all services funded under ABF, but where there is high potential for substitutability of public hospital services, they should be considered.

CONCLUSIONS

- It is generally accepted that allied health services are becoming an increasingly important part of hospital and non-hospital service delivery models;
- This study has established that some jurisdictions provide a significantly greater number of public hospital allied health services per capita, compared to others;
- The study also establishes that prices for allied health services under the NEP vary to a greater extent than other comparable payment arrangements in place around Australia in both the public and private sectors;
- Taken together, the variation in public hospital-based service provision rates and pricing present a risk with respect to equitable access to public sector allied health services;
- **It will be important to address these issues through more accurate counting of public hospital allied health services, much improved costing of non-admitted services generally, and reference to prevailing market prices in setting the NEP prior to 1st July 2014, to ensure that ABF does not create incentives that adversely impact on equitable access to public hospital allied health services.**