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Getting the incentives right

Submission to the Independent Hospital Pricing Authority on the draft 2020-21 Pricing Framework

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Overview

The prices set by the Independent Hospital Pricing Authority (IHPA) are designed to provide incentives for efficiency and best practice in public hospitals. Yet the prices used in the national funding arrangements for private patients in public hospitals yield greater revenue to states than the prices set for public patients. This is perverse and contrary to good public policy.

IHPA is constrained in its ability to address this issue because of the phrasing of the National Health Reform Agreement. IHPA should raise this issue with jurisdictions.

IHPA should also:

- Facilitate wider access to the National Benchmarking Portal;
- Enhance the National Benchmarking Portal by including more information on complications;
- Link the Patient Reported Outcome Measures data included in publicly-funded national clinical quality registries to IHPA data sets.

1. Private patients in public hospitals

There has been extensive debate in recent years about the growth in the number of private patients in public hospitals. But this growth is not the main cause of the increase in private health insurance premiums¹ – about 9.6 per cent of real growth in private health insurance benefit payments per member over the past decade is due to changes in the number of admissions of private patients to public hospitals and the costs of these admissions (see figure).

Private patients have shorter waiting times for admissions to public hospitals.² This preferential treatment undermines the Medicare principles, especially that admission should be based on clinical need

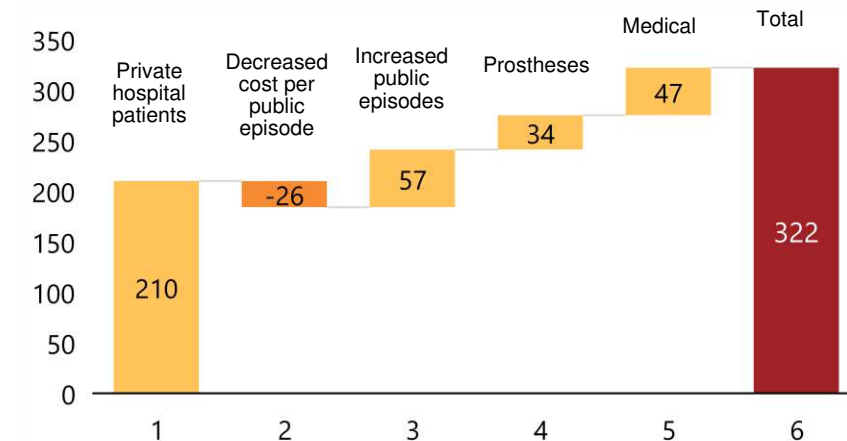
In theory, Commonwealth Government funding to the states for public hospital services is supposed to ensure that total payments for public and private patients are equal. In practice, the way the system works means states³ can get more revenue for private patients than they get for public patients.

¹ Duckett (2017).

² Australian Institute of Health and Welfare (2019).

Figure: Private patients in public hospitals account for only a small proportion of the costs of benefit growth

Real change in benefits per member 2008-09 to 2018-19



Source: Grattan analysis of APRA Health insurance data

The Commonwealth payments to states under the National Health Reform Agreement consist of a base amount and a growth amount. The latter is set so the Commonwealth pays the state 45 per cent of the cost of activity growth – up to a cap – paid at the National Efficient Price.

³ 'States' in this submission includes territories.

The Reform Agreement specifies (in section A41) how the payment for private patients in public hospitals is to work:

ABF (activity based funding) payments for eligible private patients must utilise the same ABF classification system as for public patients, with the cost weights for private patients being calculated by excluding or reducing, as appropriate, the components of the service for that patient which are covered by:

- a. Commonwealth funding sources other than ABF;
- b. patient charges including:
 - i. prostheses; and
 - ii. accommodation and nursing related components/charge equivalent to the private health insurance default bed day rate (or other equivalent payment).⁴

The draft 2020-21 Pricing Framework proposes a ‘public-private neutrality’ guideline:

ABF pricing should not disrupt current incentives for a person to elect to be treated as a private or a public patient in a public hospital.⁵

The National Health Reform Agreement is sloppily phrased. It is not clear whether it is directed to what IHPA does or to

what the Administrator of the National Health Funding Pool does, and, unlike the draft Pricing Framework, it does not include a statement of intent.

IHPA and the Administrator have interpreted section A41 to mean that the extent of exclusions or reductions that should be made will make the payment relativities⁶ of public and private patients equivalent, taking into account the additional sources of revenue for private patients.

Importantly, public-private equivalence in relativities is not the same as public-private equivalence in revenue to a state.

The concept of equivalence does not take into account the fact that the Commonwealth revenue contributes 45 per cent of a National Weighted Activity Unit (NWAU), and so the marginal impact of an additional private patient is attenuated by that same proportion, but the state or public hospital receives 100 per cent of the additional bed day or Medicare revenue. As a result, states can be better off by admitting private patients compared to public patients.

This creates a very undesirable incentive which is counter to the intent of Medicare and the principle of public-private neutrality. The appendix shows how the NWAU payment from the Commonwealth for a private patient, plus private

⁴ Council of Australian Governments (2011).

⁵ Independent Hospital Pricing Authority (2019).

⁶ ‘Payment relativities’ here refers to the payment metric, National Weighted Activity Units (NWAU).

patient revenue from insurance, will generally be greater than the Commonwealth NWAU payment for a public patient.

In general, states do not simply pass on the Commonwealth payment to public hospitals and local health networks. So the incentives for states may differ from the incentives for hospitals. State policy, naturally enough, is shaped by the incentives for the state. Therefore the incentives for a state in the Agreement should reflect the implicit intent of public-private neutrality.

Potentially, the sloppiness of the Agreement wording could allow IHPA to adjust the exclusions or reductions so that the revenue states receive from the Commonwealth for a private patient is such that the states will no longer have an incentive to admit private rather than public patients. That is, IHPA could set a private patient NWAU so the total revenue to a state and its medical practitioners from the Commonwealth and private insurers for private patients is equivalent to the total revenue for public patients.

However, the way NWAU is calculated is core to the Agreement, so IHPA should seek clarification from jurisdictions about the intent of the Agreement and its current interpretation before making changes. Specifically, IHPA should consult with jurisdictions about whether the current way NWAU is calculated is consistent with the intent of the Agreement.

The phrasing of clause A41 should also be clarified in the next Agreement, due for negotiation in the near future. The new Agreement might also require states to implement policies which ensure neutrality in incentives on public hospitals to admit public or private patients.

2. Other issues

Access to data collections

The National Hospital Minimum Data Set and the National Hospital Cost Data Collection contribute to the National Benchmarking Portal and are invaluable resources for research, policy analysis and policy development.

The more the portal can be used, subject to ensuring total confidentiality of a patient's data, the better. IHPA should facilitate wider access to the portal.

Pricing for safety and quality

The list of hospital-acquired conditions currently used in the safety and quality adjustment encompasses a very narrow range of complications. About 10.7 per cent of all patients in hospitals acquire an additional diagnosis – a good measure of complications of care. Eliminating all designated hospital-acquired complications will only reduce that to 10.3 per cent.⁷

Policy should be designed to attempt to reduce *all* complications, not just conditions on the limited list of

designated hospital-acquired complications currently used in the safety and quality adjustment.⁸ Some hospitals perform better than others in reducing complications. All hospitals should be encouraged to learn from the better-performers.

IHPA should facilitate this by including information on all complications in its benchmarking portal.

Patient Reported Outcome Measures

Several states are exploring use of Patient Reported Outcome Measures (PROMs). The place of PROMs in healthcare is complex, with international experience quite mixed.⁹

There is also considerable interest in value-based care,¹⁰ although how this organising framework should be applied to improve the system is unclear.¹¹

One element of value-based care is a focus on value from the patient's perspective, and here PROMs become relevant.

Many of the existing, well-established, publicly funded clinical quality registries already incorporate PROMs data. Those registries should be required to supply PROMs data

⁸ Duckett, *et al.* (2018).

⁹ Duckett, *et al.* (2017).

¹⁰ Woolcock (2019); Cattel and Eijkenaar (2019 Forthcoming).

¹¹ Duckett (2019 (forthcoming)).

so it could be linked and appended to the relevant patient record in the National Hospital Minimum Data Set and the National Hospital Cost Data Collection. IHPA should advocate for such an approach, and it should foreshadow that it will collect PROMs data in its work plan.

3. References

- Auditor General of Victoria (2019) *Managing private medical practice in public hospitals*, 2018-19: 30, VAGO
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- Cattel, D. and Eijkenaar, F. (2019 Forthcoming) 'Value-Based Provider Payment Initiatives Combining Global Payments With Explicit Quality Incentives: A Systematic Review', *Medical Care Research and Review*, 0(0), p 1077558719856775
- Council of Australian Governments (2011) *National Health Reform Agreement*, COAG
- Duckett, S. (2017) *Walking and chewing gum – policy needs to balance multiple policy objectives, not just consider one*. Grattan Institute submission in response to the *Options Paper on the growth of private patients in public hospitals*, Grattan Institute
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- Independent Hospital Pricing Authority (2017) *The Pricing Framework for Australian Public Hospital Services 2018-19*, IHPA
- Independent Hospital Pricing Authority (2019) *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2020-21*, IHPA
- Woolcock, K. (2019) *Value Based Health Care: Setting the scene for Australia*, Deeble Institute

Appendix: The impact of the current private patient NWAU payment

IHPA is charged with setting the cost weights – effectively the prices – for public and private patients in line with the National Health Reform Agreement.

The IHPA formula for pricing of acute inpatient activity is:

Price of an admitted acute ABF Activity =

$$\{[PW \times APAed \times (1 + ASPA) \times (1 + AInd + ARes + ART + ADia) \times (1 + ATreat) + (AICU \times ICU \text{ hours})] - [(PW + AICU \times ICU \text{ hours}) \times APPS + LOS \times AAcc] - PW \times AHAC\} \times NEP$$

Focusing on just the terms which distinguish private patients from public patients, the equation becomes:¹²

$$\{PW - [PW \times APPS + LOS \times AAcc]\} \times NEP$$

The private patient adjustments recognise that private patients in public hospitals are charged daily

¹² APPS is the Private Patient Service Adjustment; AAcc is the Private Patient Accommodation Adjustment applicable to which state the patient is treated in and the length of stay; LOS is the length of stay in hospital (in days); NEP is the National Efficient Price; PW is the Price Weight for an ABF Activity.

accommodation charges, and their treating medical practitioners (and pathology and radiology providers) bill them directly for medical services.

IHPA explains that:

The NHRA requires IHPA to set the price for admitted private patients in public hospitals accounting for these payments by other parties, particularly private health insurers (for prostheses and the default bed day rate) and the Medicare Benefits Schedule (MBS).¹³

The effect of the adjustments is that the National Efficient Price for a private patient, with expected revenue from accommodation charges and expected costs from medical services averted, is equivalent to the National Efficient Price for public patients. For example, in 2018-19 the National Efficient Price was \$5012, with the New South Wales AAcc adjustment set at 0.0711,¹⁴ which means the effective deduction for each day of stay was \$356.35, with the AAcc essentially set to be equivalent to the \$357 per day NSW hospitals charged private overnight patients in a shared ward in 2018-19.¹⁵

¹³ Independent Hospital Pricing Authority (2019).

¹⁴ Independent Hospital Pricing Authority (2017).

¹⁵ https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2018_024.pdf

But the public-private equivalence in the NWAU does not yield public-private equivalence in the revenue to a public hospital or the state.

The revenue to the state

Under the National Health Reform Agreement, the Commonwealth pays the state 45 per cent of the National Efficient Price for each additional patient from the base line.

For a public patient, the revenue from the Commonwealth (stripping out extraneous elements) is:

$$= 0.45 \times PW \times NEP$$

The length-of-stay component

For a private patient, the simplified combined revenue to the state, from the Commonwealth and the patient/private health insurance fund, for the component related to length of stay, is:

$$= 0.45 \times (PW \times NEP) - 0.45 \times (LOS \times AAcc \times NEP) + LOS \times \text{private bed day fee}$$

Assuming the private bed day fee = $Acc \times NEP$, this can be rewritten as:

$$= 0.45 \times (PW \times NEP) - 0.45 \times (LOS \times AAcc \times NEP) + LOS \times AAcc \times NEP$$

$$= 0.45 \times (PW \times NEP) + 0.55 \times (LOS \times AAcc \times NEP)$$

This suggests that the current funding formula gives states more revenue for treating an additional private patient than for treating an additional public patient. In the NSW case, that is almost \$200 per day of patient stay more for private patients than public patients.

The Medicare Benefits Schedule component

The length-of-stay effect simply affects revenue. But the effect of the component of funding relating to services to private patients which attract an MBS rebate involves a complex interaction between costs and revenues, and will vary among states and hospitals depending on revenue sharing arrangements ('facility charges') with specialists, and whether services are contracted out (as may be the case for some diagnostic services).

The table summarises how the MBS component works.

Table: Simplified MBS payment arrangements for public hospitals

	Stage in process	Public patient process	Private patient process
1	IHPA calculation	NWAU	NWAU minus estimated MBS revenue
2	Commonwealth payment	45% of NWAU	45% of NWAU minus 45% of MBS revenue
3	MBS payment (to specialist and/or hospital)	-	100% of MBS revenue
4	Residual cost to be met by the state (at National Efficient Price)	55% of NWAU	55% of NWAU minus 55% of MBS payment

The fourth row of the table shows that the residual to be met by the state for a private patient is less than for a public patient. This assumes that the state receives all of the MBS revenue. In practice, the amount of revenue states receive depends on their arrangements with medical specialists, including rights of practice and facilities charges.¹⁶

Further, the MBS revenue is an important component of public hospital specialists' remuneration, and so they will have an incentive to support an expansion of private patients.

Conclusion

Taking the medical and the length-of-stay incentives together, the net effect on a hospital depends on whether the simple revenue incentive derived from the length-of-stay component of the formula is greater than the complex interaction of facility charges, offsets to medical costs and contracting-out on the 'medical services' side of the formula.

The simple length-of-stay incentives, coupled with the interests of medical staff, combine to create a powerful financial motivator on hospitals to increase revenue and admit more private patients.

¹⁶ And these arrangements can be quite variable, even within states, Auditor General of Victoria (2019)

Such an incentive to admit private patients is not consistent with the principle of 'public-private neutrality'.