GRATTAN Institute

Incentives for efficiency

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Stephen Duckett

Overview

Australia's complex 'marble cake' federalism -– where the Commonwealth and state governments share a policy terrain – creates inefficiencies in the hospital system. These inefficiencies, especially when people are admitted to hospital for conditions which are potentially preventable, or stay much longer than necessary, mean that other people who need care cannot get it, and are left lingering on elective procedure waiting lists or 'ramped' outside hospital in an ambulance.

This submission, in response to the Independent Hospital Pricing Authority's Consultation Paper on the 2022-23 Pricing Framework, highlights two aspects of inefficiency: potentially preventable hospitalisations, and maintenance care. We support exploring new penalties for the former, and better data collection for the latter to identify the scale of the problem. We also support modernising the way 'outliers' are identified, and phasing in pricing of mental health episodes of care.

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1 Potentially preventable hospitalisations

The 2020-25 Commonwealth-state hospital funding agreement requires the Independent Hospital Pricing Authority to consider penalties for excessive rates of potentially preventable hospitalisations.[1] The new penalty would sit alongside existing penalties on states with higher-than-expected rates of adverse events in hospital.

Potentially preventable hospitalisations are defined as those that can either be avoided or their rate reduced with good primary health care.

One category of potentially preventable hospitalisations is admissions for vaccine-preventable diseases such as measles, and this category should probably now be updated and expanded to include COVID-related admissions. Potentially preventable hospitalisations also include admissions for heart disease and other chronic conditions where a higher rate of admission is an indicator of weaknesses in primary care.

The definition is still somewhat crude – could a hospital admission that is so serious it leads to a 10-day stay really have been prevented with good primary care?[2] However, since first proposed in Australia more than 20 years ago,[3] the rate of potentially preventable hospitalisations has become established as a widely used indicator of health system performance.[4]

In 2017-18 there were about 750,000 potentially preventable hospitalisations, including 85,000 that were vaccine-preventable (mostly vaccine-preventable pneumonia and flu), 330,000 potentially preventable acute admissions (including dental conditions and cellulitis), and 345,000 potentially preventable admissions for chronic diseases such as asthma and chronic obstructive pulmonary disease. Potentially preventable hospitalisations occupied almost 3 million bed-days in 2017-18 and occurred at a rate of about 3,000 per 100,000 population.[5]

Some parts of Australia have much higher rates of potentially preventable admissions than others.[6] South Australia[7] and Western Australia[8] have published atlases of potentially preventable hospitalisations, in consultation with the primary health networks in those states. The Australian Commission on Safety and Quality of Health Care includes rates of potentially preventable hospitalisations in its national safety and quality atlas.[9]

1.1 Who should be penalised for poor performance?

The task for the Independent Hospital Pricing Authority is a complex one. Potentially preventable hospitalisations are a measure of failures in primary care rather than hospital care.

In its consultation paper the Pricing Authority seeks advice on criteria for evaluating the merits of different pricing and funding approaches. We propose that an important criterion is that any penalty should fall on the level of government that has been assigned responsibility for primary care.

1. Council of Australian Governments (2020).
2. Swerissen et al (2016).
3. Stamp et al (1998).
4. Longman et al (2015); Ansari (2007); and Ansari et al (2006).
5. Australian Institute of Health and Welfare (2020).
6. Duckett et al (2016).
7. South Australia Department of Health and Wellbeing (2020).
8. Western Australian Department of Health and the Western Australian Primary Health Alliance (2018).
9. Australian Commission on Safety and Quality in Health Care and Australian Institute of Health and Welfare (2021).

The Commonwealth government is responsible for the 'system management and support, policy, and funding for GP and primary health care services'.[10] Therefore, any penalty for excess rates of potentially preventable hospitalisations should logically fall on the Commonwealth. Federalism plays out in this area because failures in primary care – where the Commonwealth is responsible – lead to excess costs in state-managed hospital systems. But designing a penalty that falls on the Commonwealth without creating perverse incentives for the state will be tricky.

One approach could be for the Commonwealth to pay states for excess potentially preventable hospitalisations. This would require the Independent Hospital Pricing Authority calculating an expected rate of potentially preventable hospitalisation for each diagnosis on the potentially preventable hospitalisations list, adjusted for factors known to lead to higher rates of admissions. The Commonwealth would then pay states the full costs of these higher-than-expected admissions in each diagnosis cluster.

But if this new higher payment for potentially preventable hospitalisations were passed on to hospitals, it would create a perverse incentive for hospitals to admit these patients inappropriately. Introduction of the new penalty should therefore be accompanied by an agreement with the states that they would not incorporate it into payments to hospitals.

States might also be invited to agree that any additional funding which flows to them should be used for state-wide programs to reduce potentially preventable hospitalisations or in areas with high rates of those admissions, as previously recommended in our Report on this issue.[11]

A new, reciprocal, and two-way penalty regime could also be used in other areas where failures in Commonwealth policy lead to higher costs in state hospital systems. New penalties on the Commonwealth might be for the costs of patients who have to remain in hospital after their acute care has been completed, because of long waits for aged care or appropriate accommodation under the National Disability Insurance Scheme. We turn to the issue of better identification of such patients in the next section.

Currently the only penalties in Commonwealth-state agreements are for safety and quality of care breaches, and these fall on the states. Broadening penalties, so that some fall on the Commonwealth, would reflect more accurately the marble-cake nature of responsibility for healthcare in Australia.

10. Council of Australian Governments (2020).
11. Duckett et al (2016).

2 Maintenance care

Maintenance care is defined as:

> care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment.[12]

In 2019-20 there were 32,785 maintenance care admissions to public hospitals, consuming more than 600,000 bed days.[13]

There are four different types of maintenance care: convalescent care; respite care; nursing home type care, and other maintenance care.

Definitionally, people classified into the maintenance care type do not need acute care and, if appropriate care were available elsewhere, use of an expensive hospital bed could be avoided. The current codes and definitions used for maintenance care, especially convalescent care shown in the box, muddle causes of these stays.

The different types of maintenance care are not used by the Pricing Authority for pricing; rather, prices are based on age, activities of daily living, and whether the patient is long stay (that is, with a stay longer than 91 days). Under current arrangements, a long-stay patient staying 150 days is priced at around $175,000 (inlier price weight of 31.4274) with an additional $1,168 for each day the patient stays longer than 197 days. The National Health Reform Agreement provides that the Commonwealth pays 45 per cent of this (about $80,000 for the base payment and $525 per day) in those states under the 6.5 per cent growth cap.

The existing coding and definitions are not sufficiently granular for policy purposes and, in particular, do not distinguish where system

Box 1: Convalescent care definition

Following assessment and/or treatment, a convalescent care patient does not require further complex assessment or stabilisation but continues to require care over an indefinite period. Under normal circumstances the patient would be discharged, but due to factors in the home environment, such as access issues or lack of available community services, the patient is unable to be discharged. Examples may include:

- Patients awaiting the completion of home modifications essential for discharge.
- Patients awaiting the provision of specialised equipment essential for discharge.
- Patients awaiting rehousing.
- Patients awaiting supported accommodation such as in a hostel or group home.
- Patients for whom community services are essential for discharge but not yet available.

12. https://meteor.aihw.gov.au/content/index.phtml/itemId/496467
13. Australian Institute of Health and Welfare (2021, Tables S4.2 and S4.3).

failures are occurring. For example, convalescent episodes could be caused by failures in the National Disability Insurance Scheme, in the aged care system, in the mental health system, or in the state guardianship system.

We recommend that the Independent Hospital Pricing Authority review the maintenance care definitions and classification, with a view to updating the categories to identify causes. This could then provide a basis for routine monitoring of underlying causes of long stays. In due course, a penalty regime for long stays might be developed.

3 Identifying unusual cases

Diagnosis Related Groups (DRGs) were developed to identify the 'normal' hospital admission, with 'trim points' used to define admissions which are outside the normal, known as outliers.[14] In the initial development of DRGs, trim points were calculated using the inter-quartile range and nonparametric measures. The first Australian implementation of activity-based funding adopted a simpler approach which was 'easily explained' – that the low trim points were one third of the average length of stay, and the high trim point was three times the average length of stay, an approach known as L3H3.[15]

This approach to identifying outliers is still used 30 years later.[16] It is time to change.

When activity-based funding was introduced, payers did not have the technology and hospitals did not have the information systems to use anything other than length of stay to identify outliers. The concept of activity-based funding was new, and funding models had to be easily understood and explained. Analysis was done using spreadsheets. The world has moved on.

Payment policy should ensure fairness and that high-cost admissions are appropriately identified and funded. Length of stay is an imperfect measure of costs. The time is now ripe to introduce cost outliers into the funding formulae.

The Independent Hospital Pricing Authority should foreshadow in the 2022-23 Pricing Framework that it will explore the use of cost-based trim points.

14. Fetter (2015).
15. Duckett (1995).
16. Independent Hospital Pricing Authority (2021).

4 Mental health care

Systematic classification development and costing has resulted in a robust mental health classification for Australia.[17] Unfortunately, the Independent Hospital Pricing Authority has still not priced mental health care, and as a result, activity-based funding cannot be used for mental health care.

However, the National Health Reform Agreement contemplates that services will be funded under activity-based funding 'where appropriate'.[18] We argue that the time is now ripe for activity-based funding to apply to mental health care, and that block funding is no longer the best option for this suite of services.

Mental health services across Australia are underfunded. This is probably the result of lack of effective political pressure and advocacy associated with the stigmatisation and lower status of mental health care. But it is also probably due in part to the fact that mental health care sits outside the dominant funding arrangements applying to other aspects of public hospital care, both in-hospital and in the community.

As a result, if there is an increase in demand for mental health care – and an increase in admissions – this is not revealed as an increase in the National Weighted Activity Units eligible for Commonwealth matching funding (at 45 per cent of the National Efficient Price). Increases in mental health demand are therefore not addressed in the same context as other services, and the needs of mental health services are neglected or disregarded.

This needs to be rectified. The Pricing Authority should price mental health services as soon as possible, to bring them within the scope of activity-based funding.

Costing and coding systems are more robust for in-hospital services, so one approach would be to price the in-hospital branch of the Mental Health Classification with effect from 1 July 2022, and the community branch from 1 July 2023.

17. Independent Hospital Pricing Authority (2020). Dr Duckett is a member of the Independent Hospital Pricing Authority's Mental Health Advisory Committee, which oversaw development of the Australian Mental Health Care Classification.
18. Council of Australian Governments (2020, Clause 9a).

Bibliography

Ansari, Z. (2007). "The Concept and Usefulness of Ambulatory Care Sensitive Conditions as Indicators of Qualty and Access to Primary Health Care". *Australian Journal of Primary Health* 13.3, pp. 91–110.

Ansari et al (2006). Ansari, Z., Laditka, J. N. and Laditka, S. B. "Access to health care and hospitalization for ambulatory care sensitive conditions". *Medical Care Research Review* 63.6, pp. 719–741.

Australian Commission on Safety and Quality in Health Care and Australian Institute of Health and Welfare (2021). *The Fourth Australian Atlas of Healthcare Variation*. ACSQHC.

Australian Institute of Health and Welfare (2020). *Disparities in potentially preventable hospitalisations across Australia: Exploring the data*. Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients.

_____ (2021). *Admitted patients 2019-20*. Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients.

Council of Australian Governments (2020). *Schedule J – Addendum to the National Health Reform Agreement: Revised Public Hospital and Health Reform Arrangements*. Australian Institute of Health and Welfare.

Duckett, S. (1995). "Hospital payment arrangements to encourage efficiency: The case of Victoria, Australia". *Medical Care Research Review* 34, pp. 719–741.

Duckett et al (2016). Duckett, S., Griffiths, K. and Swerissen, H. *Perils of place: identifying hotspots of health inequality*. Report No. 2016-10. Grattan Institute. https://grattan.edu.au/report/perils-of-place-identifying-hotspots-of-health-inequality/.

Fetter, R. B. (2015). *The DRG Patient Classification System: background*. Ed. by R. B. Fetter, D. A. Brand and D. Gamache. Melbourne: Health Administration Press, pp. 2–27.

Independent Hospital Pricing Authority (2020). *Australian Mental Health Care Classification Pricing Feasibility Report 2020-21*. IHPA.

_____ (2021). *National Pricing Model 2021–22: Technical Specifications*. IHPA.

Longman et al (2015). Longman, J., Passey, M., Ewald, D., Rix, E. and Morgan, G. "Admissions for chronic ambulatory care sensitive conditions - a useful measure of potentially preventable admission?" *BMC Health Services Research* 15.472.

South Australia Department of Health and Wellbeing (2020). *Areas To Act: A South Australian Review of Potentially Preventable Admissions*. SA Health.

Stamp et al (1998). Stamp, K. M., Duckett, S. J. and Fisher, D. A. "Hospital use for potentially preventable conditions in Aboriginal and Torres Strait Islander and other Australian populations". *Australian and New Zealand Journal of Public Health* 22.6, pp. 673–684.

Swerissen et al (2016). Swerissen, H., Duckett, S. and Wright, J. *Chronic failure in primary care*. Report No. 2016-2. Grattan Institute. https://grattan.edu.au/report/chronic-failure-in-primary-care/.

Western Australian Department of Health and the Western Australian Primary Health Alliance (2018). *Lessons of Location: Potentially Preventable Hospitalisation Hotspots in Western Australia 2017*. The Department and WAPHA.