Australian public hospitals have room to improve their efficiency:

Submission to the Independent Hospital Pricing Authority's on the 2023-24 pricing framework

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1. The first pricing framework was developed more than a decade ago. It has stood the test of time well – the broad policy settings are the same today as they were then, with minor enhancements to the framework design, but significant expansion to scope, for example in mental health.
2. The adoption of activity-based funding has provided guide rails within which policy debates can occur. With the fundamentals agreed, activity-based funding has provided a mechanism by which governments can pursue improvements in technical efficiency, provide (weak) incentives for improvement safety of hospital care, and frame debate about other aspects of care provision.
3. Activity-based funding and the pricing framework can be pushed further to drive efficiency and it is timely to reconsider the pricing settings ten years after the first iteration of the framework.

Driving technical efficiency further

4. The current approach to setting the national efficiency price sets the price at the average performance across Australia in each DRG (or other case-mix measure). Essentially the relative weights (national weighted activity units) are based on the average of the distribution.
5. Using the average rate was reasonable in the first decade, but it has now outlived its usefulness. Considerable variation in cost per patient treated can be seen within states and among states. The zeal for states to drive improvements in efficiency in public hospitals – or the skills to do so – has attenuated over time, replaced by calls for the Commonwealth government to bail out states, in the same way states are bailing out poorly performing hospitals.
6. States have diverted their attention to a fruitless play space of 'value-based care', 'paying for outcomes', and moaning that activity-based funding does not provide incentives for hospitals to address potentially preventable hospitalisations.
7. Just as the introduction of activity-based funding led to a flurry of work on addressing efficiency, with the system now mature it is time to revitalise the quest for efficiency by developing a new national benchmark price. A tougher national efficient price objective should be set for the next decade of payments. This should be phased in progressively, with the initial step being small, primarily to signal intent.
8. Conceptually, a more aggressive efficiency improvement approach could be managed either by revising the price and applying a new, lower price, to all categories, or by revising the relativities. It is the price times the relativity which yields the payment rate to states for additional activity in a category such as a DRG. Either price or relativity adjustment could work as a way of signalling a more aggressive approach to efficiency improvement. A relativity approach is recommended.
9. A new relativity could simply be set at some lower point in the distribution, rather than the average. This is not the preferred approach, as it looks like a simplistic budget cut, not about setting a benchmark for efficiency.
10. A new relativity approach should highlight the changes are about efficiency, and that the target efficiency has already been achieved in some hospitals: target efficient practice is achievable, but not yet everywhere.

11. The new approach to setting relativities should involve the following:
    a) Costs would be analysed in the standard way with interim median relativities across all categories calculated.
    b) For each of the least complex categories in an adjacent set (e.g., for acute inpatient care in the adjacent DRG), the cost of provision would be analysed in larger hospitals. This would reveal the variation of the cost distribution across hospitals. From this distribution the cost of provision at a benchmark point below the median can be at identified and the cost in that hospital used to set the relativity for the least complex category in the adjacent set.
    c) It is proposed that the initial benchmark be the 45 percentile of the distribution of costs in a DRG (or other measure), so slightly below the median.
    d) Because the national funding arrangements treat base funding and growth separately, a reduction in the national efficient price from average to 45 percentile only applies to the growth in activity so initially has a very small impact.
    e) Using a hospital basis means it is clear that there are many hospitals that can provide care at the new cost and so provide examples from which other hospitals can learn. The Independent Hospital Pricing Authority should publish the names of all larger hospitals who already can meet the efficient price in each adjacent set.
    f) Once the new, benchmark relativity has been established, the relativities for other elements of the adjacent set, together with any other modifiers such as the First Nations loading, can be applied from step (a) above. That is, the other categories in an adjacent set would also be set at an estimated benchmark, with the least complex in the set as the base, with relativities for other categories in the set as determined in step a.
12. This new approach for setting the national efficient price would signal the start of a move toward stronger incentives on states to improve efficiency. It has the advantage of highlighting that there are hospitals which already operate at the target level of efficiency and raises the question of why other hospitals cannot.

Moving toward outcomes – best practice payments

13. The existing pricing framework has a weak extrinsic incentive for quality (in fact, safety) based on the hospital acquired classification system. Because events in this classification are rare, and the operation of the 6.5% cap, this results in a trivial reduction in overall payments to the states.
14. The English National Health Service has developed an approach using 'Best practice tariffs'. This applies across a range of high-volume conditions.
15. A new approach to driving improvement in quality of care should be implemented in parallel with a new drive to enhance efficiency. The English best practice tariff includes payment supplements for those cases which adhere to a nationally-determined best practice pathway. These pathways are evidence-based and there is no reason to believe they could not be adopted without change in Australia.
16. The best practice tariff requires additional information collection and not all hospitals or states will be in a position to collect that information immediately. This should not be a

barrier to implementation of best practice payments, as those which can collect information and provide best practice should be rewarded for that as soon as possible.

17. Importantly, the best practice payment would be a supplement — hospitals not adhering to the best practice pathway would not lose money directly.

Further outcome-based data collection

18. There has recently been much discussion about value-based care, which has all the attributes of an over-hyped fad. However, core to value-based care is ascertaining what patients want from treatment and focusing on patient relevant outcomes. This element of the fad is unequivocally worthwhile.
19. There is currently no national systematic, agreed collection of patient reported outcome measures.
20. It is proposed that the Independent Hospital Pricing Authority mandate the collection of before and after patient reported outcome measures for a small number of conditions e.g., scheduled (elective) joint replacements. This could eventually be used to develop a system of outcome supplements to be incorporated in the pricing framework.

Maintenance care

21. The current public hospital funding approach is that Commonwealth payments to the states increase in line with increases in activity paid for at the national efficient price. Subject to the hospital acquired conditions adjustment, all activity, whether useful or useless, is counted equally, and the Commonwealth contributes 45% of the cost of the increase in activity.
22. However, some increase in activity is entirely the responsibility of the Commonwealth and is waste. The Commonwealth should have an enhanced incentive to improve the efficiency of their processes.
23. Most maintenance care is provided for patients waiting for appropriate accommodation either in a residential aged care facility or under the auspices of the National Disability Insurance Scheme. Both of these settings are the responsibility of the Commonwealth. The weights for maintenance care should be adjusted so effectively the Commonwealth is required to pay 100% of the cost of increases in maintenance care days.