The effect of public sector developments on the private sector

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Introduction
The health industry is under huge cost pressures in both the public and private sectors. The public sector manages demand and restricts supply through waiting lists. As an uncapped funder of health services, the Private Health Insurance (PHI) sector has difficulty in managing demand and increasing provider capacity, leading to cost pressures and increasing premiums. This is the financial consequence of meeting uncapped demand. As a result, health insurers are questioned because their premiums are rising at rates greater than inflation.

From a strategic perspective there are three main differences between the public and private sectors:

- Capped versus uncapped funding – increased utilisation of the private sector is largely due to volume increases, which is a major driver of above Consumer Price Index premium rises. This is a mixture of the ageing of the insured population and the ready availability of many new technologies in the private sector.
- Price setting – although both sectors use the same classifications, the setting of price varies significantly. In the public sector, price is laid down by the Government through the work of the Independent Hospital Pricing Authority (IHPA). In the private sector, it is a commercial arrangement which often follows robust negotiations between health funds and private hospitals (or groups). While the same classifications may be used for reporting (the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification [ICD-10-AM]/Australian Classification of Health Interventions [ACHI] and Australian Refined Diagnosis Related Groups [AR-DRGs]), the degree to which these classifications are used in funding varies and the price is negotiated between insurers and hospitals rather than set by administrative directive as occurs in the public sector.
- Influence – while PHI is affected by legislation such as the rebate, doctors have the major influence on private hospitals, as they provide income, referrals and volume depending on where they choose to practice. In the public sector, it is primarily funding bodies, Government Departments and politicians that have the major influence on where and how many services are provided.

Public sector policy and strategy that impacts on the private sector is often a consequence of lack of understanding of the flow on effect. It is important to note that with the exception of the above three factors, the private and public sectors are highly similar and face many of the same issues, including:

- Ageing population, particularly our baby boomers. This effect is heightened by increased life expectancy and an increasing burden of chronic disease.
- Technology advances. Some of these are more readily accessible in the private sector, while others are generally only available in the public sector.
- Increased patient expectations.
- Hospital cost increases; for example hospital wage increases, such as nursing.

As Health Information Managers (HIMs), we possess a unique set of skills that can be drawn on for all aspects of the health sector, and even beyond health. This paper looks at how HIMs in the private sector, including the PHI sector, can use their skills to make a contribution to the ever changing landscape of health.

Background
When health reforms were announced under the Rudd government, key concepts were introduced including “single provision, multiple use” (of data), “benchmarking”, “comparability”, “transparency” and “quality”. These concepts can be applied easily to the private sector. The private sector was very much a quiet voice and considered to be distant to the creation of national activity-based funding (ABF). Six years on, the impact to the private sector of public policy is significant. However, the private sector has had some success in increasing the whole industry’s understanding of the flow-on effect of these policy decisions and the relevance of our contribution to the industry. Some of the areas where the impact on the private sector is significant are:

- Single provision, multiple use of data principle
- Classification developments
BENCHMARKING INSURER VIA ELECTRONIC CLAIMING


SINGLE PROVISION, MULTIPLE USE PRINCIPLE

INFORMATION IS CAPTURED AT VARIOUS POINTS ACROSS THE SPECTRUM OF SERVICES, BE THEY PUBLIC OR PRIVATE. ALL STAKEHOLDERS, HEALTH FUNDS INCLUDED, ARE REQUIRED BY LEGISLATION TO CONTRIBUTE TO VARIOUS NATIONAL DATASETS. THE GREATEST REPORTING BURDEN LIES WITH PRIVATE HOSPITALS, AS THEY ARE REQUIRED TO SEND THE SAME INFORMATION TO FOUR DIFFERENT LOCATIONS:

- Insurer via electronic claiming
- Insurer (or Australian Health Service Alliance [AHSA] via the Hospital Casemix Protocol [HCP]) (under legislation: Private Health Insurance Act 2007; Private Health Insurance (Health Insurance Business) Rules 2007)
- Commonwealth Department of Health via the Private Hospital Data Bureau
- State health department.

In 2013, I wrote with a great deal of excitement at the degree of effort put in by the private sector to attempt to align these reporting requirements wherever possible following the single provision, multiple use principle (Predl, 2013). It is disappointing that in some areas, the appetite (or funding) for a reduction in reporting burdens has lowered, and while the public sector has moved down this pathway, the private sector is yet to follow. As HIMs, it is important that we continue to lobby for better ways of reporting the same information, to promote efficiency and reduce duplication.

IMPACT OF CLASSIFICATIONS

WHEN A CLASSIFICATION CHANGES, THE GREATEST IMPACT TO THE PRIVATE SECTOR IS WHEN IT IS MANDATED, SUCH AS ICD-10-AM or the Medicare Benefits Schedule (MBS), given their links to commercial funding arrangements in the private sector.

Casemix classifications such as AR-DRGs and the Australian National Subacute and Non-Acute Patient (AN-SNAP) classification are widely used in the private sector, but in variable ways for funding. Regardless of sector, HIMs have a significant contribution to make in terms of:

- Strategies, systems and processes to manage multiple AR-DRG and AN-SNAP versions
- Management of conversions of contracts from one AR-DRG version to another
- Management of health datasets (see Data)
- Using classifications for health service development, such as selecting patients for chronic disease management, understanding growth variation in clinical specialties, determining if sentinel events have occurred, analysing criteria for Hospital Acquired Complications (HACs) (Australian Commission on Quality and Safety in Healthcare, n.d.), providing information on readmissions or developing audit methodologies.

The private sector certainly makes a significant contribution to the development of classifications in Australia, given that it does have an impact, and some changes could have a negative effect on future use of the classification in the private sector. Any significant changes to the AR-DRG classification need to be “fit for purpose” to the private sector in terms of usability in future contracts. AR-DRG formulation and development should consider both sectors, not only in relation to cost, but volume. Recent examples of changes that affect the private sector are those made to the Rehabilitation Coding Standard (2015), and the removal of the specific AR-DRGs for neurostimulator devices, which are growing in the private sector despite a decline in the public. If AR-DRGs are to have the optimal utility for classification purposes with the consequence flow on to areas such as payment models and benchmarking, they should be based on activity and data over all health sectors, not just the public sector.

BENCHMARKING

IN ORDER TO EFFECTIVELY BENCHMARK BETWEEN SECTORS, COMMON CURRENCY IS ESSENTIAL. REGARDLESS OF THE FUNDING MECHANISMS BETWEEN SECTORS, IF A COMMON CURRENCY AND A ROBUST CLASSIFICATION ARE USED SUCH AS AR-DRGs OR AN-SNAP, IT CREATES A POWERFUL TOOL TO FACILITATE COMPARISONS OF CASES BETWEEN HOSPITAL GROUPS AND SECTORS. SOME AREAS WHERE THIS CAN BE DONE INCLUDE VALUE FOR MONEY, WHEN TAKING INTO CONSIDERATION HOSPITAL CHARGES (SUCH AS PROSTHESIS, THEATRE, ACCOMMODATION) FOR THE SERVICE PROVIDED, LENGTH OF STAY (LOS), AND FOR REHABILITATION CASES, FUNCTIONAL INDEPENDENCE MEASURE (FIM) EFFICIENCY. WHILE SOME OF THESE PARAMETERS SUCH AS CHARGES ARE DIFFICULT TO COMPARE BETWEEN SECTORS, OTHER SUCH AS A CASEMIX ADJUSTED LOS, RATE OF SENTINEL EVENTS AND HACs, AND UNPLANNED READMISSIONS ARE COMPARABLE BETWEEN SECTORS.

MBS IS NOT CONSIDERED TO BE A ROBUST CLASSIFICATION. IT DESCRIBES A PROCEDURE, SERVICE OR INTERVENTION AND DOES NOT TAKE INTO ACCOUNT AGE, SEVERITY, LOS, DIAGNOSES OR COMPLICATIONS. IT IS ALSO NOT UNDERPinned BY A ROBUST SET OF LOS PARAMETERS NOR A WELL-BASED CLINICAL COSTING STUDY. GIVEN THESE FACTORS, IT IS NOT AN APPROPRIATE BASIS FOR BENCHMARKING.

THE OTHER ESSENTIAL ELEMENT FOR BENCHMARKING IS CONSISTENT ADMISSION CRITERIA. VARIATION IN ADMISSION PRACTICE BETWEEN AND ACROSS SECTORS IS A CHALLENGE NATIONALY, AND AN AREA OF AGREED FOCUS IN THE FUTURE. THE PRIVATE SECTOR EXPERIENCES THE SAME CHALLENGES IN REGARD TO INCONSISTENT REPORTING OF TYPES OF SERVICES SUCH AS CHEMOTHERAPY AND NON-OVERNIGHT REHABILITATION BETWEEN GROUPS AND STATES.
By way of scenario, if a patient suffers from cholecystitis and requires an elective cholecystectomy, with the exception of access (i.e. waiting time variation), it is reasonable to expect that the experience would be the same, in terms of care, treatment, discharge planning, relative cost, quality, the way in which the episode is coded using ICD-10-AM and the ACHI, and the means by which it is reported to state health authorities to ultimately form part of the national minimum data set.

As HIMs, we know that while the payment may be different in absolute and payment model terms, with like classifications, such as AR-DRGs, regardless of sector we can benchmark cases in terms of LOS and value for money. HIMs can assist in providing the tools so that robust benchmarking can occur, so that a common currency can be achieved. This enables analysis, sometimes by HIMs, which can pose questions such as: why is there variation in LOS and/or cost for the same procedure between sectors, or between hospitals within the same sector?

**Quality**

There are several new initiatives in recent IHPA work plans in the quality arena; namely reduced payments for sentinel events, unplanned readmissions and HACs (IHPA, 2017). While the private sector are not bound by these requirements, HIMs using coding, data management and casemix skills are able to assist with the replication of this work in their workplaces to determine how the same criteria look in the private sector and to assist both hospitals and insurers to consider appropriate processes and systems for monitoring and responding to these events. The use of a common set of measures also facilitates benchmarking between sectors.

**Data**

Accurate, complete, and timely data are essential to effective management of any organisation, and the health sector is not alone in this. Effective data management underpins most of the topics included in this paper: benchmarking, quality and ultimately payment models. Across both sectors and including health insurers, HIMs make an enormous contribution to data management, in terms of collection, reporting, cleansing and managing deadlines. For some HIMs, there are also opportunities to use our skills to assist with data development and definitions work. Much of this work reinforces the “single provision, multiple use” principle, to ensure that as an industry, we strive to ensure consistency in all aspects of health data management.

A good example is hours of mechanical ventilation (HMV), or “Duration of Continuous Ventilatory Support” (Australian Institute of Health and Welfare Metadata Online Registry, [METeOR], n.d.) This field was introduced in Victoria and South Australia during the 90s, due to the direct links to casemix based funding in these states. Furthermore, there was a HCP definition introduced in 1995 when the dataset was established, which covered HMV in intensive care units and was silent on the finer points of detail. Other states followed over various years, however a national definition was not introduced in METeOR until 2013. While the HCP specifications now comply with the national definition, for various reasons, including ideology, the states have not. This provides HIMs and others with challenges when they are required to report the same information with definition variation to various stakeholders and statutory authorities.

**Costing**

It could be argued that, regardless of cost in absolute terms, the underlying relative cost should not greatly differ between the private and public sector. To test this hypothesis, clearly only “like” cost buckets can be compared, excluding types such as pathology, radiology and ward medical costs. Recent papers have shown this hypothesis to be true; underlying costs between public and private sectors have a high correlation (Hanning, 2013). However, it has been several years since a costing study has been released based on the private sector, with the most recent being in AR-DRG version 6x. Health insurers and private hospitals are limited to using AR-DRG version 6x as the most recent AR-DRG version in use by the private sector.

It is a much greater challenge to achieve robust costing studies in the private sector. As it is not mandated, the process relies on hospitals to have the resources and willingness to participate. Several costing studies have been abandoned at various points due to low participation rates. Furthermore, private hospitals are understandably less enthusiastic to have their costs put into the public domain. Given the commercial arrangements which exist between hospitals and insurers, release of private hospital costing information in a detailed form could impact negotiations. However, while health insurers are not able to access the full detailed information by cost bucket at the moment, there is an understanding across the private sector as a whole, that health insurers need this information to ensure the development of robust payment models that more closely align with cost. A reasonable balance exists between the protection of commercially sensitive information and the need for the costing data from a health insurance business perspective, to enable both to be achieved.
The private sector is keen to see whether the changes to the process of costing studies in the private sector increase participation rates. IHPA have suggested that they would like to reduce the available AR-DRG versions to three (back to version 7 and no further) (IHPA, 2017), however that is unachievable in the private sector without regular and robust costing studies.

**Payment models**

Changes to classifications, data and quality can also have an impact on payment models. With the assistance of HIM expertise through coding, some health insurers have introduced quality outcome penalties in their contracts in order to reduce payment for sub-optimal quality outcomes. This has been minimally achieved with varied success for some insurers, however in the context of this paper, HIM skills are highly utilised in payment model work in the private sector.

From a payment model development perspective, AHSA uses national benchmark data from the Australian Institute of Health and Welfare to set the LOS parameters. Once this is done, in combination with the private sector cost data from the same time period, cost weights are developed for each AR-DRG (Hanning, 2005).

Health insurers generally do not develop payment models frequently. In addition to having robust private sector cost weights, payment models in the private sector need to be more static and have a greater life span than the public sector where cost weights generally change annually, and the AR-DRG classification generally changes biennially. The main reason for this is that, once payment models are developed, thoroughly tested and ready for use, each hospital and/or group needs to be approached to convert their contract version. If agreed in principle, the usual practice is that individual hospital needs be modelled to ensure that the total revenue for all cases in the agreed period are accurate in the original AR-DRG version. For example, if there is $1m paid over a 12-month period, that $1m is redistributed over each AR-DRG according to the new version, and as such, in the future, both insurers and hospitals will receive changes in funding for AR-DRGs. Some will increase, and some will decrease. Therefore, considerable impact modelling needs to occur for all stakeholders, before agreement is reached to convert AR-DRG version.

**Conclusion**

The unique skills of HIMs are used diversely across the private and public sectors, even when outside of the hospital setting such as in the health insurance sector. HIMs contribute significantly to health policy changes, including quality, benchmarking payment model development and classifications. There is not only a considerable overlap between the public and private sectors, but an inter-dependence between the two. Active engagement with the private sector in public sector development work is both helpful and appropriate, given the flow-on effects, and the contribution that can be made.

**Acknowledgement**

The author wishes to acknowledge the contribution of Dr Brian Hanning, Medical Director, Australian Health Service Alliance.

**References**


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