Case study

Australia

Jane Hall, Maryam Naghsh Nejad, Kees Van Gool and Michael Woods

University of Technology

Sydney, Australia

Contents

Abbreviations

Abbreviation	Term
ABF	Activity Based Funding
ACFA	Aged Care Financing Authority
ACFI	Aged Care Financing Instrument
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
CPI	Consumer Price Index
DRG	Diagnosis Related Groups
GP	General Practitioners
HCH	Health Care Homes
HTA	Health Technology Assessment
IHPA	Independent Hospital Pricing Authority
MBS	Medicare Benefits Schedule
MSAC	Medical Services Advisory Committee
NWAU	National Weighted Activity Unit
PBS	Pharmaceutical Benefits Scheme
WASE	Weighted Ambulatory Service Event

Abstract

The Australian health system consists of a mix of public and private service providers. Health is a shared responsibility between the various levels of government across the eight state and territory governments and the federal government. The actual responsibilities that fall on each level of government are largely historical, and, in some cases, are enshrined in the Constitution of the federal government and serve to limit government functions. The actual responsibilities that fall on each level of government were determined by the Australian Federation in 1901, with health care left to the states (and private interests) apart from a national quarantine service. The federal government gradually acquired greater responsibilities over time, particularly with the power to raise income taxes (during World War II) and to provide pharmaceutical, sickness and hospital benefits and medical and dental services (Constitution Alteration, 1946). This allowed the establishment of federally funded pharmaceutical benefits and medical benefits and federal grants to states to support public hospitals due, in large part, to this history and ongoing constitutional limitations. Thus, a myriad of ways has developed in which health care is funded. Each part of the health system therefore has its own set of funding rules, including the determination of pricing.

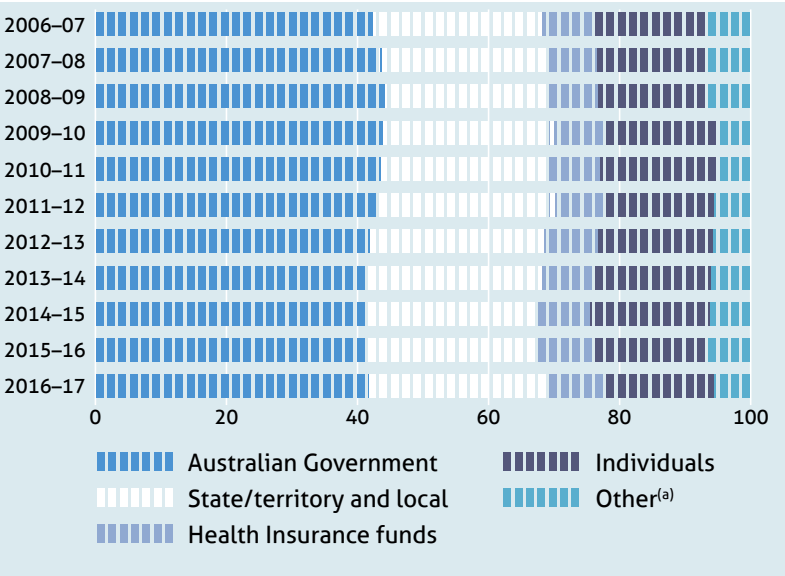
In this case study, we examine a range of Australian experiences in the determination of health care prices, from a system that is heavily influenced by market factors to one that is highly regulated and based on a cost-input approach. We discuss arrangements in four different sectors comprising hospitals, primary care, outpatient care and aged care, recognising that arrangements vary across (and even within) these sectors. In each instance, we describe the price setting arrangements as they currently stand, with a focus on recent developments.

Background

Australia's universal health insurance arrangements have been designed and implemented within the context of Australia's constitution. Funding is provided by all levels of government, health insurers, and non-government organisations and by individuals. Medicare (or Medibank as it was originally known) was introduced in 1974, dismantled between 1976 and 1983, and re-introduced in 1984.

About 70%[1] of total healthcare expenditure is funded by government. Of this, the federal government (also referred to as Commonwealth) funds two thirds, and the state, territory and local governments contribute the other one third. These proportions have been fairly steady over the last decade (Figure 1).

Figure 1
Source of funding as share of total health expenditures



(a) Includes funding by injury compensation insurers and other private funding. All non-government sector capital expenditure is also included here, as the funding sources of non-government capital expenditure are not known. If funding sources were known, this capital expenditure would be spread across all funding columns.

Source: AIHW, 2018.

The federal government's contributions are mainly through national health subsidies comprising:

- Medicare Benefit Scheme (also known as Medicare): subsidizes the cost of a wide range of health services provided out of hospital and for private inpatients.
- Pharmaceutical Benefits Scheme (PBS): subsidizes payments for a large proportion of prescription medicines bought from community pharmacies.

1 In 2016-2017, this number was 68.7% (AIHW, 2018). The other 31.3% of total health care expenditure in those years was funded by individuals, private health insurers, and non-government organizations.

- Through the 2011 National Health Reform Agreements between the federal government and governments for each State and Territory: the federal government contributes to the cost of public hospitals based on activity and efficient prices.

In addition to the above schemes, the Australian government also provides funding for health care through social welfare arrangements, regional and remote health care programs, funding programs for chronic and complex conditions, indigenous health, and health care arrangements for Australian Defence, veterans and support of clinical education and training. Figures 2 and 3 show the percentages of total health expenditure by area across different funding sources in the year 2016-17.

Figure 2
Total health expenditure percentages by funding source across areas of expenditure (%), 2016-2017

Areas of expenditure	Federal	State/ local	Total government	Private health funds	Individual	Other	Total non-government expenditures	Total health expenditures
Hospitals	0.343	0.67	0.461	0.57	0.109	0.534	0.298	0.411
Public hospital services	0.292	0.646	0.42	0.076	0.049	0.328	0.088	0.319
Private hospitals	0.051	0.023	0.041	0.494	0.06	0.206	0.21	0.093
Primary health care	0.369	0.223	0.316	0.176	0.678	0.364	0.488	0.369
Unreferred services	0.137		0.087		0.026	0.22	0.039	0.073
Dental services	0.02	0.02	0.02	0.12	0.196	0.008	0.152	0.06
Other practitioners	0.029	0	0.018	0.053	0.078	0.063	0.069	0.034
Community health and other	0.014	0.172	0.071		0.008	0.037	0.009	0.052
Public health	0.017	0.031	0.022		0.001	0.026	0.003	0.016
Benefit-paid pharmaceuticals	0.143		0.092		0.047		0.027	0.072
All medications	0.009		0.006	0.003	0.322	0.011	0.189	0.062
Referred services	0.185		0.118	0.104	0.102		0.091	0.11
Other services	0.046	0.087	0.061	0.15	0.111	0.039	0.115	0.077
Patient transport services	0.004	0.066	0.027	0.014	0.014	0.017	0.015	0.023
Aids and appliances	0.011		0.007	0.044	0.096	0.022	0.072	0.027
Administration	0.03	0.021	0.027	0.093	0.001	0	0.029	0.027
Research	0.058	0.02	0.044	..	0	0.063	0.007	0.033
Total recurrent expenditure	1	1	1	1	1	1	1	1

Source: AIHW, 2018. Note: Each column shows the share of each health expenditure item as a total of each funding source expenditure.

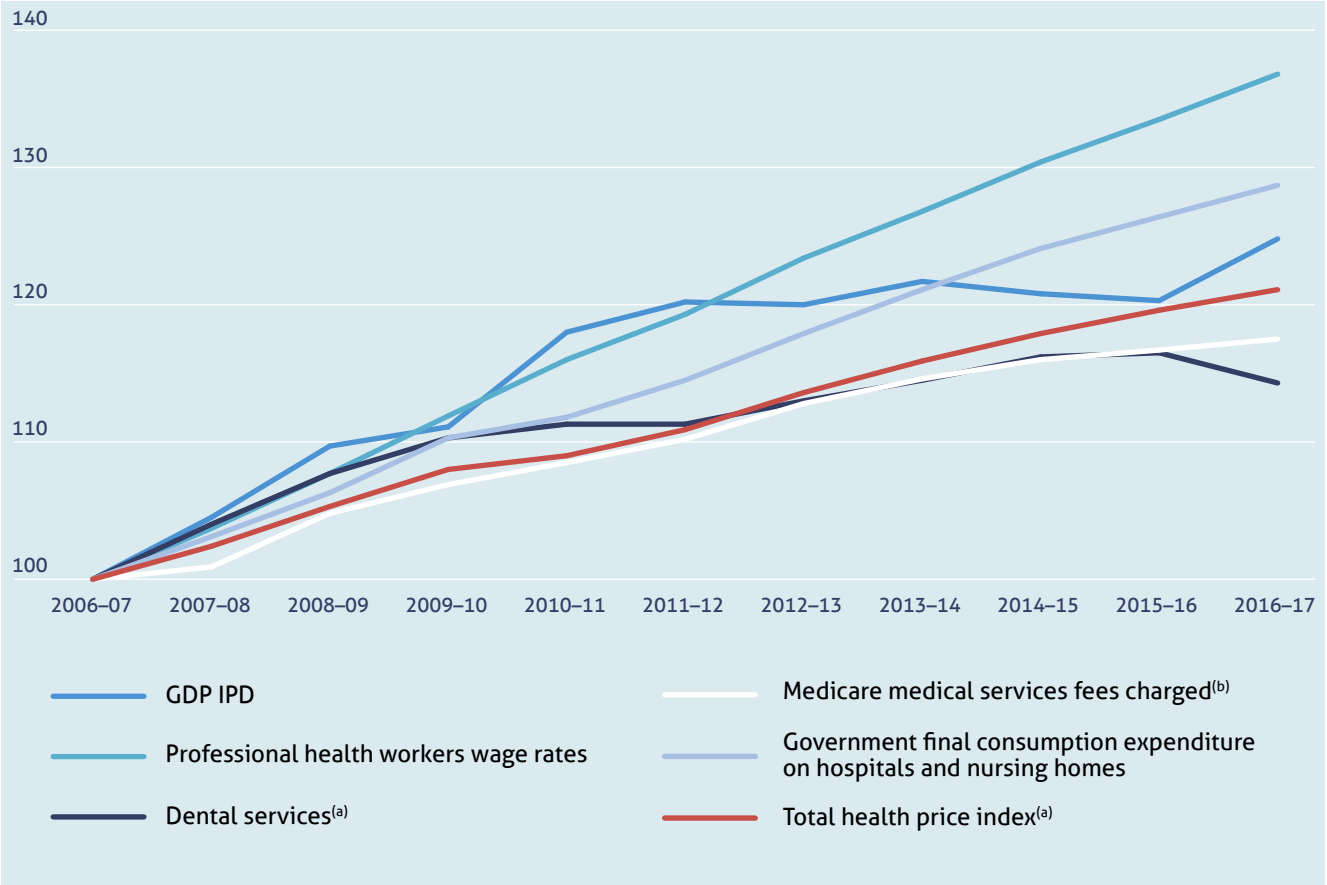
Figure 3
Total health expenditure percentages by areas of expenditure across funding sources (%), 2016-2017

Areas of expenditure	Federal	State/ local	Total government	Private health funds	Individual	Other	Total non-government expenditures	Total health expenditures
Hospitals	0.369	0.409	0.778	0.131	0.047	0.044	0.222	1
Public hospital services	0.406	0.51	0.916	0.023	0.027	0.035	0.084	1
Private hospitals	0.244	0.063	0.307	0.503	0.115	0.075	0.693	1
Primary health care	0.444	0.152	0.595	0.045	0.326	0.033	0.405	1
Unreferred services	0.835		0.835		0.063	0.102	0.165	1
Dental services	0.149	0.082	0.232	0.187	0.577	0.004	0.768	1
Other practitioners	0.378	0.001	0.378	0.148	0.41	0.063	0.622	1
Community health and other	0.116	0.832	0.949	0	0.027	0.024	0.051	1
Public health	0.468	0.47	0.938		0.007	0.054	0.062	1
Benefit-paid pharmaceuticals	0.884		0.884		0.116		0.116	1
All medications	0.064		0.064	0.004	0.926	0.006	0.936	1
Referred services	0.746		0.746	0.089	0.165		0.254	1
Other services	0.26	0.284	0.544	0.183	0.255	0.017	0.456	1
Patient transport services	0.079	0.726	0.805	0.058	0.111	0.025	0.195	1
Aids and appliances	0.187		0.187	0.153	0.633	0.027	0.813	1
Administration	0.484	0.193	0.677	0.318	0.005	0	0.323	1
Research	0.781	0.154	0.935		0.001	0.065	0.065	1
Total recurrent expenditure	0.443	0.251	0.694	0.094	0.177	0.034	0.306	1

Source: AIHW, 2018. Note: Each column shows the share of health expenditure item as a total of each funding source expenditure.

Figure 4 shows the increase in the health price index as a unit from 2006 to 2017. The total health price index was developed by the Australian Institute of Health and Welfare (AIHW) and is derived as annual ratios of the estimated total national health expenditure at current prices to the estimated total national health expenditure at constant prices. It shows that among expenditures, the wage rates for health professionals had the highest increase during this period.

Figure 4
Health price index



[a] implicit price deflator (IPD): An index obtained using the ratio of current price expenditure to constant price expenditure, constructed by the AIHW.
[b] Chain price index, constructed by the AIHW.

Source: Authors using data from AIHW, 2018. Note: The implicit price deflator (IPD) is an index obtained using the ratio of the current price expenditure to the constant price expenditure. (a) IPD constructed by the AIHW. (b) Chain price index constructed by the AIHW.

Governments have been concerned about growing health care expenditure and the impacts on their budgets. The main pressures are considered to be expensive technologies, population expectations, and an ageing population with a growing burden of chronic disease. Although health sector inflation has outstripped general price rises, there has been no explicit objective around price control. However, policy aimed at hospital pricing and medical fees (as explained below) is evidence of some objectives to restrain price increases.

1
Hospital care

The funding of Australian hospitals reflects both the intricacies of Federal-State financial relationships and the interplay of public and private interests. State governments own and operate public hospitals but are reliant on financial transfers from the federal government, which has greater tax raising powers. Until 2011, specific bilateral agreements for public hospital funding (most recently termed Australian Health Care Agreements) were negotiated on a five-year basis since the 1940s. The introduction of Medicare in 1984 gave every Australian the right to treatment in a public hospital free of charge. This required a higher level of financial compensation from the Federal government, which has been around 50% of total public hospital expenditure (Deeble, 2008). However, this share was not fixed and was influenced by the timing of elections and the cycle of the Australian Health Care Agreements, reaching a low of 38% in 2007. This funding was provided to State treasuries, which then determined how to channel it to hospitals and other services. Increasing budgetary pressures for all governments, increasing hospital costs and growing demands, and public concern about their access to public hospital care provided the perfect environment for each level of government to blame the other for not providing sufficient funds and ineffective management.

The National Health Reform Agreement of 2011 introduced a basis for shared hospital funding (NHRA, 2011). The new arrangements provided increased federal government funding determined by the growth in public hospital activity and hospital costs. Activity was measured by DRG (Diagnosis Related Groups) weights. Hospital costs were set by determining a national efficient price. Federal government funding was paid directly to local hospital networks comprised of regionally based groups of hospitals. States and territories were designated the system managers with responsibility for managing volume growth, and their treasuries provided the balance of funds, a relationship that was expected to ensure a constraint on volume growth.

The NHRA initiated the establishment of a national Activity Based Funding (ABF) for the public hospital sector. Australia has had a long collected national case-mix data on activity and costs. These data included Australia's own version of DRG (Australian Refined-DRGs). The state of Victoria was the first jurisdiction in the world to introduce case-mix funding (Duckett, 1995). Over time, most but not all states and territories had moved to this form of funding in whole or in part. Although the introduction of a national ABF represented a significant change, there was already considerable infrastructure in place around case-mix classification, activity measurement, and costing.

Public hospital pricing

The 2011 Agreement established a new body, the Independent Hospital Pricing Authority (IHPA), to determine the national efficient price for public hospital services (IHPA, 2018a). IHPA has a responsibility for the ongoing development of the component parts required by ABF: a classification system (AR-DRGs; and for sub-acute and non-acute services, the Australian National Subacute and Non-Acute Patient classification), data collection on activity (the National Hospital Data Collection) and calculating costs (with a standard framework for costing activities; the Australian Hospital Patient Costing Standards). Expenditure is split across five types of services: admitted acute, emergency, non-admitted, sub-acute and non-acute, and 'other'.[2] For the financial year 2017-2018, IHPA total expenses were $A 17.9 million, and IHPA employed 42 staff at year's end (IHPA, 2018e).

The National Efficient Price is based on the average cost of an admission (IHPA 2017; IHPA 2018d). IHPA faced the challenge of determining what would represent the efficient price in the absence of any discussion of how this should be defined in the NHRA. Initial analyses showed wide variation in the cost per case across hospitals. ABF was intended to drive efficiency through pricing, but at the same time provide stability and certainty in the federal funding contributions. IHPA determined to adopt average pricing initially, as this would not remove funding from the hospital system while still providing a robust incentive to reduce costs. Case mix is adjusted by the National Weighted Activity Unit (NWAU), with more complex cases having a NWAU of greater than one. NWAUs are a common metric across admitted, sub-acute, emergency and outpatient services. Prices are also adjusted "to reflect legitimate and unavoidable variations in the cost of delivering health services" (NHRA, 2011), including indigeneity, the remoteness of patients' residential area, and the remoteness of the treating hospital. Prices are updated annually.

There are some other adjustments to ensure the Commonwealth does not pay twice for the same services. Where the federal government makes direct payments under special programs (i.e., highly specialized drugs, supply of blood, etc.), these payments are deducted from the calculation of the National Efficient Price. Public hospitals can also treat privately insured patients who can use their private insurance or pay for their own stay. In this case, private insurers and the federal government (through the reimbursement of fees for private medical practitioners) make payments to hospitals, and the National Efficient Price is adjusted to allow for this (IHPA, 2017). Adjustments are made for outliers, with long-stays receiving a per diem rate. This latter adjustment is intended to reduce the revenue (and hence the incentive) for long stay patients, while recognising that some long stay outliers are inevitable.

2 SNAP is applied to admissions for rehabilitation care, palliative care, geriatric evaluation and management, or maintenance care.

Australian geography is such that there are a number (approximately 400) of small hospitals serving small and often rural or remote population groups where ABF is not viable. IHPA determines a National Efficient Cost based on size, location, and type of services. A National Efficient Cost is also determined for services which are not yet able to be described in terms of activity. For these services, block funding amounts are directed to states and territories to allocate to the hospitals.

Consultation and stakeholder feedback is an integral part of the price setting process. IHPA works with a Jurisdictional Advisory Committee and a Clinical Advisory Committee in developing its systems and analysing the data. Its pricing framework establishes various principles, including transparency, and the framework itself is reviewed annually in consultation with the federal government, states and territories, along with a period of public consultation. Its work is published on the IHPA website. This includes full details of pricing frameworks and the list of prices.

One important provision of the National Health Reform Agreement is that, where changes are made to the classification systems or costing methods, these should not result in unwarranted payments (either due to apparently more or less activity). IHPA has developed a back-casting policy for the purpose of calculating federal government funding, remembering that this contribution is based on a share of growth in both prices and activity (IHPA, 2018b). The National Hospital Cost Data Collection is independently reviewed to assess quality (IHPA, 2018c). Because states and territories and the federal government scrutinize IHPA's determinations, there is considerable scope for review.

There have been several developments over time, reflecting improved data collection, changes in practice, and new technologies. From June 2017, pricing was required not just to recognize efficiency, but also to address safety and quality. IHPA worked with another independent body, the Australian Commission on Health Care Safety and Quality, to develop its approach. Hospital admissions that include a sentinel event (never events) attract no payment. Hospital-acquired complications attract a lower payment, which is risk adjusted for patient characteristics. Avoidable hospital admissions have been investigated, but as yet are not included in pricing or funding (IHPA, 2017).

Finally, IHPA has a responsibility in price determination. The actual payment of monies is the province of the National Funding Administrator, who recommends payments to the Treasurer after reconciliation of the activity data.

Pricing for private hospitals

Private hospital charges cover accommodation and facility fees (such as operating theatres, intensive care, etc.), and other costs such as prostheses. The federal government sets minimum prices, for which private insurers must pay. Many of these prices were significantly reduced in early 2018 following a review but are still significantly higher than prices paid in the public sector or compared to international best practice. Medical fees, including imaging and pathology, are generally billed directly by the professional providers under private practice arrangements. This means that a private patient can receive a series of accounts related to one hospital stay, for which private insurance does not reimburse the full amount. This was the cause of widespread consumer dissatisfaction. Simplified billing arrangements mean that the hospital provides one account for an admission, though this does not necessarily include medical fees. It is not clear how widespread simplified billing arrangements are. There is no evidence that simplified billing arrangements have been accompanied by better co-ordination of care, and it is unlikely this would be the case, given that these arrangements were financial administrative arrangements only.

Private hospitals principally treat private patients covered by private health insurance; a small group of patients choose to pay themselves, with others covered as veterans or as claimants under workers compensation or motor vehicle accident insurance. Private health insurers negotiate directly with hospitals on accommodation and facility fees, with each fund separately reaching agreements with each insurer. The federal government sets the default benefit payable for accommodation in the absence of an agreement.

There is also National Cost Data Collection for private hospitals undertaken by IHPA. Participation is voluntary (91 from a total of 630 private hospitals in Australia in 2015-16, representing 60% of overnight admissions) for the purpose of reporting a range of hospital costs and activity data. No comparisons have been made with public hospital performance. Private hospitals are also required to submit data to the federal government Department of Health (DOH) for each admission on the DRG case type, benefits paid and charges, length of stay and demographic data. The AIHW publishes data on private hospital activity and expenditure (AIHW, 2014).

2
Primary care

Primary care services in Australia have historically been provided by general practitioners (GPs). GP practices are, by and large, privately owned but are publicly funded through the Medicare Benefits Schedule (MBS) and, to a lesser extent, copayments paid by patients directly.

Although health care is a shared responsibility between the various levels of government, the MBS is funded solely by the federal level of government. Ever since the 1946 constitutional referendum, the federal parliament has powers to make laws with respect to a range of social benefits, including medical services but not so as to authorize any form of civil conscription.

In the context of price setting, the 'civil conscription' prohibition has important implications on the government's ability to exert price controls. For example, former High Court Justice Michael Kirby stated that "any form of civil conscription" acts as a guarantee against any federal intrusion into what was in effect the small business option for the provision of medical services in Australia. The test for attracting the prohibition is whether regulation intrudes into the private consensual arrangements between the providers of medical services and the individual recipients of such services. The most obvious intrusion would occur if an attempt was made to nationalize the healthcare professions or to force their members into full-time or part-time work for the federal government or its agencies (Faunce, 2009).

The MBS funds primary care for all Australian citizens and permanent residents. Under this scheme, patients are entitled to a rebate for treatment from eligible providers who have been issued a Medicare provider number. In the case of primary care, providers are usually medical practitioners as well as nurse practitioners working directly under the supervision of a general practitioner.

GPs are paid on a fee-for-service basis, with patients receiving a rebate that is equivalent to 100% of the MBS fee.[3] The MBS fee is determined by the Federal government. When the MBS list was first introduced, the fees were based on the Australian Medical Association's (AMA) indicative list of "most common fees" charged. At that time, the AMA's fees reflected a market-based price based on a practice costs and patient's willingness to pay.

3 Since 2004, Australians have also been eligible to receive benefits under the Extended Medicare Safety Net (EMSN). This program exists for those families who have incurred very high out-of- pocket costs during a year for out-of-hospital services. Once a family qualifies, they are eligible to receive an amount that is higher than 100% the MBS fee. Approximately 5% of the Australian population qualifies for the EMSN each year. Whilst primary care consultations are covered by the EMSN, the majority of benefits (90%) are actually directed towards specialists' services. Further details of the EMSN and its effect on prices will be provided in the outpatient's specialist section of the Australian case study.

Since the introduction of Medicare, MBS fees for primary care consultations have routinely been indexed based on a discounted version of the wage-price index and the consumer price index. As part of various austerity measures, the federal government froze MBS indexation arrangements in 1996-97 and also between 2013 and 2018 (Parliament of Australia, 2019). This method of indexation has led the AMA to argue that the growth in MBS fees is far behind the rising cost of medical practice. The AMA reports that between 1985 and 2015, MBS fees increased by 80%, whereas practice costs (defined by CPI and wage indexes) increased by 220% over the corresponding period.

It should be noted that doctors, including GPs, are not bound by the MBS fee. Doctors have the freedom to charge any fee to any patient at any time. However, any GP fee that is higher than the MBS fee creates a gap that the patient must pay. No supplementary private health insurance is available for out-of-hospital services that are covered by Medicare.

The MBS rebate acts as a floor price for doctor fees. If the doctor charges a fee that is equal to the MBS rebate, the patient faces a copayment amount of zero. From the doctor's perspective, there is no financial reason to charge less than the rebate. If they were to do so, the patient copayment would still be zero, and hence would not affect demand for their service. However, it would reduce their revenue. Although doctors have complete discretion over their fees, it turns out that in most cases, the fees charged by GPs are, in fact, equal to the MBS fee. This practice is commonly known as 'bulk-billing'. In 2017-2018, 86% of all primary care consultations were bulk- billed, indicating that in all these instances, the MBS fee acts as an effective floor price and the patient incurs no out-of-pocket-cost for the consultation.

For the remaining 14% of primary care services, the average gap between the doctor's fee and the MBS rebate is just over $A 37 (DOH, 2018). This indicates that, on average, for those consultations that are not bulk-billed, the GP fee is $A 37 higher than the MBS fee. For reference, the most commonly claimed GP MBS item has an MBS fee of $A 37.60.[4] This implies that for the 14% of non-bulk-billed services, the average GP price is $A 74.60 for a standard consultation.

Due to the extensive use of bulk-billing in primary care, the government has strong regulatory power over prices through its control over the MBS fee. It can control a highly effective floor price. That said, its control is tempered by the GP's ability to switch from bulk-billing their services to charging fees above the MBS fee at any time.

4 Item 23 is described as a professional attendance by a GP at consulting rooms (other than a service to which another item in the table applies) lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history, (b) performing a clinical examination, (c) arranging any necessary investigation, (d) implementing a management plan, and (e) providing appropriate preventive health care for one or more health-related issue with appropriate documentation for each attendance.

The aforementioned mechanisms provide an accurate description of the historical manner by which the federal government has exercised influence over GP prices. These mechanisms remain current for the vast bulk of GP consultations. In addition, the federal government has introduced a raft of reforms that have some bearing on the prices paid to GPs. In particular, the government has introduced:

- new Medicare items to define primary care services.
- price-based incentives to meet government objectives.
- staged roll-outs of bundled payments.

The remainder of this section will focus on the mechanisms used to set prices in primary care under the auspices of the MBS as well as recent reforms that have the potential to influence price settings.

New Medicare items to target high-need populations and incentivize quality of care

Over recent decades, there has been a considerable expansion of the types of services listed in the MBS that relate to primary care. Back in 1997, for example, the MBS listed 48 different items that primarily related to the types of services provided by GPs. Back then, the most distinguishing features between items were the length of the consultation and the place of the consultation (e.g. at the patient's home, at the doctor's office, or nursing home). The June 2018 edition of the MBS counts 148 items relating to primary care. In most instances, these additional items provide a more in-depth description of the type of consultation that is required before a claim can be made against such items. Examples of these new items are:

- Multidisciplinary case conferencing and care planning for people with chronic and complex needs
- Health assessments for people with chronic illnesses or at risk of developing chronic illnesses such as diabetes
- Home medication management review in collaboration with a community pharmacy
- Out-of-hours consultations
- Completion of an annual cycle of care for patients with chronic diseases such as diabetes and asthma

The main difference between these items and those that were previously listed on the MBS is that new items are more prescriptive. The new items tend to define the type of medical services and/or are targeted at particular types of patients before patients are eligible to make a Medicare claim. For example, some items can only be claimed by patients of a certain age or with certain conditions. Items have also been added that expand the types of professions able to claim Medicare benefits including nurse practitioners and psychologists working alongside GPs.

The federal government has, in general, made the MBS fee for these new items more financially rewarding for GPs than previous ones. For example, the MBS fee for the health assessment of a person with a chronic disease is $A 137.90 – well above the $A 37.60 for a standard consultation.[5] Through the establishment of these new items, the federal government has created a new set of price signals to direct care towards specific target populations and also for providing more comprehensive care. There is no unequivocal evidence that this has changed the process or improved the quality of care or patient outcomes. It is clear, however, that larger and better organized practices are more likely to bill these new items.

Price-based incentives for access to care

Similar to the establishment of new item descriptions, the federal government has also used price-based incentives to improve access to care. In 2003, the federal government introduced financial incentives for GPs to provide greater access to services through lower copayments for particular patient groups. These incentives were introduced after a sustained period of increasing copayments (Wong et al., 2017). In the six years leading up to this reform, the percentage of bulk-billed GP services (where patients pay zero copayment) fell from 84% to 68%.

The new incentives gave metropolitan-residing GPs an extra $A 5 if they bulk-billed (i.e. charge zero copayments) patients who hold a concession card (i.e., lower income families and pensioners) or are 16 years or less. The corresponding incentive for GPs practicing in rural, remote, and some outer metropolitan areas was $A 7.50. The reforms were strongly associated with a rise in bulk-billing, but evidence also showed that price-discrimination became a stronger feature of the primary care system. Wong et al. (2017) showed that while concession-card holders were more likely to face a zero copayment, other types of patients were more likely to witness an increase in their copayment. This reflects a change of pricing behaviour on the part of GPs, where concession card status became a greater marker of a doctor's decision to charge lower fees compared to fees charged to the general population.

Health care homes bundled payment

In 2017, the Australian government commenced the first roll out of its Health Care Homes (HCH) program. This program moves away from the traditional fee-for-service model by providing a capitated payment to general practitioners to care for the chronic condition needs of complex patients. It is intended to give practices greater flexibility in the delivery of services by allowing them to broaden the use of technology and the roles of the workforce.

5 Medicare item 703 versus item 23.

GP practices and Aboriginal Community Controlled Health Services are eligible to become HCH. Once they become an approved HCH, they can enrol patients into the program. Three tiers of payments are available depending on the patient's level of complexity and need. The value of each tier is:

- Tier 3 — the highest level of patient complexity: $A 1795 per annum
- Tier 2 — increasing level of patient complexity: $A 1267 per annum
- Tier 1 — the lowest level of patient complexity: $A 591 per annum

The payment values represent an 'average' payment based on a bundle of services that complex patients are expected to use for the management of the chronic disease and were previously funded through the MBS. It should be noted that enrolled patients can still access care outside of their HCH and are also able to access MBS funded fee-for-service episodes of care not related to a patient's chronic conditions. However, the government expects that for the vast majority of HCH patients, the number of fee-for-service episodes will be small (DOH, 2017).

3 Outpatient care

Outpatient care in Australia is funded through a myriad of public and private financial sources. As such, the price setting arrangements depend very much on the funding source. In this section, we will cover price setting arrangements for:

- Outpatient services covered by the MBS
- Privately provided allied health services
- Hospital based outpatient departments

Outpatient services covered by the Medicare Benefits Schedule

Aside from general practice consultations, the MBS covers a vast range of outpatient services including specialists' consultations (including psychiatry), pathology services and diagnostic imaging, some allied health services as well as a large range of procedures and operations. The funding and pricing rules are identical to those described in the primary care sector. However, because the market structures are very different across these different types of services, the pricing mechanisms vary accordingly.

The Medicare rebate for most outpatient services is set to 85% of the MBS fee. There are two exceptions to this rule. The first exception is primary care items (e.g. GP consultations) which, since 2005, are reimbursed at 100% of the MBS fee. The second exception is the Greatest Permissible Gap (GPG) rule. This rule requires that the difference between the MBS fee for an item and the 85% Medicare benefit must not be greater than a specified amount. From 1 November 2018, the GPG has been set at $A 83.40. For example, if the MBS fee for an item is $A 1000, then the 85% benefit would be $A 850, which means that the gap is $A 150. In this case, the GPG would apply and the patient would receive a Medicare rebate of $A 916.60, not $A 850. This amount is indexed by the consumer price index each year. In 2018, the GPG is relevant for any out-of-hospital Medicare item which has an MBS fee of $A 556.30 or more.

Above, we discussed the role of the Medicare rebate acting as a floor price for services. In primary care, this is a highly effective pricing mechanism because 85% of GP consultations adhere to the Medicare rebate. High rates of floor price adherence can also be found for pathology services, optometry, practice nurse consultations and diagnostic imaging. Figure 5 reveals the percentage of services where the doctor fee is equivalent to the Medicare rebate. Overall, the fees for 86.4% of all Medicare claims in the out-of- hospital sector are equivalent to the Medicare rebate and therefore incur zero copayment. For these services, the floor price is the effective price. However, this percentage varies considerably between different types of health care providers. In the primary care market, this percentage is influenced by high levels of competition (particularly in metropolitan areas) and the patient's ability to consult any doctor (there is no registration). For specialists' attendance, on the other hand, the Medicare rebate acts as an effective floor price for only 41.3% of all services. This implies that for the remaining 58.7% of services, the doctor's fee is higher than the floor price. In fact, as shown in figure 5, the specialist attendance fee, on average, is $A 79.94 higher than the floor price. The reason for the higher price often relates to supply-side market power and the patient's ability to pay. The number of specialists are controlled by training places accredited by specialist colleges. Further, patients require a GP referral for a specialist attendance so it is not so straightforward for a patient to find another specialist. There is also a strong positive association between higher fees and the wealth of the area in which the specialist practices.

When doctors charge fees that are higher than the Medicare rebate, the government's control over pricing is limited.

Figure 5
Medicare claims, fees, benefits and copayments out-of-hospital (2017-18)

Services	per capita	Services with zero copayment %	Average benefit per service $A	Average fee charged per service $A	Average copayment $A	Average copayment excluding services with zero copayment $A
Total	15.3	86.4	53.33	61.87	8.54	63.47
GP	5.5	84.9	45.54	51.04	5.5	36.5
Practice nurse	0.1	99.6	13.38	13.39	0.02	4.43
Specialist attendants	1	41.3	84.86	131.79	46.94	79.94
Obstetrics	0.1	61	64.82	162.52	97.69	250.27
Pathology	5.2	99.3	20.37	20.43	0.06	24.54
Diagnostic imaging	1	84.3	135.31	150.9	15.59	99.52
Operations	0.3	68.5	107.35	135.93	28.58	90.76
Optometry	0.4	94.3	46.6	48.07	1.48	26.08
Radiotherapy and nuclear medicine	0.1	76.1	210.21	223.48	13.26	55.5
Allied health	0.5	62.7	74.73	91.95	17.22	46.11
Other	0.4	74.3	160.04	189.1	29.06	112.89

Source: Department of Health, 2018.

As noted in the primary care section, the setting of the rebate for each MBS item has, by and large, been historical. However, there are clear processes in place to advise the Minister for Health about new items proposed to be listed on the MBS. A formal Health Technology Assessment (HTA) is required on any proposed new (or amended) service to evaluate the safety, effectiveness, cost-effectiveness and budget impact. The Medical Services Advisory Committee (MSAC) considers the evidence and makes recommendations to list or not to list the proposed new service to the Minister.

A 2011 Government Discussion Paper articulates the MBS principles upon which proposals for new items should be made (DOH, 2011). The paper proposed an improved evidence-based MBS fee setting process by making explicit the components of fees for new and revised MBS items. The new process aims to increase transparency in the resource inputs, measurements and calculations going into a recommendation for an MBS fee. In doing so, MBS fees are based according to their time and cost components, consistent with the broad range of MBS fees for services offered within a specialty. It is expected that MBS fees will become more incentive-neutral than is currently the case so that there are fewer perverse incentives to provide particular services as well as less cross-subsidisation from one item to another (DOH, 2011).

It is not entirely clear from public documents how the discussion paper recommendations have been implemented. The costing information for many MSAC proposals has been redacted and is not available to the public (see http://www.msac.gov.au for details). That said, under the MSAC guidelines for the proposal of new items, applicants are asked to indicate the likely cost of providing the proposed medical service, including any equipment and consumable costs as well as to specify how long the proposed medical service typically takes to perform. On the basis of these inputs, applicants are asked to provide an indicative MBS fee for the proposed service, which is then included in the cost-effectiveness analysis. This implies that the MBS fee is based on an input cost basis but assessed on the basis of value for money through a formal HTA.

While MSAC may give advice on MBS fees, it does not set them. Once MSAC makes a positive recommendation to list a service on the MBS, the DOH will consult with stakeholders to finalize the MBS fee. If the final fee greatly differs from the proposed fee considered by MSAC, then DOH reserves the right to redirect the proposed fee back to MSAC for further consideration.

Privately provided allied health services

Although the MBS covers some allied health services, these can only be accessed under strict conditions and constrained to a limited number of allied health professions. For example, the MBS will cover up to 10 consultations per year with a clinical psychologist if the patient is referred by a medical practitioner and has a GP Mental Health Treatment Plan. Coverage of allied health services by the MBS is a relatively recent addition, and coverage is by no means complete. Dental and physiotherapy services, for example, are mostly excluded from the MBS.

Consumers can purchase private health insurance for outpatient allied health services that are not covered by the MBS. In general, allied health practitioners set their own fees, and private health insurance companies will contribute a fixed amount towards the cost of a service. Services are described in a similar fashion to the MBS, however, instead of the government paying a set benefit, the private health insurance company does. Insurance companies can and do enter into agreements with some allied health providers that restrict the prices charged by providers and, as a result, the copayments faced by patients.

Hospital-based outpatient departments

Public hospitals have traditionally been owned, operated and funded by the state and territory governments. Prior to the introduction of Medicare (universal health coverage in 1984), outpatient services were provided free of charge to patients meeting a means test. Under Medicare, all Australians are entitled to the same level of reimbursement for medical services provided out of hospital, which resulted in a

substantial move of this form of care from hospital campuses to private consulting rooms funded through the MBS. The extent to which hospital outpatient clinics declined varied from state to state.

As noted above, until 2013, the federal government contributed to the funding of public hospital services through 5-year block grants. Since the National Health Reform Agreements were signed in 2011, the federal government has paid state governments on an activity-funded basis.

Funding for public hospitals applies across several service streams in addition to inpatient activity including emergency, non-admitted, sub-acute and non-acute, and 'other'. Sub-acute and non-acute services are applied to admissions for rehabilitation care, palliative care, geriatric evaluation and management, or maintenance care. Under the 2011 Reform Agreement, the federal government share of funding includes all hospital emergency services and some non-admitted services. The current funding agreements cover specialist clinics which were reported prior to 2011 and non-admitted services which meet the following criteria: directly related to an inpatient admission or Emergency Department (ED) attendance, substitute for an admission or ED attendance, or are expected to improve the health of people who have a history of frequent attendance or admission. However, certain services are excluded, including primary care, family planning, and aged care assessment (IHPA, 2018a).

Activity and cost data for outpatient services are collected as part of the national hospital cost collection. At this stage, there is no non-admitted services classification that is patient centred and suitable for the Australian setting. Therefore, these services are categorized by the nature of service and type of clinician involved.

State governments are still in the process of fully implementing these reforms, although some states such as Victoria have provided details of their new funding and pricing model.

In 2017–18, Victoria introduced the Weighted Ambulatory Service Event (WASE) funding model for acute non-admitted specialist clinic activity, covering, for example, home renal, radiotherapy, and home enteral nutrition. The WASE model is intended to encourage health services to improve their data reporting, drive technical efficiency, and deliver greater transparency and accountability for the funding received (DHS, 2018).

Under the WASE model, activity will be counted as service events and classified according to the national Tier 2 classification with cost weights calculated based on Victorian cost data. Tier 2 classifications are published by the IHPA and categorize a hospital's non-admitted services based on the nature of the service provided and the type of clinician providing the service. The major categories are: procedures, medical consultation services, diagnostic services, and allied

health and/or clinical nurse specialist intervention services. Hospitals have been allocated an activity target that matches their historical non-admitted specialist clinics funding. The framework has been established to adjust funding when health services under-achieve their targets. Currently, the WASE model will not have a direct impact on health service funding in 2018-2019 (DHS, 2018).

4
Residential/long-term care

Context and objectives

The federal government subsidizes the cost of services which provide non-medical care and support for the elderly (Australian Government, 2017). The subsidies are given to consumers (for home care) or providers (for long-term residential care). Not-for-profit and private for-profit providers deliver care and are paid the same rates of subsidy. In home care, there is open competition between authorized providers (those who meet safety, quality and prudential requirements). In residential care, there is restricted competition as the government limits the number of licensed beds in each region and allocates the licences to authorized providers through recurring competitive Approval Rounds (Australian Government, 2017).

The aged care programs are undergoing a medium-term agenda of reform (Australian Government, 2017). The agenda is based on a report by the Australian Productivity Commission in 2011 titled Caring for Older Australians (Productivity Commission, 2011), together with consultation by the government and subsequent studies. The first tranche of legislation to enact the reforms came into effect in July 2014. Despite changes of national governments, there is bipartisan support, and the reforms continue within the initial framework.

The objectives for providing public subsidies to support the delivery of aged care services, including long-term residential care, are set out in legislation of the federal parliament known as the Aged Care Act 1997 (as amended). The objectives (in summary) are to:

- Provide care recipients (and carers) with access to diverse, flexible, responsive and affordable high-quality care and accommodations that achieve appropriate outcomes.
- Promote ageing in place and encourage independence and choice.
- Provide funding based on the quality of care and the type and level of support delivered.
- Hold providers accountable for the funding they receive and outcomes achieved.

- Consider equity and merit given the limited resources available.
- Target services to places and people with the greatest need and integrate aged care with related health and community services.

The reforms have adopted a market approach to the delivery of aged care and therefore prices play an integral part.

- Care recipients should contribute to the costs of their care and accommodations according to their income and assets. They should have choice and control, be the subsidy fund-holders and 'purchase' care from authorized providers according to quality, quantity, price, and timeliness.
- Public subsidies must be sustainable over the long term, particularly given the fiscal impact of the ageing of Australia's population (reduced per capita revenue from taxation as well as increased public expenditure on aged care and health care, including salary pressure from the increasing demand for a proportionately declining workforce).
- The forces of market competition between providers should be harnessed to deliver more efficient, effective and higher quality services that are attuned to the consumers' needs. The sector needs to be viable overall, but individual providers must make their own market judgements and can fail. The regulation of safety and quality must be rigorous, and consumer information must be accessible.
- Funding for an adequate level of approved care is treated separately from residents paying the market price for accommodation (with safety nets) and paying for additional care.

The Aged Care Act 1997 provides the legislative authority for funding and price setting. The next two sections describe the relevant funding and fee setting arrangements, and the final section explains the legal instruments and institutions.

Funding arrangements

There are four main forms of funding for residential aged care:[6]

- Paying for basic daily services. This covers day-to-day living costs such as meals, cleaning, laundry and air-conditioning. With minor exceptions, all residents are required to pay a basic daily fee.
- Care funding. This is the amount received by a provider for delivering care to the residents according to their needs. Apart from residents with low income and assets, nearly all residents make a financial contribution for their care according to their capacity to pay. The government makes a balancing subsidy payment.

6 Please refer to https://www.myagedcare.gov.au/aged-care-homes/working-out-the-costs for more information.

- Accommodation funding. Providers charge separately for the cost of the accommodation they offer. Some residents have their accommodation costs fully funded by the government, and some others receive a partial subsidy. The remainder pay the full cost of their accommodation.
- Paying for additional and extra services. Residents can agree to pay extra for a higher standard of accommodation or for additional services.

Care funding

Care funding to the provider

The level of funding to the provider is determined by the provider assessing the care needs of the residents in accordance with the Aged Care Financing Instrument (ACFI). This provider assessment can be subject to independent audit. The funding comprises a care fee which is paid by residents whose income and assets are over a certain threshold, together with a balancing government subsidy.

The ACFI is a regulatory funding instrument, but it is not a comprehensive clinical assessment of care needs. It consists of 12 sets of questions about assessed care needs, each having four ratings (A, B, C or D) as well as two diagnostic sections. The government claims that the ACFI provides sufficient precision to determine the overall relative care needs profile and the subsequent funding for each of the residents. Providers pool the funding received for resident care within each of their facilities and deliver care to the residents according to residents' needs. By way of contrast, recipients of home care services are allocated individual funding and exercise control over its expenditure.

Care fee

Residents pay a means-tested care fee as a contribution towards the cost of care. The amount paid depends on an assessment of their combined income and assets (set out in regulation), which is conducted by a government agency and the cost of their care, as determined by the assessed input costs of delivering the care needs (ACFI). However, there are limits in place. For persons of low income and assets, the government funds providers for the full cost of the resident's care. There is a sliding scale to an upper threshold, above which residents pay a capped maximum fee. Fees are subject to quarterly reviews. There are annual and lifetime caps in place to limit the amount of the means-tested care fee that a resident can be asked to pay.

5
The market price of accommodation and additional and extra services

The price of accommodation

Aged care homes can, within a wide limit, set the price of their accommodation in the market. They must publish their maximum accommodation prices on the government's My Aged Care website, their own website (if they have one), and in other relevant materials they provide to people who are considering becoming residents. There may be different maximum accommodation prices for different room types in an aged care home. The published accommodation prices are the maximum a provider can charge, but a lower price can be negotiated.

Providers wanting to charge accommodation prices of more than $A 550 000 as a lump sum (or the rental equivalent) must have their prices approved by the Aged Care Pricing Commissioner (an independent statutory office holder appointed under the Aged Care Act 1997 who reports to the Minister for Aged Care).

The government fully funds the costs of accommodation for those on low income and assets and provides a tapering subsidy for partially supported residents. All other residents pay the full agreed price of their accommodation.

Residents who must pay a partial contribution or the full price can choose between making a lump sum, fully-refundable accommodation payment (at nominal, not real, value) or a rental-type daily accommodation payment. The daily payment is set by a regulatory formula to provide the provider a return that is the equivalent of the refundable lump sum.

The government provides incentives to providers to upgrade their standard of accommodation and provides financial disincentives to have less than a minimum proportion of residents who are fully subsidized.

Fees for additional and extra services

Residents can agree to pay extra for a higher standard of accommodation or for additional services. The prices and the services must be published and explained to the residents. Extra service fees are to be approved by the Aged Care Pricing Commissioner. Residents cannot be charged additional fees for other care or services that they do not receive a direct benefit from or that cannot be used for care. Residents cannot be charged for additional or extra services that the aged care home is required to provide by law.

6
Instruments and institutions

Fees and Payments Principles and Schedules of Fees and Charges

The Aged Care Act 1997 authorized the Minister to make principles relating to a wide range of issues including provider accountability, consumer information, quality of care, sanctions, subsidies, fees and payments. The Fees and Payments Principles 2014, No. 2, specify the Rules and Approval Processes. They cover such matters as:

- Resident fees
- Accommodation payments and accommodation contributions
- Calculation of the equivalence between refundable accommodation contributions (lump sums) and daily accommodation contributions (rental payments)
- Approval of higher maximum accommodation payment amounts
- Financial hardship
- Prudential standards of providers

The DOH publishes up-to-date schedules of fees and charges for residential aged care (and home care), which have been set in accordance with the Act and the Principles.[7] Each schedule also specifies the period for which the fees and charges are current.

Aged Care Financing Instrument

In addition to these short-term measures, the government is investigating alternative approaches to determining residential care funding that delivers more stable funding arrangements. The government is engaging with the residential care sector on the development of longer-term reform. One of the actions has been to commission a Resource Utilization and Classification Study to determine the characteristics of residents that drive residential care costs.

7 For the most recent schedule, please refer to https://agedcare.health.gov.au/funding/schedule-of- fees-and-charges-for-residential-and-home-care-from-20-september-2018.

Aged Care Pricing Commissioner

The Aged Care Act 1997 established the position of the Aged Care Pricing Commissioner. The Commissioner is an independent statutory office holder appointed under the Act who reports to the Minister.

The functions of the Commissioner are set out in the Act and are to consider and approve extra service fees and accommodation payments that are higher than the maximum amount of accommodation payment determined by the Minister.

The functions of the Commissioner increase the level of transparency in the pricing of the specified residential aged care services and aim to ensure that aged care recipients are charged appropriately through approval of these prices.

Aged Care Financing Authority

The Aged Care Financing Authority (ACFA) is a committee of experts established by legislation and appointed by the Minister to provide independent advice to the government on funding and financing issues. The committee is informed by consultation with consumers and the aged care and finance sectors.[8] ACFA publishes research that it has commissioned as well as an annual report titled "Funding and Financing of the Aged Care Sector". The report examines developments, issues and challenges affecting the sector, and provides a range of statistics and analyses of the provision of aged care in Australia. ACFA has no price setting or other regulatory responsibilities.

8 More information is available at https://agedcare.health.gov.au/aged-care-reform/aged-care- financing-authority.

References

Australian Government. Aged Care Act 1997. Federal Register of Legislation. Health; 2017. (https://www.legislation.gov.au/Details/C2017C00241, Accessed 14 March 2019).

Australian Institute of Health and Welfare (AIHW). Australian hospital statistics 2012-13: private hospitals. AIHW; 2014.

Australian Institute of Health and Welfare. Health expenditure Australia 2016-17. Health and welfare expenditure series. Canberra 2018;64:HWE74.

Constitution Alteration (Social Services); 1946. (https://www.legislation.gov.au/Details/C1946A00081, Accessed 14 March 2019).

Council of Australian Governments. National Health Reform Agreement 2011; 2011. (https://www.publichospitalfunding.gov.au/national-health-reform/agreement, Accessed 14 March 2019).

Deeble JS. Medicare: where have we been? Where are we going? Australian and New Zealand Journal of Public Health 2008;23:1-7.

Duckett SJ. Hospital payment arrangements to encourage efficiency: the case of Victoria, Australia. Health Policy 1995;34:113-34.

Department of Human Services (DHS). Department of Health and Human Services policy and funding guidelines 2018 Volume 2: Health operations 2018–19. DHS; 2018. (https://www2.health.vic.gov.au/about/policy- and-funding-guidelines, Accessed 14 March 2019).

Department of Health (DOH) Development of a quality framework for the Medicare Benefits Schedule. DOH; 2011. (http://apo.org.au/system/files/21205/apo-nid21205-43271.pdf, Accessed 14 March 2019).

Department of Health (DOH). Health Care Homes: factsheet: payment information. DOH; 2017. (https://www.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes-cp/$File/payment-information-factsheet-letterhead.pdf, Accessed 14 March 2019).

Department of Health (DOH). Annual Medicare Statistics. DOH; 2018. (https://www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1, Accessed 14 March 2019).

Faunce T. Constitutional limits on federal legislation practically compelling medical employment: Wong v Commonwealth; Selim v Professional Services Review Committee. Journal of Law and Medicine 2009;17(2):196-205.

Independent Hospital Pricing Authority (IHPA). Pricing Framework for Australian Public Hospital Services 2018-19. IHPA; 2017. (https://www.ihpa.gov.au, Accessed 14 March 2019).

Independent Hospital Pricing Authority (IHPA). Annual Review of the General List of In-Scope Public Hospital Services; 2018a. (https://www.ihpa.gov.au, Accessed 14 March 2019).

Independent Hospital Pricing Authority (IHPA). Back-casting Policy; 2018b. (https://www.ihpa.gov.au, Accessed 14 March 2019).

Independent Hospital Pricing Authority (IHPA). National Hospital Cost Data Collection, Independent Financial Review, Round 20 (Financial Year 2015-16); 2018c. (https://www.ihpa.gov.au, Accessed 14 March 2019).

Independent Hospital Pricing Authority (IHPA). National Efficient Price Determination 2018-19; 2018d. (https://www.ihpa.gov.au, Accessed 14 March 2019).

Independent Hospital Pricing Authority (IHPA). Annual Report 2017-18; 2018e. (https://www.ihpa.gov.au, Accessed 14 March 2019).

National Health Reform Agreement (NHRA). Council of Australian Governments; 2011. (http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-agreement.pdf, Accessed 14 March 2019).

Parliament of Australia. Medicare. 2019. (https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201718/, Accessed 2 May, 2019)

MedicareProductivity Commission. Caring for Older Australians. Final Inquiry Report No. 53. Canberra; 2011.

Wong CY, Greene J, Dolja-Gore X, van Gool K. The Rise and Fall in Out-of-Pocket Costs in Australia: An Analysis of the Strengthening Medicare Reforms. Health Economics 2017;26(8):962-979.

Barber SL, Lorenzoni L, Ong P, editors. Price setting and price regulation in health care: lessons for advancing Universal Health Coverage. Case Studies. Geneva: World Health Organization, Organisation for Economic Co-operation and Development; 2019.