Welcome to this issue of HIM-Interchange, which focuses on the theme of ‘Health services funding models: national and international perspectives’. The National Health Reform Agreement that will impact on all jurisdictions puts funding models, in particular activity-based funding (ABF), into prominence for all of us. It is, therefore, worth understanding the role of funding models, and how Health Information Managers (HIMs) can contribute to development of an effective funding model.

Objectives of funding models
Appropriate funding models are necessary components of the healthcare sector given that we have increasing demands, increasing costs and limited capped budgets. Health purchasers and funding agencies must consider the impost of the model and the objectives they wish to achieve when choosing the most appropriate model to apply. A funding model on its own cannot impact on healthcare delivery, but when implemented as a component of an overall governance structure where there are accountabilities and financial implications it can support the following objectives:

- **Equitable access.** Models that promote equitable access to services ensure that patient health needs are treated alike (horizontal access equity) and that patients with the greatest needs are treated preferentially (vertical access equity). Such models promote patient choice and the delivery of appropriate care at the appropriate time and in the appropriate setting to maximise quantity and quality of healthcare.

- **Effectiveness.** Effective funding models increase healthcare outputs and/or improve health outcomes. To do this they promote integrated, evidence based, and multidisciplinary models of care.

- **Technical efficiency.** Funding models can promote technical efficiency in the management and provision of health services where the highest possible quality care is delivered for the resources used. Such models assist in allocating funds efficiently where they are needed.

- **Transparency and accountability.** Allocation of funds should be transparent and with the capacity to be audited to ensure purchasers know where money is spent and to allow for the evaluation of the model.

- **Sustainability.** To have any longevity a funding model must be able to be maintained without over-burdensome requirements. Ultimately they should also reduce long-term health expenditure. Inappropriate funding models can also promote perverse incentives; for example they may promote inefficient or ineffective models of care, allocate funds disproportionally to need or costs and not promote patient focused care. A comprehensive perspective is required when establishing system wide funding models to ensure that remedies for one aspect of a healthcare system do not generate unintended – and potentially negative and costly – implications for another part (Farrell & Henke 2007).

Types of funding models
The dominant types of funding models that have been developed and applied in the health sector include the following that can be combined to draw on the strengths of each:

- **Block funding.** This is the traditional approach by government, often based on historical levels of funding. It is based on a set payment for an intention to provide services. This type of funding allocation is simple to develop and administer, can be targeted to specific services and provides predictable budgets to health services. It does not however provide any incentives to promote efficiency, innovation, improving access, coordinating care across facilities and sectors or improving quality (Constant & Mulvale 2010) and can promote inequity in funding allocation. There is also limited transparency and accountability; however it can be linked to some measures and is often appropriate to supplement other funding. State-wide and highly specialised services are examples where block funding may be appropriate.

- **Population-based funding.** These models base payment for anticipated activity on the population being treated. Measures of expected health need (e.g. standardised mortality ratio, socio-economic disadvantage, age/sex population adjustments) are used to predict expected costs to build budgets or distribute the budget from a fixed pool. Such models do promote an understanding of the community and can promote development of health promotion and prevention programs if services are to remain financially viable. They are also relatively simple to implement and understand, which facilitates transparency and equitable allocation of funds. Population-based methods have been used to complement other funding models by addressing inequities in funding among regions or jurisdictions. The disadvantages are that they can be based on inappropriate measures of the population’s health needs, which may result in inequitable distribution of funds and limit access to services due to inappropriate and inefficient service configuration. Such models are
not appropriate for state-wide and specialist services that cannot be dispersed throughout the community. These models may also not allow for the fact that patients can choose to travel for care outside their area and that some areas have barriers in providing comprehensive services in all fields.

- **Fee-for-service.** In these models funding is provided on a per service basis, for example per diem payments and visiting or sessional medical officer fee-for-service payments. A standard price, which is transparent and equitable, is set and applied to all providers. The price paid should ideally be related to the cost, although maintaining this parity over time can be difficult. A criticism of paying for each service provided is that it could encourage the provision of unnecessary services, or selection of 'profitable' patients. It may also discourage innovation and efficiency gains if the cost of new often more expensive treatment is not covered in the fee.

- **Pay-for-performance (P4P).** These models seek to reward appropriate, high quality care by paying a supplement for acceptable measures or patient outcomes. International experience suggests that P4P possibly increases quality and efficiency in public health interventions, such as cancer screening, and improves management of chronic conditions (Organisation for Economic Co-operation and Development [OECD] 2010). There are significant overheads required to implement P4P, for example developing and measuring performance data and the need to avert unintended consequences such as rewarding existing practices and increasing inequities in the health system.

- **Activity-based funding or casemix.** In these models, health services are reimbursed for provision of patient care based on the type and mix of the patients treated. A set amount is paid to the provider based on the relative cost of the group to which the patient is classified. Funding is transparent, being based on measurable outputs. This promotes accountability and technical efficiency; that is, least cost delivery of services and more outputs for the fewest inputs, which can promote innovation. Importantly, the financial risk is shared between the purchaser and the service provider. It does however require significant infrastructure to establish, for example classification, reporting and governance. A criticism of many applications of these models is that funding provided does not necessarily equal cost. When this is the case, then there may be incentives to select 'profitable' patients or provide fewer services than what is clinically appropriate.

- **Capitation.** This refers to longitudinal episode-based payment with reimbursement to provider(s) for multiple episodes of care bundled into a single, comprehensive payment that covers all of the services involved in a patient's care. These models focus on specific conditions, such as those with defined timeframes, defined services or based in specific care settings. The goal is to improve population health, boost the patient care experience and reduce costs. They can promote cost control, integration of care and restructure of the delivery of care. They also share the financial risk between the funder and the provider. The disadvantage of these models is that it can be difficult to set prices, and if the price is inappropriate then the funding allocation will be inefficient. They may also promote providers selecting 'profitable' patients or providing fewer services than what is clinically appropriate.

### Victorian funding model

In 1993 Victoria was the first jurisdiction in Australia to introduce casemix funding. The reforms also introduced the establishment of statutory health authorities that separated the purchaser (state) from the providers (health services). The casemix funding model deployed applies to acute separations only and was moderated by also providing a fixed grant based component. Funding allocation was capped by means of setting hospital budgets based on targets of activity, with a small tolerance level (−2%) and recall policy if targets were not reached.

Since its introduction the model has evolved and been associated with a range of short- and long-term effects (Auditor-General of Victoria 1998; Duckett 1995). Initially, casemix funding was viewed sceptically by health services as it was introduced along with significant budget cuts and the impacts of both became confused. Over time, however, it has been accepted as significantly better than historical based funding as it is fair, transparent, efficient and promotes accountability. Because of these features it has become a valuable tool for measuring and implementing state health funding policy. It has introduced financial incentives that have brought efficiency gains to the public health sector to treat more patients with the same or less resources. It has also increased access through reductions in waiting lists and increases in elective surgery (Auditor-General of Victoria 1998).

While they have not negated the benefits, it must also be acknowledged that there have been some undesirable outcomes. The model funds outputs, not outcomes, and as such does not address the issue of whether or not the activity is needed, appropriate, of quality or value for money, or beneficial to the patient. As such, it has been criticised for driving increased volume of services, without necessarily providing improved outcomes for patients. Several gaming practices by health services emerged at various time at various levels (Duckett 1995) that have required additional governance and accountability frameworks to address. The impact on quality of care has been more difficult to access and it remains a policy objective to pursue a greater understanding of this issue. As the Victorian model is predominantly concerned with funding acute admitted care (and more lately admitted rehabilitation and non-admitted specialist outpatient services), another criticism is that it does not promote integration of the delivery of care. Hence a balanced view of the whole package of health funding should be adopted and promoted through funding and policy development and the governance and account-
ability arrangements that support the funding of health services in Victoria.

**National Health Reforms**

Australian government arrangements that give jurisdictional responsibility for funding health have resulted in a variety of funding models across the nation. While each jurisdiction has to date applied different funding models, the National Health Reform (NHR) (Council of Australian Governments 2011) will enshrine ABF as the future basis of national and jurisdictional funding allocation.

The implications for health information management are significant. As a profession, HIMs have the opportunity to contribute as significant players at both the operational and strategic levels. The national implementation of ABF will be a ‘game changer’ (Independent Hospital Pricing Authority 2012: 13). The NHR will link hospital activity directly to the funding received based on the ABF funding model. Our Prime Minister has stated her support for the reform and provided some indication of her objective: ‘People want to know what happens to the money that goes into fund health,’ Ms Gillard said. ‘They do not want it beyond their line of sight.’ (Gillard 2011)

While the details of the national agreement and funding model have been negotiated by politicians and public servants at state and federal level, the activity it funds and affects is provided at the Local Health Network (LHN) level. Within LHNs, HIMs will have the opportunity to contribute to the implementation, maintenance and refinement of the models.

While there is no doubt the initial ABF funding model will not be perfect, and in fact may contain elements that are perverse, the benefits of the NHR need also to be embraced. There will be increased emphasis on information, including patient activity, coding and cost data. The role of HIMs will be fundamental to ensuring the integrity and utility of this information. There will be the need for development of improved classification models, especially in the areas where the ABF has not been historically applied, such as emergency, non-admitted and sub-acute services. There will be a need for constructive debate and defining of the datasets and business rules that underpin them. The extension of ABF into non-admitted areas may also mean that HIMs need to further develop their skills and roles within health services. The technical knowledge of HIMs can contribute to ensuring a sustainable future ABF model if we choose to embrace the challenges.

**References**


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