Implementing Activity Based Funding in Ireland.

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Introduction
This abstract is an update from a presentation in Qatar on the introduction of an Activity Based Funding in Ireland.

The introduction of an Activity Based Funding (ABF) approach to hospital funding is a key element of the reform and an essential building block for Universal Health Insurance (UHI), the stated policy of the current Government. The plan for ABF is a phased one and the full roll out of is a multi-year project.

Phase I of ABF was implemented in 2014 in the country's 38 hospitals participating in Casemix. The work now underway represents the very early elements of such a system and is best described as the embryonic phase, as the aim is to change behaviour and practice while maintaining financial stability during the transition period, allowing hospitals to prepare for subsequent phases of implementation.

Methods

ABF in 2014
Hospitals initially received their full budget in 2014 as part of the normal budgetary process. A major element of their budget was 'earmarked' as ABF. The amount earmarked was determined based on inpatient and day case activity levels and DRG prices set by the Healthcare Pricing Office (HPO). The balance of the budget was regarded as a normal block grant.

For 2014 each hospital was provided with an activity target which was primarily based on HIPE data for each hospital for the year to the end of June 2013. The activity target was profiled for the year on a monthly basis reflecting the seasonality issues associated with such activity.

At the end of each month each hospital was provided with a report detailing the activity carried out during the period by coding activity to HIPE in the normal manner and timescales. The HPO carried out their standard validation checks and review process to determine the level of funding that equated to the activity carried out. Once hospitals delivered the planned activity levels there was no effect on budgets.

Indicative Benchmarking
An Indicative Benchmarking analysis was also completed at the end of 2014 using forecasted cost and activity data. In practice 'indicative benchmarking' compares a hospital's expenditure in the ABF areas against their ABF revenue. The gap between revenue and expenditure is being called a transition adjustment. For those hospitals who are operating above the national average price, plans will be required to move the unit costs of that hospital towards the average. The period over which that move must be completed has yet to be determined, however ABF will bring a level of scrutiny and focus on to those hospitals which will create significant pressure for change.

In order to allow the system time to understand the indicative benchmarking, 2015 is being regarded as a 'conversion year'.

Results

Evaluation Framework
We know that the transitional adjustments are as a result of both 'measurement' issues (accuracy of coding, accuracy of costing etc) and 'efficiency' issues (LOS, skill-mix etc). The job in 2015 is to stratify these elements for each hospital so that we can isolate any which are structural in nature and develop plans to
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address those which are not.

We are developing an 'Evaluation Framework' which will be circulated to all hospitals. This document will set out the major areas where checks need to be undertaken on the benchmarking data and give indications of what data is available to support hospitals in assessing their own position. We have also engaged an external company to undertake systematic HIPE audit which will allow each group to validate the quality of their HIPE coding.

Conclusions
The indicative benchmarking is the first step on a journey towards full Activity Based Costing (ABF). During 2015 the HPO will work with the Acute Hospitals Division and the group CFOs to investigate the range of reasons for hospitals running above and below the national average price.

ABF will represent a sea-change for the Irish hospital system and has the potential to change the conversation about Irish health expenditure. It can move the debate from a dialogue about deficits to a dialogue about unit-costs, quality of patient outcomes, volume of cases and type of cases. ABF provides explicit linkage between money and cases, thereby creating a new way of describing health expenditure. In time, payments can be linked with clinical objectives, driving better outcomes for patients.