One size does NOT fit all:

IHPA Draft Pricing Framework: Dire Implications for Mental Health Services

Response from Combined National Mental Health Senior Professionals

For TAMHSS: Transforming Australia’s Mental Health Service Systems

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Introduction:

According to the Independent Health Pricing Authority (IHPA) website, the National Health Reform Agreement (NHRA) set out the intention of the Australian Government and state and territory governments to work in partnership to improve health outcomes for all Australians. IHPA was established as a Statutory Authority on 15 December 2011 by the National Health Reform Act 2011. Under the NHRA, the IHPA is responsible for critical aspects of a new nationally consistent approach to activity based funding of public hospitals. Health Policy Solutions (in association with Casemix Consulting and Aspex Consulting) represented by Sharon Wilcox and Stephen Duckett, are the authors of a discussion paper for the Independent Health Pricing Authority entitled: “Activity based funding for Australian public hospitals: Towards a Pricing Framework” (http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/draft-pricing-framework). This discussion paper sets out to develop “the elements of a Draft Pricing Framework for use by the Independent Hospital Pricing Authority in the national implementation of activity based funding (ABF) for Australian public hospitals”, as a key component of current Commonwealth Government health policy.

It was published 21 December 2011, but has been widely disseminated only recently, and has been subject of a nationwide travelling road-show coordinated by the AHHA, on behalf of DoHA, which commenced on 31 January 2012. It has only a short-time frame for comments, ending on 21 February 2102.

This framework is to form the basis of activity-based funding for all acute health care, including mental health. Despite the fact that the DRG (Diagnostic Related Group)
system works very poorly in mental health, the framework proposes that acute mental health be funded by DRG regardless.

The IHPA appears to be determined to get a “one size fits all” solution and standardized formula out of the blocks and operating quickly now, even if it is rough and in the process of its application, disadvantages, or even dismantles, some services. The impression given was that these were the starting orders given to its development consultants. In the recent travelling road-show outlining the IHPA-DPF, we were told that we “shouldn’t let perfection get in the way of implementation”. From the viewpoint of the mental health service community, this refrain could be more accurately interpreted as “don’t let evidence-based effectiveness get in the way of financial convenience”. We have known that ABF has been coming for the last 3-4 years, yet there has been no attempt by the Commonwealth to re-engage the mental health classification and casemix experts with an established track-record in developing a pricing mechanism appropriate to the complexities of this field. Now, we are told that there is no time to develop appropriate pricing mechanisms for mental health services, and that we will just have to fit in with this wholesale approach.

If implemented, this pricing framework is likely to fragment mental health services, and to further disadvantage the funding of psycho-social and rehabilitation/recovery-oriented mental health services, by favouring funding of acute bio-medical interventions in emergency department and acute inpatient settings.

This is occurring at a time when:-

a) there is still so much unmet need for mental health services, requiring the timely engagement of individuals in need in community settings, as established by both National Surveys of Mental Health and Wellbeing, and

b) there is so much evidence and reform impetus to integrate clinical, functional and support services for people with mental illnesses, and to coordinate all-of-government and all-of-community effort.

1. This DPF has the potential to regressively skew, distort and dismantle evidence based mental health services

Contemporary evidence based public mental health services tend to develop integrated teams, which provide both inpatient and community services, acute and follow-up, including rehabilitation and recovery services, and both clinical and functional support services, offering biomedical as well as psycho-social mental health modalities of treatment and care (see 2, a-d). As recognised in the National Health Reform Commission Report, mental health services are essentially community based services with hospital in-reach for the small minority that are admitted.

An Activity Based Funding system which uses the AR-DRG casemix classification to
classify acute admissions and an outpatient clinic classification for acute outpatient care will provide perverse incentives for LHD and service managers to skew and distort mental health services towards:

a) more clinical and less psychosocial interventions,
b) more Emergency department presentations, and away from community based assessments and care, at a time when ED’s are experiencing access block and are seeking to divert mental health presentations elsewhere,
c) more hospital inpatient episodes of care, at a time when psychiatric inpatient units are already overloaded, partly due to the increase in psychiatric complications of increased drug use, and partly due to the depletion by the states of community mental health teams, in the absence of any financial signals from the Commonwealth to the states to rebuild community services.

Access to psychiatric inpatient admissions is crucial and can be life-saving in some circumstances. However, avoidable inpatient admission can often be considered to be a complication in itself in psychiatry, as it disrupts home life, is highly stigmatising and often demoralising, is most often resisted and is therefore usually involuntary in the public sector, and can lead to contagion e.g. of suicides, of aggression due to being “cooped up”, or prolonged passive dependent “institutionalised” behaviours.

Specialised community based mental health care, when properly resourced, more squarely acknowledges and addresses the social and cultural determinants, as well as the biomedical aspects of mental illnesses, often working with clients and their families in their homes, and coordinating the involvement of other agencies, in partnership wherever possible, with NGO’s and fee-for-service providers. This is yet another important instance where community mental health services have been neglected by the Commonwealth, through a failure to provide appropriate signals to the states, putting more nails in the coffin of specialised community mental health care, and making increased hospital admissions and pressure upon inpatient units inevitable.

NGO’s in this sector may provide support services, in conjunction with public or fee-for-service clinical services, for clientele who need care both in acute, sub-acute or ongoing episodes. They are often funded via the state mental health service budgets, apart from those funded by the Commonwealth largely via FACSIA. This framework is silent on the issue of whether the Commonwealth will be committed to taking over an increasing proportion of funding and enhancements for these services to the same extent, or even any extent, as compared to acute services eligible for Activity Based Funding.

2. Integrated Acute and Follow-up Mental Health Services Will Not be in Scope

The IHPA is only determining the price for hospital services, raising the thorny issue of what is in and out of scope. Page 35 sets out proposed criteria. An informed interpretation is that early intervention community services would be outside the scope of services eligible for Commonwealth funding, while crisis oriented services would be in scope for such funding if the IHPA consultation paper was
accepted. Likewise, mental health crisis teams would be in scope but mental health services providing long term support to people with mental illnesses would be out of scope. This determination places services which provide both acute care and longer term care in one integrated team structure out of scope. These exclusions include well-recognised evidence based modules of mental health care such as:

a) Assertive Community Treatment (ACT) teams;
b) Early intervention in Psychosis teams;
c) Combined Crisis and Case management teams, particularly in regional/ rural settings;
d) Community based 24 hour supervised acute/subacute respite facilities.

Mental health service stakeholders feel strongly that this will create perverse incentives to deliver more hospital and clinical care (at the expense of community and psychosocial care) and more acute treatment services (at the expense of integrated crisis and follow-up recovery care, early intervention and supportive care). It will fragment all our efforts to integrate clinical & functional mental health services.

3. Even if part of a mental health service is in scope, the Unit and Machinery of Purchase will not be appropriate or acceptable for mental health services

Once the scope is resolved the next question is: what will be the unit of purchase? The IHPA is proposing to convert all hospital activity into standardized currency called a National Weighted Equivalent Unit (NWEU). There will be a national efficient price for an NWAU and that price will apply whether the activity is surgery, mental health, emergency department, outpatients or anything else. A local health network or district will receive Commonwealth funding for a total quantum of NWAU’s (eg, $x for 50,000 NWAUs) rather than separate Commonwealth allocations for different streams. Under this arrangement, there will be no separate financial allocation by the Commonwealth for mental health activity. The local health network can distribute the 50,000 NWAUs across its clinical streams in any way it wants. This transfer of allocated resources always proceeds in one direction, out of mental health. There is ample evidence of this, locally, nationally and internationally. It presently occurs tacitly, in an undeclared and often underhand fashion, but with this framework, it will become legitimate. From the IHPA perspective, the more activity included in the NWEU the better. In other words, they are regarding whatever mental health scope to be part of the hospital rather than part of a mental health service. The consequence is that Mental Health will be vulnerable to:

- losing control of all funding for any non-technical or humanitarian, self care and support services, and lurching towards making the service far more clinically oriented;
- losing even more of its budget and expenditure to medical & surgical procedural practices as usual, but even more so;
lowering quality of care, as managers will perceive incentives in providing high volumes of low quality inpatient care that will focus on risk management and restrictive custodial care, the LHD will reap the benefit of these from the Commonwealth, and divert the proceeds out of mental health, rather than improving quality;

4. AR-DRG’s are a poor fit for Mental Health: One size does NOT fit all.

IHPA Draft Pricing Framework (DPF) p80-81: “The only part of the mental health service delivery system where there is an acceptable national classification is for inpatient separations in general and specialist acute hospitals (using the national ICD-10-AM classification for mental and behavioural disorders, and AR-MDC 19, Mental Diseases and Disorders including AR-DRGs U40Z to U68Z). “

The proposal for the first year is that acute inpatient mental health be converted to NWEU’s by using DRGs. All other mental health would be block-funded, at least initially (IHPA DPF page 80). However, it is not factually correct to say that DRG’s are ‘acceptable’ for the classification of mental health when the RID (Reduction in Deviance) performance is so poor. At 16.6% it is by far the worst fit of all DRG categories. Drug & Alcohol come a close 2nd bottom. Even “sundries”, or the sump of otherwise unclassified conditions, performs twice as well at 30%, and 3rd worst. An acceptable RID is more like Urinary Tract Infections at 75%.

Blanchard et al (2011) have become very concerned about the poor performance of the mental illness diagnostic class (AR-MDC-19) of the AR-DRG classification. They investigated the AR-DRG classes relating to mental health, as one of the AR-DRG key clinical focus areas, for a number of reasons:

- the RID of LOS (excluding same-day DRGs) for this MDC is by far the worst across the classification, in 2008-09 data it was 16.6% for LOS and 14.5% for cost.
- the CVs for all non-same-day mental health DRGs are high*
- this MDC is one of the higher cost by volume MDCs – ranked 7 out of 23 MDCs
- the current national focus on mental health including mental health being set as a national health priority area.

[*Reduction in variation within classes is normally measured by the Coefficient of Variation (CV) measure, with the accepted standard being that each class should have a CV of less than 1.0.]

5. Mental Health Services are not averse to casemix, only DRG’s. We are pro-casemix, but we want one that works for integrated mental health services

While like other disciplines in health services, only a minority of us are passionate advocates for casemix in a form that works for mental health services, many mental health clinicians do favour a rational approach to casemix, and to fair distributive effects flowing from it. Others are at least reconciled to the inevitability of a form of
casemix becoming linked to resource distribution. However, they have been generally highly sceptical of the application of DRG’s to mental health. Most of them have seen DRG’s as a regressive force within mental health, skewing incentives towards hospital centred care, and disaggregating all our integrative endeavours in this field. Three of our combined mental health response group were members of the National Clinical & Academic Reference Group for the MH-CASC study, or a core member of the study.

6. There is a more widely acceptable and integrative alternative, of much better fit for mental health.

The MH-CASC study
This Mental Health Classification & Service Costs (MH-CASC) Study, (1998) examined 18,000 episodes of care, focussing on whole episodes of care, encompassing both acute and rehabilitation, inpatient and community components. It’s principles were:-

a) that the use of patient related characteristics or variables, rather than diagnosis, should be favoured to explain cost;

b) that it should seek to reduce variance within classes, giving minimum variation within each class and maximum variation across classes (see Coefficient of Variance CV above);

c) that the clinical groups should make sense to clinicians, so clinical factors have therefore to be balanced alongside statistical criteria; and

d) that there should be ease of data collection: the variables used to define the patient classes should be capable of routine data collection, coding and data entry, which should also provide clinically useful data.

It demonstrated that pricing units are more reliable when adjusted for salient service-user characteristics factors such as:-

a) predominant inpatient or community care;  
b) complete or incomplete episode;  
c) age, severity (via HoNOS);  
d) involuntary status;  
e) level of functional disability (for community care, via LSP).

This approach was shown to be a far more accurate resourcing formula template than wholesale DRG’s. A prolonged debate was resolved for the majority in the mental health field, favouring the MH-CASC approach.

7. MH-CASC has not been given any opportunity to develop beyond a short term project
IHPA DPF p80: “There is no national consistency of product classification/ definition for mental health services. Importantly, there is no imminent agreement to such a classification system. This is despite a significant investment over the years in a national Mental Health Casemix and Service Classification (MH-CASC).”

It is untrue that there has been “a significant investment over the years” in MH-CASC. There has been no investment in Australia in it since the publication of the original 2 year project in 1998. This is despite a successful application of it in New Zealand (NZ-CAOS, 2003) and in contrast to the related sub-acute and non-acute SNAP casemix system, which has been widely implemented in NSW, SA and Queensland, and is now regarded by the Commonwealth as a national model.

8. Quality is more than the absence of adverse clinical events

The draft pricing framework purports to ensure optimal quality of services, but in fact only has questionable incentives to reduce adverse clinical events and to encourage risk management.

P8: “A hospital operating at the national efficient price will …… minimise negative consequences that fall on patients (including those attributable to poor quality) or on other parts of the service system;”

P8: “In setting the national efficient price, it is proposed that:…… payment is adjusted for quality through adoption of the United States Medicare list of hospital acquired conditions, so that specific complications occurring during a hospital admission are not included in the payment”.

This framework, in reality, only addresses the negative aspects of quality to bring the outcome back to a baseline of absence of iatrogenic complications. It does not address more constructive and positive aspects of quality of care. It is these latter aspects of enhanced quality of services as described by the emerging evidence base and by service user and family perceptions, which mental health service reform addresses, and that this draft framework threatens to dismantle.

9. Loss of Transparency

This framework purports to increase transparency between the Commonwealth and the States. However, in being able to spend ABF funding received by a LHD in any way the LHD sees fit, it decreases transparency between the Local Health Networks and their constituent services, particularly those which are historically low in the pecking order, such as mental health services.

10. Recommendations:

1. That the IHPA recommend to COAG that the scope of the 2011 National Health Reform Agreement include all public specialist mental health services.
2. That mental health be recognised as a distinct care type (just as services such as rehabilitation and palliative care already are).

3. That mental health has its own ABF model that is developed specifically to meet the needs of people requiring mental health treatment.

4. That, until this model has been developed and is ready for implementation, all public mental health services be block-funded.

5. It is not acceptable to start by including acute mental health in a generic DRG based system, separating it off from community follow-up and rehabilitative care for the 1st year or more, on the basis of vague assurances that it will be adjusted once more specific pricing signals are ascertained. Realistically it might never be altered once begun, and even for an initial period it sends all the wrong signals to LHD managers.

6. That, as part of this development, the IHPA fund (1) a mental health casemix classification study and (2) the development of an integrated mental health funding model. This would build on existing work, including the Mental Health Classification and Service Costs (MH-CASC) study completed in 1998. It would require 1-2 years to develop this casemix classification as it must incorporate admitted and non-admitted specialist clinical mental health services and take account of the patient complexity factors that drive mental health costs.

7. That this work be tendered out and commenced forthwith, as an urgent priority for the IHPA, as the need for it has been ignored or delayed for far too long already.

8. That public mental health services not be disadvantaged during this period: it should be block grant funded in the interim period. This can be achieved by the Commonwealth agreeing to increase its contribution to public mental health services at (at least) the same rate as its contribution to public hospitals.

9. That the IHPA recommend to COAG that, during this interim period, all governments agree to quarantine existing mental health funding.

10. That the IHPA recommend that the National Mental Health Commission provide an annual report on both existing and new mental health funding.

11. The resulting funding model should provide signals encouraging the meeting of presently unmet needs; and the upgrading of quality of
services, both in terms of ensuring safety and implementing evidence based service delivery systems and interventions.

12. The collaborative approach foreshadowed by the IHPA should not only be with the National Performance Authority and the Safety and Quality Commission, but also with the National Mental Health Commission and via the commission, consulting with all key stakeholder groups.

10. Conclusions:

1. The informed Mental Health Community is broadly in favour of a casemix approach to funding design for mental health services. However, it has to be a much better fit than a DRG approach, and an approach that is understandable and workable in terms of retaining and further developing the integration of acute and rehabilitative, community and hospital based, public and NGO delivered components of contemporary mental health services. The media eg. Adam Cresswell (Weekend Australian, Feb 2012) Julie Robotham & Anna Patty (SMH 3 March 2012) have put their respective index fingers on many of the immense problems with the Independent Health Pricing Authority’s proposed system of activity based funding based on Diagnostic Related Groups(DRG’s). It will be even more calamitous for mental health, where pricing signals derived this way are by far the worst fit. They will fragment our more integrated hospital and community mental health services, and contribute to the further dismantling of our community services, just when evidence increasingly demands that they should be built up.

2. It does not make sense for the case-mix and funding system design for mental health services to be “diagnosis” driven. Individuals with most particular psychiatric diagnoses can present with a range of severity and complexities of their condition which can demand a high level of variability in intensity of response. What is more, conditions infrequently present in pure or isolated form: comorbidities are common. Rather, the evidence suggests that the funding system should be derived in consideration of the demands of having to deal with “d” words other than diagnosis, representing more practical and functional categories contributing to cost, such as danger (voluntary/involuntary) , disability (functional impairment), distress, duration, disorganization, depth (severity) and disaffiliation (social isolation, lack of confidantes and immediate supports).

3. The collaborative approach foreshadowed by the IHPA (page 4 of report) should not only be with the National Performance Authority and the Safety and Quality Commission, but also with the National Mental Health Commission. Through the NMHC, this casemix system for mental health services should be developed in consultation with all mental health service stakeholder networks. The process of designing 10 year roadmaps for mental health services and national mental health scorecards cannot be left separate from the process of funding design. Conversely, funding design for mental health services cannot be isolated from the federal funding
signals required to reform mental health services to become much more evidence-based and recovery–oriented.

4. We are aware of an apparent wide discrepancy between a more hard-line stance taken on behalf of the IHPA by at least one strong voice purporting to represent its views, stating that there should be no exceptions from a standardized DRG approach encompassing acute mental health services starting in July 2012, and a more modulated and flexible approach taken by others. The latter suggested that the starting date for mental health services casemix funding will be delayed until case-mix arrangements accommodating the special circumstances of these services can be ascertained. Subsequently it appears that the main IHPA spokesperson has been changing his position every 2 minutes in recent weeks on how to deal with mental health services, possibly under pressure from the Department of Health & Ageing. The Acting CEO of the IHPA, Dr Tony Sherbon, has been quoted as stating that yes, Mental Health will be starting on the same basis and at the same time as acute general medicine (SMH) on 1 July 2012, no it won’t (The Weekend Australian, Feb 2012), yes it will again (SMH 3 March 2012). We are concerned that, without public clarification of one firm IHPA policy on mental health services out of this confusing spectrum of stated positions, a more inflexible approach ultimately may be allowed to prevail, with the assumption or claim that the mental health community had been consulted about it.

5. There is a possible implication of blame in the report (p80), that mental health professionals have had more than 15 years to get our act together on case-mix, and have failed to do so. However, Casemix funding design is a government responsibility, not a job just for the clinical community. The Commonwealth Government needs to engage the clinical community to make case-mix clinically and functionally meaningful, useful and workable. Moreover, the Commonwealth Government only funded 2 years of work on this until 1998, and have neglected to do so since, to further refine the clear and reasonable cost and pricing signals that emerged from the MH-CASC study. Further, the Commonwealth Government have known that health services funding was very likely to move towards Activity Based Funding for at least 3 or 4 years. However, we understand that even if we are to believe the most optimistic forecast, in-depth substantive work on mental health service case-mix funding design is yet to commence, with a view to beginning operation in 2013-14, and presumably only if a viable casemix alternative to DRG funding design is determined.

6. Unsubstantiated claims by the IHPA that 2 jurisdictions (SA and Victoria) have been doing DRG based funding for mental health services for years, and that up to 4 jurisdictions (WA SA Queensland & ACT) have already signed on to generic DRG based casemix for mental health from 1 July 2012 are highly misleading. They just look like some attempt to stampede governments into signing on to this “one size fits all” system. It appears that just one jurisdiction (ACT) has indicated in principle only that it is prepared to trial DRG’s for mental health from 1st July 2012, on the promise that it will not be used as a mechanism for funding for at least the 1st 2 years, by
which time more specific funding mechanisms may be available for mental health. Another, Queensland has been in caretaker mode due to a protracted election campaign. Senior officials from the two others firmly state that they have not signed up. The IHPA spokesperson has also been claiming widely that Victoria & South Australia have both been doing DRG based funding, including for mental health, for some time, “without the sky falling in”. In fact, Victoria has been collecting DRG data for mental health but has specifically excluded Mental Health from its DRG funding system, and South Australia has been collecting mental health DRG’s in 6 general hospitals only, but not in their major psychiatric hospital (Glenside) and has not been using them as a basis for funding, particularly for mental health, which is block funded with annual top-ups as required. In any case the stated intention of the IHPA is not in accordance with the National Health Reform Agreement, which HAS been signed off by all Australian jurisdictions. It states that mental health will not be subjected to generic DRG related case-mix funding from 1st July 2012, but will await development and application of a more tailor-made case-mix system from 2013 or 2014. It is alleged that the Commonwealth may be trying to pressure or even “blackmail” the states into doing its bidding by threatening to leave privately referred outpatients substantially out of scope if the states don’t comply and sign on to their generic pricing mechanism.

7. The current IHPA proposal to start mental health using generic DRG based casemix system from 1st July 2012, with a view to possible adjustment when a more specific set of pricing signals for mental health can be completed, possibly by July 2013 or 2014, seems like a smoke and mirrors effect. Firstly it sends all the wrong signals from the start to health managers, that it is in the financial interests of their organizations to favour heavy-duty hospital based episodes of care over timely community interventions. Secondly, despite soothing assurances to the contrary, there is no credible undertaking that mental health will ever be allowed to get off the generic DRG tread-mill once it has been put on it. Thirdly, despite the long delay already, there is no priority being given by the IHPA to consult widely to design the guidelines for a tendering process to develop specific pricing signals for mental health services, which will not fragment or further dismantle them. The folks at the IHPA, it seems, are too busy to even think about it until the middle of this year.

8. The Australian Hospitals and Healthcare Association endorsed all our recommendations for mental health services in their submission to the iHPA. The Australian Medical Association stated in theirs: “The treatment of mental health services in the proposed framework presents a high risk that those services will be inadequately funded and further fragmented. There needs to be a much stronger commitment to improve the quality of care in both community and hospital settings, a commitment which needs to be shared by all levels of government without equivocation or cost-shifting.” The Australian National Mental Health Commission and the Royal Australian & New Zealand College of Psychiatrists generally concurred with our concerns and conclusions. The Centre for Health Service Development also stated its strong support for the development of an all-setting casemix classification for mental health, and that this classification could build on the work undertaken in the MH-CASC study that was undertaken in the mid-1990s.
Mental Health Council of Australia both welcomes and cautions the federal government: “The introduction of the Commonwealth as a funding partner in the provision of services is welcome, but must be in the context of the continued and higher goal of providing integrated services and programs across the spectrum of services currently available, rather than creating disruption and fragmentation by simply increasing the funding to one point in the system.” It continues: “The great concern of the mental health sector, particularly at the cusp of hospital based services and community based services, is that implementation of new arrangements could inadvertently create negative or perverse incentives, that will drive consumers away from the most efficient cost effective programs.” The Australian College of Mental Health Nurses argues against the leaving the evidence-based work of community mental health teams and NGO’s out of scope, and states that “the draft criteria place a heavy reliance on the public hospital emergency department or inpatient service as a gatekeeper to non-admitted specialised mental health services. This may act as a perverse incentive to direct more people with mental illness to hospital services” . “Given this situation, the ACMHN believes the timetable proposed to introduce activity based funding for mental health service (even) in July 2013 is highly ambitious. The ACMHN supports the continued use of block funding for mental health services while the current ABF mechanisms for mental health are refined. It also supports a more staged introduction of ABF for mental health services. “The National Casemix and Classification Centre submission states: The Mental Health (MH) Major Diagnostic Category (MDC 19) is the worst performer of the whole AR-DRG classification in terms of ability to explain differences in resource consumption between patients.. The length of stay (LOS) performance measure testing degree of fit for the MH DRGs is around 16%. In contrast, the LOS RID for the best performing diagnostic category (MDC 11 - Diseases and Disorders of the Kidney and Urinary Tract) is 76%, and for the AR-DRG system as a whole around 61%. At only 16%, the Mental Health DRGs do not perform well enough for them to be used as the basis of a payment model for the specialist mental health sector.

9. The case-mix system for mental health services should be derived by careful research and development, and should result in an evidence-based funding design, of best possible fit, and not be generated by 1-off, quick and impressionistic consultancy reports.

References:


Australian Healthcare & Hospitals Association Response to Activity based funding for Australian public hospitals: Toward a Pricing Framework (by Health Policy Solutions) February 2012

Australian Medical Association: AMA submission on draft hospital pricing framework, 21 February 2012

The Centre for Health Service Development, Comments on the document “Activity based funding for Australian Public Hospitals: Towards a Pricing Framework” University of Wollongong February 2012.

National Mental Health Commission, Activity Based Funding for Australian Public Hospitals: Towards a Pricing Framework Response by the National Mental Health Commission February 2012


National Casemix and Classification Centre, Comments on the document “Activity based funding for Australian Public Hospitals: Towards a Pricing Framework” February 2012, University of Wollongong