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Making Medicare Better

Prepared by

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Foreword

Like National Health systems in other countries, Medicare is the icon of public policy. Health is personal and intimate to us all. Medicare taps into one of our most basic fears and gives us a feeling of security at a time when we might be vulnerable.

Whichever way you look at it, Medicare was a substantial public policy achievement. Most public policy is achieved through incremental change. Medicare is one of a handful of examples of successful "big bang" public policy initiatives and the solitary example in health care of "big bang" public policy change in Australia in three decades. Some would take this further and argue that, with global health policy littered with "big bang" policy failures, Medicare is an uncommon success.

Medicare was born into a different world - the original thinking behind it was of the late 1960s. It was first implemented under the guise of Medibank in 1975, and its rebirth in 1984 was in a form largely unaltered.

It was born into a world of low healthcare technology, limited options for medical treatment and a rigid demarcation of what was done in hospitals and what was done outside hospitals. It was a world with little discussion of quality of healthcare, for it was almost taken as fact that doctors provided excellent standards of healthcare, as a matter of course. So many of the issues that challenge and confront us today were simply not a factor 30 to 35 years ago, at Medicare's conception and birth.

The problem Medicare was designed to address was the problem of access to healthcare and, for people in urban locations (which is the majority of Australians), it did this very well.

Medicare does, however, have a fundamental failing. As a system of health care funding it has been frozen in time. As a major issue of philosophical and ideological divide during the 1970s and 1980s, government intervention in healthcare was loathed by those on the right, just as many on the left retained a dewy eyed sentimentality for the scheme implemented in 1984.

There are many times when Medicare has been found wanting. Medicare was silent when immunisation rates plummeted in the late 1980s and when Sydney was suffering measles epidemics in 1993 and 1994, Medicare had no solution. Medicare remains mute while Australia continues to be the only western nation to suffer trachoma and, on current trends, indigenous Australians will be the last people on the planet to retain this affliction.

Similarly, Medicare failed many rural Australians, simply because doctors could not be accessed, so a system of health care financing was seen to be wanting.

Australia's health care system is not alone here. In early 2000, as the Commonwealth Minister for Health, I visited Denmark. Denmark has the dubious distinction of having had the longest life expectancy in the world in the mid 1960s yet, today, has the shortest life expectancy in western Europe. Yes, in that time Denmark's life expectancy has gone up three years, but the rest of Europe has seen an eight year improvement in life expectancy.

Clearly on this most basic and general indicator of health systems of a nation, Denmark's health system is failing miserably.

Yet, when I raised this with the Danish Health Minister over breakfast, her reply to me was that the people of Denmark were so attached to their health care system they would vote out of office anyone who attempted major change.

Perhaps, at the beginning of the 21st century, it's time to have a look at the future of our health delivery system. Australia will retain a universal healthcare system, largely funded by government. The debate on that is over and Medicare has won. But, as the world of healthcare is so totally different and more complex today, perhaps it is time to start asking about health outcomes, health quality and a more patient focused system.

On this background, Russell Schneider has provided a provocative, challenging and thoughtful critique on Medicare. With two decades in healthcare, Russell's experience is unquestioned. Not all will take kindly his comments or prescriptions. Given Russell's background in the private health insurance industry, the paper has a health insurance flavour with which others in the private health sector may not agree, and some on the sentimental left of politics will be positively apoplectic at a number of his suggestions. That should not detract from what is a very thoughtful piece from a man who has contributed a great deal to health care and health policy in Australia.

Michael Wooldridge

Preface

Medicare, Australia's national health scheme is sick. As a result hundreds of thousands of Australians each year do not get the care they need, the care to which they are entitled to, or have to wait far longer than they consider reasonable to receive it. And some will die.

It is sick because the Medicare icon has made it impossible for governments to break away from the idea of providing free healthcare without worrying about the outcome. The result has been a bonus for healthcare providers who have been able to ride this government funded gravy train, without necessarily being concerned for patient welfare or having to demonstrate good results. The question is how long this can be sustained.

The solution is simple: change from funding (which means paying healthcare workers regardless of what happens to their patients) to purchasing (which means buying healthcare from those doctors, nurses, hospitals and others who can produce a quality product based on the best possible evidence and giving the best possible outcomes).

Can we do it? In the public sector it's going to be very difficult, because the health unions (in concert with the administrators) have a vested interest in the status quo. They are, in fact, a major part of the Medicare Conspiracy. In the private sector it depends on the extent to which governments are prepared to create a framework which forces competition between hospitals, doctors, and other health workers based on the cost of their services and the outcomes they achieve: in other words, rewarding those who give their patients the best treatment resulting in the best outcome.

So what's wrong?

- Medicare pays doctors, but it doesn't tell you, or your GP (or the doctors themselves), which are the best performers, who actually get the best results, and whose practices conform with best practice based on evidence.

- Privacy laws stop you, your GP, and the general community from knowing how hospitals and doctors really perform.

- Entrepreneurs are encouraged to offer services in the private sector not because of their intrinsic, evidence based value, but because government regulations over health funds give medical entrepreneurs a guaranteed income if they can convince you to use their services

- People with chronic illnesses fall through the cracks, even if insured, and end up in public hospital casualty wards, when a proper health management system would keep them away from the Emergency Department, allowing health professionals in Casualty to provide the best care to those who really need it.

- Any health fund that tries to provide its members with comprehensive medical care outside hospital — helping them stay out of hospital — faces crippling financial penalties.

- Health insurance premiums are higher than necessary because health funds are forced to pay for anyone who gets a license to practice medicine or run a hospital—regardless of how well they do it. So the consumer ends up paying for bad practice—avoidable infections, medical mistakes, bone breaking falls, and a whole range of bad (if not mal) practices in our healthcare system.

So what can we do?

- Measure the performance of individual doctors and hospitals, and let consumers—and their GPs—know where to go for the best treatment. Knowledge is power.

- Encourage GPs and other healthcare workers to provide comprehensive care for people with risky conditions, reducing the likelihood of them having to be rushed to a public hospital casualty ward in the middle of the night.

- Let health funds offer their members products which provide full cover for those performers who get on going good results, and who practice medicine based on best possible evidence, but don't have to cover poor performers.

- Encourage the development of healthcare businesses, which aim at treating particular conditions, such as various types of cancer, and pay them on the basis of their results.

And how do we do it?

- Get the Federal Government to change the law so that health funds can pay for doctors' treatment outside hospital, especially for high risk conditions.

- Allow health funds to make deals with GPs specialist doctors and other healthcare workers to manage their high-risk patients, and keep them out of hospital.

- Provide more information, to patients but especially their GPs, about which hospitals and specialists continually achieve best results.

- Require doctors to adhere to proven best practice medicine if they are to receive full reimbursement from health funds for their services.

- Support health insurers and doctors developing specialised medical groupings which achieve optimal outcomes in their own specialty, combining the talents of specialists, GPs, nurses and other healthcare workers to give patients the best possible outcome at prices they can afford to pay via their own health fund.

All around the world governments, health insurers, employers and consumer advocates are looking at how to overcome the problems of paying for the healthcare needs of an ageing population. Australia's mix of public and private healthcare payers and providers puts it in a unique situation to grapple with this problem. But it can only be successful if we harness the private sector's ability to use competition to get the best results.

To date private healthcare competition has been about health funds offering better service or lower prices, neither of which end up affecting patient outcomes. **We need to transfer healthcare competition down to the level of the hospital, doctor, nurse or other health professionals to ensure that they strive to deliver the best possible care to their patients—and get decent rewards for doing so.**

This paper looks in more detail at what is wrong with our system, what needs to be changed, and how we can get there.

Private health reform: the need for action

Australia's population is ageing, and with it our healthcare system. While the Medicare concept of free healthcare for all is naturally popular, it is not necessarily the optimal system, and more than a quarter of a century after its inception it is timely to consider the extent to which the way Australian taxpayers meet the cost of healthcare is consistent with the way healthcare is, can, and should be provided to them. This becomes increasingly relevant when one considers the extent to which an ageing population will need, want, and demand healthcare delivery and payment arrangements which meet their requirements and those of their children and grandchildren.

In fact, Medicare is neither a health scheme nor an insurance scheme. It is in its fundamentals a doctor reimbursement scheme. Unlike genuine health schemes Medicare is not, itself, concerned with outcomes, or the quality of care provided by those who it pays. To the extent it measures doctor performance it is virtually limited to financial considerations, the number of consultations provided in a given period being one of its key benchmarks, not for satisfactory service but to protect the taxpayer (or consolidated revenue) from excessive costs brought about by over-servicing.

This lack of concern with outcomes is even more evident in the hospital area, as is repeatedly demonstrated, almost daily (and, most vividly and tragically, with the recent Dr Death inquiry in Queensland). In his report into the deaths at Bundaberg and other hospitals Inquiry Commissioner Geoffrey Davies posed what he saw as "the fundamental question: Can Australia ever provide, at no cost and at an adequate and safe level, all of the services promised to all people, at least without a substantial increase in taxation or a substantial increase in income from other sources?"

In hospital services, Medicare provides funding from the Federal Government to the States, and the States then add money from their own resources to fund the provision of hospital services. But the principal funder—the Commonwealth government—has little capacity to look in detail at what it gets for its dollar. While it can (and does) try to establish goals and targets for hospital activity, in fact this has little direct impact on the individual patient. More specifically the prime payer has little influence, or even awareness, of whether the care it is paying for is the most appropriate, based on best practice, or achieving the best possible outcome.

The use of the term funding is significant, for it implies paying for activity, not outcomes. While it is likely that governments will, for a number of reasons, continue to fund services, the private sector has moved from being, like government, a passive payer for care and become a more active purchaser, despite limits to its capacity to purchase on the basis of best practice and most desirable outcomes. Any changes to the existing system need to not only allow insurers to become even more active in their purchasing, based on rewarding those who consistently achieve best measurable outcomes, but also on assisting health funds to become intelligent investors in healthcare itself, by developing payment arrangements which reward best practice.

Perhaps due to understandable political pressures State Governments are more concerned with minimising political problems in their hospital system, as a result of which they become captive to the healthcare workforce and its unions, who are quick to draw attention to crises in the system, crises which they are exquisitely positioned to create. Health is one of the few systems where if you have too many workers you get supply induced demand, and if there are too few you have demand induced inflation. Either way the care providers end up with a capacity to maximise their incomes, contrary to normal rules of supply and demand. That, more than any other feature, is what makes the healthcare market act in mysterious ways that defy conventional economic theory.

Private *and* Public or Private *versus* Public?

Each year one Australian in five will go to hospital — for anything from a few hours to a few months — and their treatment will be provided and paid for either from public or private resources. Thus the two sectors — public and private — are inextricably linked and the health of one inevitably impacts on the other. Australia is relatively unique in this respect: it has the highest private health insurance participation rates of any country with a universal public health scheme. Unfortunately this situation — which should be seen as a virtue — is all too often criticised as a vice, and all too often for either ideological or self-interested reasons.

While it suits some to promote the idea of a crisis (because dealing with a crisis is the best way to push for more resources, power or money), there is no real crisis in healthcare in Australia, although, like any system, there is no doubt ours can be improved. But before we look at that we need to consider that inter-relationship between public and private health.

The role of the public health system is to meet the health needs of the nation's population and in Australia it actually does this very well. It provides us with everything ranging from clean water and food hygiene standards through to very high technology tertiary care, teaching facilities, excellent — by world standard — accident and emergency services, quarantine, epidemic control and immunisation. Indeed Australia's public health system looks after the needs of our population better than most public systems anywhere in the world. But there is a very great difference in providing the healthcare that the **population** needs and that which **the individual** may require, and this is where public systems have difficulty.

By their very definition, public systems have to look after populations. Looking after the health needs of the population doesn't always mean providing the healthcare that the individual may need or may want at the time they may believe they need it. And while the public sector has an obligation to provide treatment on the basis of medical urgency this prioritising is not always understood or accepted by a person whose suffering is as real to them as it may be to someone who is, in public health prioritisation, more ill or a higher priority. This is where the private sector can provide the necessary facilities and financing to allow those individuals who wish to obtain particular services for themselves or members of their family at a time and place that suits them to do so. In doing that it allows the public sector to work better because it releases public sector resources that would otherwise ultimately have to be devoted to the needs of those individuals.

This needs to be recognised by those who pejoratively condemn the privately insured for jumping the queue, or, even worse, condemn the very existence of private health insurance as inequitable. The fact is private insurance makes it possible for people to *leave* the public sector queue, opening up space for others to be treated and secure better use of the scarce public health dollar. And because many users of private insurance require intense treatment resources their use of the private sector in fact speeds up treatment times for others. These outcomes have quite significant social benefits, which are totally ignored by those who regard this as inequitable.

Equity in healthcare is one of the most abused terms around, and usually the resort of the scoundrel. In Britain recently the equity of a nationalised system was starkly illustrated in the case of a woman suffering a rare form of cancer for which no treatment was available under the National Health Service[1]. She learned of a new and expensive drug used in the United States, researched it thoroughly, and asked her British consultant to prescribe it, having been advised her health insurers would be prepared to pay for it. He refused, on the basis that since he could not prescribe this for

[1] Sunday Times, 9 June 2002

his NHS patients he was not prepared to let her have it either! So instead the worst of worlds occurred: in providing her with NHS endorsed treatment he effectively withdrew resources from other patients while providing an ineffective and unwanted treatment for this patient. So much for equity.

When politicians look at health policy they are often torn between the need to meet the wishes of healthcare workers and others who passionately believe health is a fundamental human right which should be provided free of charge to all and the practical problem that someone must pay for services. When Labor introduced Medicare in 1984 most observers would argue it got it fairly right **at the time**: provision of a system of virtually guaranteed access to all forms of healthcare, from primary care through to tertiary hospitalisation, with minimal or no out of pocket payment, and funded on a progressive scale via general taxation and a Medicare levy (which was, in fact, provided to cover the EXTRA costs to government associated with Medicare and NOT to fund the system itself). It was accepted that private health insurance would continue to have a role to play, as a 'safety valve against excessive demand on Medicare itself (if not actually described that way). We should, however, remember that was in 1984 — almost two decades ago!

So what's happened since:

- Despite Medicare, large numbers of people on low incomes have retained their private health insurance, and many of these people are traditional Labor voters. More than two million Australians with a household income less than average weekly earnings have retained health insurance.

- In many cases they are older Australians on fixed incomes, and the number is growing. Today more than 40 percent of the over 65 population are insured.[2]

- In many cases they are poor because they are sick, or sick because they are poor. Despite Medicare they struggle to pay health fund contributions often because their health status means they have constant contact with the health system and regularly use the same specialist and hospital. They particularly don't like it when politicians talk about private health insurance being for the rich.

- The fact is the 43 percent of the population with private health insurance pay 60 percent of the nation's total hospital bill — even after the rebate is taken into account![3]

- When Medicare was introduced large numbers of good risks, mostly on higher incomes, dropped their cover. They made logical decisions about their health status in the knowledge that if the unexpected occurred they could always fall back on Medicare. Older people and those with chronic illnesses tended to remain insured.

- The consequential distortion of health fund profiles increased prices, forcing more and more people out of the insurance system.[4]

- At the same time State Governments were reducing their bedstock. While it's fashionable for States to attack the current Federal Government, we should remember that when Medicare was introduced there were 74,229 public hospital beds in Australia. By 1995 the

[2] Private Health Insurance Administration Council, annual report 2001
[3] AHIA Research Department estimate, based on Commonwealth Taxation, ABS and PHIAC figures
[4] Productivity Commission Report 1997

uninsured population rose from 5.5 million pre-Medicare to 12 million — while **public beds decreased by almost 20,000.**[5]

- Coincidentally private bed numbers increased slightly — paradoxically at a time when insured numbers were reducing.

- The result was a reduction in capacity in an area where demand was growing and an increase in capacity where demand was falling.

- In these circumstances we should not be surprised at stresses developing in both the public and private systems, which were careering out of balance if not control.

- That all changed from 1998 on with the introduction first of the Federal Government's 30 percent rebate followed up by Lifetime Health Cover premium prices. **The ratio of public beds to the uninsured population has increased from 3.9 per thousand to 4.6 per thousand as a direct result of the increase in private insurance participation rates!**[6]

- Now it is currently popular for some to argue that the rebate is denying funding that should be spent on the uninsured population. The fact is the increase in the privately insured population has led to a marked increase in federal dollars available to the uninsured. By 2002 the Federal Government was providing, through the Medicare Agreements, $628 in hospital grants per uninsured person, compared with $420 per uninsured in 1998.[7]

- A few years ago only 30 percent of the population was insured, and had the trend continued coverage would be less than 20 percent today[8]. This fact — along with the marked increase in Federal dollars provided per uninsured person — is conveniently forgotten by those who rubbish the 30 percent rebate. The system is now in relative balance – 44 percent insured, 56 percent uninsured, and bed proportions are much closer to likely demand levels. While at the moment I believe the private bed supply is sufficient to meet demand (there has also been an enormous growth in free standing day surgeries which add considerably to private sector capacity) there could be problems in the future if the insured population increased much more — especially if our health insurance system remains static.

- While the public sector complains about increases in health insurance premiums, the public sector is no more efficient than the private one (and arguably less so). It practices cost containment by queue, limiting the total dollars available for hospital care and hoping this will lead to efficiencies. Waiting lists question that model. Nevertheless, despite budget capping, the New South Wales Treasurer in June 2006 admitted that health costs had been growing annually in the public sector by an average 7.4 percent a year not dissimilar from the more open ended private sector!

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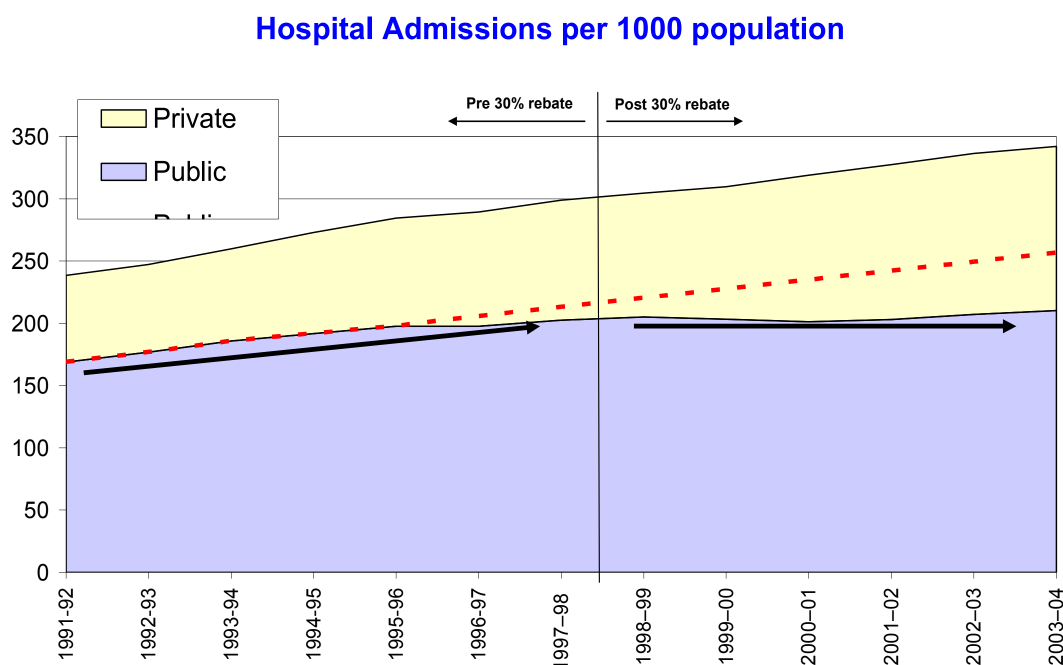
[5] Australian Institute of Health and Welfare reports
[6] AHIA Research Department estimate, based on AIHW and ABS
[7] AHIA Research Department estimates based on Australian Healthcare Agreements
[8] AHIA Research Department estimates

The Rebate

The Federal Government introduced a 30 percent rebate on private health insurance premiums in 1998, an action which has, perhaps, created something of a war about whether the private sector is effectively contributing to the nation's healthcare needs. The facts suggest it is. Perhaps the most pertinent is the fact that, since introduction of the rebate, public hospital utilisation per 1000 population has remained relatively static, while private hospital utilisation per 1000 has increased significantly.



And this leads to some consideration of current problems.

What is Medicare?

One of the biggest problems facing all concerned with health policy is defining what the fundamentals of Medicare are. Different people would have different definitions. Universal access to services regardless of financial resources does not, of itself, require a fully nationalised system. Nor does the confinement of health funds to in hospital funding necessarily represent sensible policy in the 21st century.

Health delivery has changed in the last two decades

Confining hospital and medical insurance activities to in hospital treatment means that insurers are at the end of the line, unable to actively protect their members interests, and very constrained in their capacity to control costs. Their only weapons are relatively blunt instruments; prospective contracting about benefit levels and structuring of medical gap benefits aimed at a point which, one would hope, would be sufficiently attractive to doctors to reduce their propensity to seek additional co-payments from the patient. Premiums are vitally affected by two things; the cost of individual episodes and the volume of admissions. funds have limited power to deal with the former, and virtually no power to deal with the latter.

Insurers are subject to mandatory requirements forcing them to pay every provider a minimum fee. No such restrictions apply to providers, who are free to charge whatever they think the market can bear. If a health fund wishes to increase the price for its product it must seek approval by the Minister for Health and Aged Care: but there is no legislative sanction against a doctor charging a patient double, treble, quadruple the schedule fee: the sky is the limit. Nor is there any maximum fee imposed on a hospital (or limit to the possibly unnecessary or even inappropriate services a hospital or doctor may provide a patient for the purpose of rendering additional charges).

While a fund must pay a hospital a minimum default benefit the Parliament does not protect the consumer by capping the charge the hospital may add on to the benefit. A hospital can reject a benefit offer from a health fund but the health fund cannot refuse to pay the minimal benefit to the hospital, nor can it, in the absence of a contract, limit its contributors' financial exposure if they are admitted to that hospital. In addition regulation severely compromises a health fund's capacity to negotiate or offer effective disease management or coordinated care arrangements for their members, and very effectively inhibits any attempt to use market forces to encourage cost and efficiency competition.

If a fund wishes to provide home nursing or similar support for a member in an early discharge program — or any other form of outreach service — it must be arranged by a hospital if they wish the cost to be debited to reinsurance. This is difficult if the service is intended to avoid a hospital admission!

Facilities, particularly day facilities, proliferate, increasing the prospects of supply induced demand. Once a facility is licensed by State Government, the Federal Department virtually automatically declares it eligible for health fund benefits. Funds have no capacity to decline to pay even if they are concerned about standards.

Funds capacity to deal with Medical gaps — a major source of dissatisfaction with the product — is limited to paying more. There are no sanctions on doctors who insist on charging fees above fund benefits, because ultimately they can pursue the patient through the courts for recovery.

Despite these limits, health funds and many private hospitals are making some headway in the most important area of all: improvement in quality and safety, and this is likely to lead to more efficient and better healthcare. Health funds and hospitals' capacity to promote quality improvement via contracting has been enhanced by one aspect of the 2nd tier default arrangements: if a hospital is to qualify for 2nd tier it will have to meet increasing standards of quality[9], including:

- Specific infection control policies and procedures
- Recording, analysing and feeding back information on adverse events
- Implementation of evidence based clinical pathways
- Application of continuum of care principles for an episode of care, including proper discharge planning
- Maintaining accurate and comprehensive patient medical records including medication histories, allergies etc.
- Ensuring patients on discharge understand the use and possible adverse reactions of medications
- Ensuring proper qualifications of all staff
- Providing appropriate information, including the use of interpreter services, to consumers and act on consumer feedback.

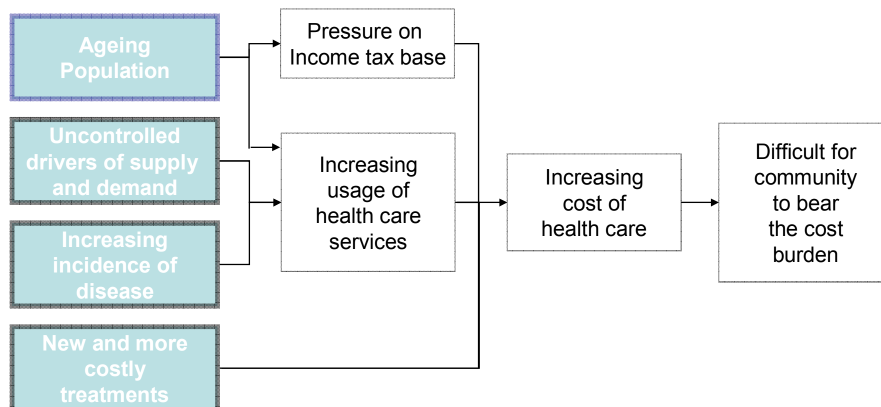
[9] See DHAC HBF Circular 721 - 2nd tier default criteria

In many ways these criteria are significantly ahead of requirements imposed by governments on public hospitals, yet State Governments refuse to acknowledge the important part private hospitals play in their own healthcare systems—except when they decide to buy beds to overcome short term political problems about waiting lists!

The cost of care

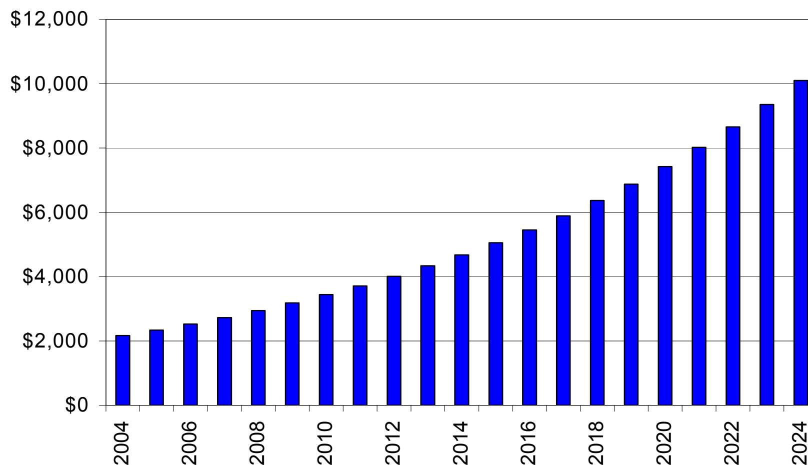
Healthcare consumes an enormous part of the Australian budget, and it will invariably consume even more in the future. Undoubtedly this is in part due to an ageing population, which needs (and wants) more healthcare, and an increasingly technology based healthcare system which is well equipped to provide it. As a result it is possible to provide services, which could not have been contemplated only a few years ago, and many people who would have been untreatable are now able to receive more and better care. But even when the new treatments cost less than those they replace the fact that they make it possible for far more people to be treated means total costs continue to rise, even though there may be some savings at the individual treatment level. The challenge is how community expectations, combined with a capacity for technology to meet and expand those expectations, can be paid for.

Australian Health System Dynamics



In 2006 about 2.7 million people are aged over 65. By 2012 the over 65 population will have increased to 3.2 million. Assuming the cost of hospital care for the 58 percent of the over 65 population who are uninsured is the same as for the insured, hospital services averaged out at $2800 per person over 65 in 2006.

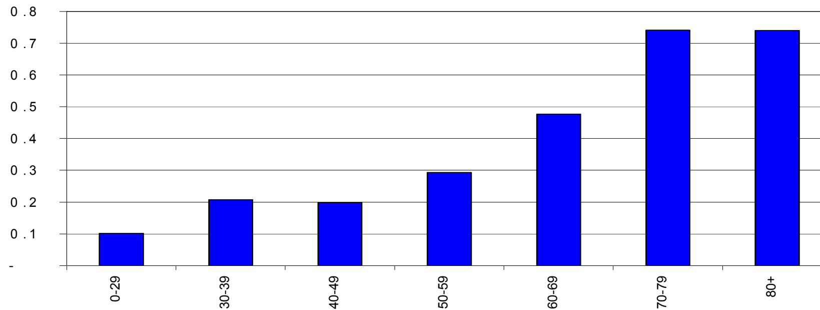
If the healthcare inflation rate of the last few years continues on to 2012 we will be spending more than $4000 per person over 65. There is a multiplier effect at work here. While the number of over 65s is going to increase in the next six years by 18.5 percent, the cost of care per person will rise by 42 percent. And the combination of more older people and healthcare inflation will mean that, if things stay the same as today, the total cost of hospital services for over 65s will have risen from $7 billion in 2006 to $13 billion in 2012—or 85 percent – in **today's** dollars!



Medical services, pharmaceuticals, allied health professional services, etc, will drive this cost even higher. This is a far more realistic healthcare crisis, or healthcare funding crisis, than those we read about in the daily press today. If there are to be sufficient dollars to provide adequate and expected care for older Australians—AND younger Australians—it is essential that our healthcare system itself be as efficient as is reasonably and realistically achievable. This underlines the need for a healthcare system which minimises costly mistakes and errors, and which delivers the most appropriate care possible via the right provider, in the right setting, and at the right price.

Much of the emphasis of private health policy, and private health fund marketing, has been directed to the need to recruit younger, lower cost members to the health insurance marketplace with a view to reducing the cost pressure on premiums brought about by an ageing population. To some extent this is a commendable activity, but it also contains elements of defeatism. The first difficulty is recruiting sufficiently large numbers of younger, healthier members to offset the cost of older ones. It assumes these younger members will represent little or no cost.

However young people have little interest in taking out health insurance in large numbers, and are considered to be reluctant to pay the price that would represent an average community rate. As a result products are developed and priced low enough to attract young, healthy members, reducing the margin available to cross subsidies the old and the sick. And with lower margins the need to recruit many more young healthy members increases, or the price of products, which meet the needs of the elderly increase (discouraging young healthy members remaining in them). Of course, as the younger members age, or their health deteriorates, they will migrate to the more expensive products but by then their own healthcare costs will be driving up the cost of what is today seen as comprehensive coverage. This is a very real vicious circle that threatens the long term existence of the private health sector.



Each person over 65 costs an average $2500 per year. Assuming a single premium for a young, healthy person is about $800 (and some are as low as $500) the system needs to recruit three people who do NOT claim at all for each person over 65. At $500 per person, it needs to recruit 5 non-claiming under 65s for every member aged 65 or more. And as the above graph shows, even the younger age cohorts still involve hospital claimants.

If we look at the growing cost burden of healthcare to meet the demands of the baby boom generation, our efforts need to be directed at smarter, more competitive care systems which reduce the rate of growth of cost per elderly (or younger—they get sick too) member. *A relatively small reduction in the cost of care per older member should have a far more dramatic impact on the cost of health insurance than any realistically achievable increase in the enrolments from younger members.*

Getting competition where it belongs

In a recent article in the Harvard Business Review, *Redefining Competition in Healthcare,* Michael Porter queries why the US healthcare system had under performed in both costs and quality over many years. Porter points out that such underperformance might be expected in a state controlled sector, but is "nearly unimaginable in a competitive market—and in the United States healthcare is largely private."

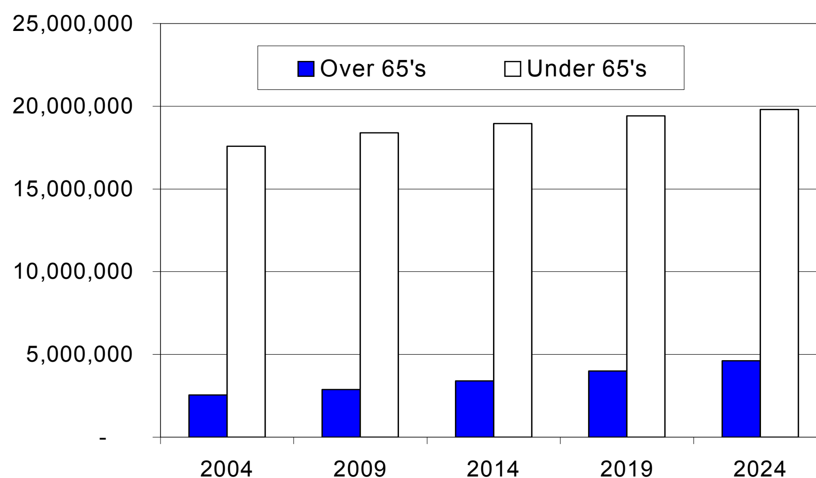
In healthy competition, relentless improvements in processes and methods drive down costs, product and service quality rise steadily, innovation leads to new and better approaches and uncompetitive providers are re structured or go out of business. This is the trajectory common to all well functioning industries—computers, mobile communications, banking and many others.

"Healthcare could not be more different. Costs are high and rising, despite efforts to reduce them, and these rising costs cannot be explained by improvements in quality. Quite the opposite, medical services are restricted or rationed, many patients receive care that lags currently accepted procedures or standards, and high rates of preventable medical error persist. There are wide and inexplicable differences in costs and quality among providers and across geographic areas important constituencies in healthcare view innovation as a problem rather than a crucial driver of success these outcomes are intolerable in healthcare, with life and quality of life at stake."

Although Porter's criticisms are directed at the US healthcare system, they could as easily be applied to Australian Medicare. The problem in the US (and Australia) is not competition, but the nature of competition in the healthcare system. Neither State control nor a single payer system will solve this problem—indeed, as Porter says, these would only compound the problem (take, for example, the UK National Health Service or the Canadian Medicare system, both of which have been subject to on-going efforts to revive their near corpse like condition).

In Australia the debate about competition is usually confined to the extent to which the private health insurance market is competitive, which usually means providers and politicians want funds to compete to offer lower premiums and higher benefits something of an oxymoron.

As in the US, this discussion needs to focus much more on the extent to which healthcare provision is subjected to normal competitive market forces, and policy measures need to be adopted which encourage, facilitate, or even compel competition among healthcare providers—especially doctors and hospital operators—and which provide rewards for the best performers. This may not be easy in the public sector, though should not be as difficult as may be argued. It will be more easily achieved in the private sector, but only if the regulatory and legislative environment allows and encourages insurers to develop payment and other financing arrangements, which identify and encourage best practice. That cannot be done under today's restrictions, especially Section 126 of the NH Act.



When Medicare was introduced the government effectively banned private health insurance from covering medical fees. Until then a combination of health fund and Federal Government benefits were paid for all medical services (other than for public patients in public hospitals) whether inside or outside hospital, up to a government determined benefit. People were also able to insure for gap cover, i.e., to cover all of a bill that might be higher than the insured benefits which were based on the most common fee.

Medicare replaced the most common fee with the Medicare Benefits Schedule, initially establishing items for all medical services and fees for Medicare insurance purposes negotiated between the government and the AMA. A key component of the scheme was the introduction of bulk billing; essential if the then government was to honour its promise of free medical services. This was promoted in public as an equity measure, but in fact was a cost containment one. Under bulk billing a doctor would receive 85 percent of the Medicare Schedule fee provided they did not charge the patient any extra and sent their bill to the Health Insurance Commission, which would pay the doctor within a determined period. It was thought (wrongly, overtime, as the schedule ceased to keep in line with inflation and the financial expectations of the profession) that competition between doctors would encourage most to bulk bill or risk losing patients to those that did.

But for bulk billing to work it was essential that there be no other payer to meet the difference between a doctor's charge and the Medicare benefit. As a result the enabling legislation—the Health Insurance Act—contained a special section 126-headed *Prohibition of certain medical insurance* and which reads:

> "A person shall not make a contract of insurance hat contains a provision purporting to make the person liable to make a payment in the event of the incurring by the other person of a liability to pay medical expenses in respect of the rendering in Australia of a professional service for which Medicare benefit is or **would be payable**" (my emphasis).

Section 126 was justified as an equity measure, in that it would prevent a two tier system and ensure doctors did not give favoured treatment to wealthier, insured persons rather than those who would be disadvantaged if they weren't bulk billed (ignoring the fact that the genuinely wealthy would be able to pay above the bulk billing fee anyway). In fact it was aimed at providing more encouragement for doctors to accept the discounted bulk-billing figure and hold down medical cost inflation.

Under pressure from both the States and the private hospital (and medical) sectors, however, the government decided to require health funds to pay the 15 percent difference between the 85 percent Medicare rebate and the Schedule Fee for a private patient in hospital, (in a further cost cutting move the rebate was dropped to 75 percent and funds required to pay the extra 25 percent). The rationale behind this move was to eliminate any financial incentive for a privately insured patient to opt for Medicare status, as the Medicare design team were concerned to minimise excessive demand on the public hospital sector at least in the transitional stages of Medicare's introduction.

In practice, however, the ban on any form of gap cover for medical treatment outside hospital has had less impact on bulk billing rates than the relevance of the Schedule to inflation and lack of competition in some areas. What it has done is expose many low income families with chronic illnesses living in areas where there are few doctors to either pay gaps themselves or face significant reduction in choice of GP.

More significantly, however, Section 126 effectively prevents a health fund from providing any form of reimbursement for medical services covered by Medicare (and virtually all are) except for those provided to admitted in-patients of a public or private hospital.

This leads to a situation where patients can pass through the healthcare system with different pay arrangements applying in each stage. It also encourages payers to look to avoiding costs by shifting them to another payer. It reduces the capacity of the payer to be concerned about what they are purchasing. In an ideal environment a single payer (or purchaser) for an episode of care would be far more interested in securing the best outcome at the lowest cost from the most efficient providers.

The table below shows the various payment arrangements depending on where a person is treated. This is not only confusing to the patient; it also creates an environment in which the only person concerned about the outcome is the patient. The other players are more concerned with minimising their share of the bill.

Who Pays ???

	HIC	Feds	State	PHI	Patient
GP	✓				✓
Specialist - Rooms	✓				✓
Specialist - Outpatient		✓	✓		
Public Patient - Public Hospital		✓	✓		
Private Patient: Public Hospital	✓		✓	✓	✓
Private Patient: Private Hospital	✓			✓	✓
GP - Post Discharge	✓				✓
Specialist - Post Discharge	✓				✓

Anomalies and Perverse Incentives

The ban on providing any cover for Medicare services outside hospital (combined with the requirement that a fund must pay 25 percent of the MBS for services rendered *inside* hospital, and later legislation encouraging gap cover above the MBS for in hospital patients) has resulted in a number of anomalies in what health insurance can and can't cover, and this must flow into how care is delivered, as it provides quite visible perverse financial incentives for both doctor and patient...and even health insurer.

If a patient is treated outside hospital the only third party benefit provided comes from Medicare, at 85 percent of the Schedule fee, and the doctor must bill the patient for any additional amount (and wait for payment to be made, or incur costs chasing it). If the patient is insured and treated inside hospital, however, the combined Medicare (75 percent of MBS) and health fund (25percent) means 100 percent of the Schedule is covered by third party payers AND their fund will invariably pay a gap cover amount averaging around 25 percent of the Schedule, bringing total third party payer reimbursement to 125 percent of the MBS compared with 85percent for services outside.

This difference provides a very tangible financial incentive for both doctor and insured patient to look to admission to hospital on financial grounds rather than appropriateness ones for those services, which could be provided in either setting.

This is not to say that medical practitioners are, on a large scale, admitting patients to hospitals so they can charge higher fees, or that patients are opting to go into hospitals to avoid any out of pocket expense. But the fact is the regulatory framework has created circumstances in which that will be the outcome of a decision about whether or not to admit. In an efficient and equitable healthcare system such decisions should be financially neutral to both patient and provider.

If there were a clear distinction about what services can only be delivered inside hospital and what must be delivered outside, the above incentives may be irrelevant, and to some extent that was relatively true in 1983. Since then, however, healthcare technology and other developments have blurred the distinction, in surgery, psychiatry, cancer treatment, dialysis and many other areas where medical care can be provided outside hospital without any harm to the patient.

Coincidentally with the introduction of Medicare, Australia saw the introduction of its first free standing Day Surgery Unit in the private sector. In 1983 day surgery was a relatively new concept in Australia and was regarded with some scepticism or suspicion by both surgeons and patients. The drivers behind day surgery were, in many respects, anaesthetists, for whom income could be maximised if they could work with fast surgeons who made few, if any, mistakes. For day surgery to work, the patient needs a relatively light anaesthetic and earlier recovery time if they are to be discharged on the same day, which means more patients can be treated in the same amount of theatre time. Lacking the overheads of a large hospital, and able to concentrate resources and staff on specialised activity, day surgeries should involve lower costs than overnight hospitals and, in theory and with the right financial incentives for both patients and providers, should result in an extensive shift of procedures from overnight (higher cost) facilities to dedicated, free standing, day only ones with lower cost structures.

To some extent this has happened, but the shift of overnight stays into day surgeries has been far less than might have been hoped. While the number of day only admissions has risen dramatically in recent years the majority involve diagnostic procedures, many of which could be provided in lower cost environments such as professional rooms. But a day surgery is, in fact, a licensed day hospital, and therefore patients admitted to it qualify for health fund medical benefits (as well as the fees charged by the day centre itself) whereas doctors rooms are not, and patients treated there only receive Medicare benefits.

This not only explains the large increase in admissions on a day only basis, but may also explain the growth in licensed day surgeries—from none in 1985 to more than 250 in 2005. It may also explain why many day surgeries are owned by members of the medical profession.

Private hospitals responded to the growth in freestanding day surgeries by developing their own on-campus day surgery areas. These have the added attraction that, should a patient need an overnight admission, it should be relatively easily organised, especially if the hospital has relatively low occupancies. Thus, rather than reducing demand for overnight hospitalisation the reimbursement system has encouraged extensive investment in additional resources without necessarily providing appropriate economies to the healthcare system.

In the United States more than 80 percent of operative procedures are performed in day surgery facilities, with projected throughput up to 85 percent by the end of the decade. Many of these procedures are highly complex ones. In Australia, by comparison, only 55 percent of total procedures are same day.

Consistent with its other benefit policies, the Commonwealth Department of Health imposed default benefits for day surgery aimed at allowing health funds to pay the same amount for certain procedures regardless of whether performed overnight or on a same day basis. This was based on a penal philosophy of punishing hospital providers who kept patients in overnight when they could adequately be dealt with in a day setting.

This assumed the hospital could control such admissions. In fact it cannot. The decision to be treated on a same day basis is one made by the patient and their doctor, not the hospital. To achieve any significant increase in day surgery procedures for procedures currently undertaken, unnecessarily, overnight will only be done by rewarding doctors for accepting the additional responsibilities involved in day procedures, without the back up of an overnight hospital. **Funds should be encouraged to provide higher benefits to surgeons and other doctors who accept the additional responsibilities involved in treating patients on a same day basis for those procedures which can reasonably be transferred from one setting to the other.** And least this should be

regarded as managed care the Australian Association of Surgeons Day Surgery Committee several years ago recommended the concept of differential medical benefits.

Chemotherapy and radiotherapy treatment for cancer can also be provided outside hospital settings for many patients. Again, however, if the treatment is delivered outside a licensed or recognised hospital, fund benefits are not payable. The same applies in respect of psychiatric treatment and many other services. Again the regulatory environment encourages investment in higher cost centres (or facilitates the charging of higher fees, or both).

The ban on cover for medical services outside hospital does not extend to other healthcare services provided by allied health professionals—physiotherapists, nurses, podiatrists, pharmacists, psychologists, dieticians, etc—all of whom can treat within or outside a hospital setting. Indeed, recent legislation actively encouraged health funds to pay benefits for podiatrists (who receive benefits for non hospital treatment) who performed surgery in hospital.

To illustrate the absurdity of the current situation, consider this: a health fund will pay a benefit for a podiatrist to cut the nails of a diabetic to minimise the possibility of the patient suffering a foot infection, but it cannot pay the diabetic's GP to advise the diabetic to have their feet treated properly, nor reimburse an endocrinologist for providing (outside hospital) advice, treatment and care to reduce the possibility of a hospital admission. If, however, the diabetic patient does suffer a foot infection, which becomes gangrenous, the fund must pay thousands of dollars for the resultant amputation in hospital! This is neither good healthcare nor sound economics.

Power without responsibility

These perverse incentives are further facilitated by the system in which hospitals qualify for health fund benefits. The licensing of a hospital or day hospital is a function of State Governments, whose departments have shown themselves over the years to pay little regard to the private health sector. In most States the issue of a licence to establish a day hospital is little more complex than issuing a licence to run a pub (indeed, the State licensing laws and Courts subject an applicant for a liquor license to far more public scrutiny and justification on a community interest basis than applies to securing a licence to provide healthcare, a licence which, in fact, involves at least as much, if not more potential to do harm).

Once a State authority has licensed a hospital the operator simply applies to the Federal Health Department for a provider number which is issued once the department is satisfied the licence is valid. There is no scrutiny of the quality of the premises, consumer demand or need, location or the number of similar facilities nearby, nor is its on going performance subject to any monitoring or review. The issue of the provider number does, however, mean that the facility is automatically entitled to charge health funds a minimum mandated fee (matched by a default benefit which is compulsory for every patient admitted to the facility) and a medical gap fee to every doctor who works there. The issue of a licence is, in fact, a licence if not to print money, then to demand it.

The party which is most exposed in this situation—the health fund and its members—are given no opportunity to question or challenge the issue of the licence, nor the provider number. This results in an unnecessary and uneconomic proliferation of resources and adds to the cost of health insurance. It may also create further perverse incentives for patients to be admitted or encouraged to seek admission not on the grounds of most appropriate or best practice care, but for financial reasons.

Reinsurance: Discouraging effective care

The limitations on the current hospital table create further perverse incentives that add to costs and compromise quality. The existing system is intended to ensure the costs of identifiable high risks (based on age, as a reasonable proxy for increased need for health services) are shared between all players, whether they have an aged membership or not. This is, in effect, consistent with the community rating principle of ensuring that healthier members subsidies the costs of sicker members, and to that extent works reasonably well, although there is a need for some refinement.

However, the current system applies only to the *in-hospital* costs of older members. This, by definition, excludes services to older members that might reduce the incidence of hospitalisation or reduce length of stay.

As a result, a fund which is prepared to invest in providing care arrangements for its members which act as a substitute for hospital can find the cost, after reinsurance is taken into account, is greater than paying for the patient to be in hospital! Even worse, as the patients in the alternative setting are not included in re-insurance, a fund which takes the risk of entering into a commercial contract with other service providers may actually worsen its competitive position compared with the rest of the industry!

The following example is based on information provided by a health fund. The actual figures are commercially confidential, but the illustration shows the perversity of the current scheme.

Example 1: Health fund contains a number of older members who are in hospital due to the absence of a suitable alternative program. These patients cost the fund about $1.8 m in hospital benefits, but because they are over 65 this amount can be included in reinsurance, and results in an offsetting reinsurance claim for the fund of $1,087,830.

Net cost to fund of patients remaining in hospital = $712, 170
Net cost to other funds = $1,087,830.

Now, assume the fund decides to support a special program outside hospital, which costs it $550,000. This saves the fund paying $1.8 m in hospital benefits, but because the program is outside hospital the benefits paid are not eligible for reinsurance this results in:

Net saving to the fund (hospital benefits that would have been paid net of reinsurance $712,170, less actual cost of program $550,000) = $162,170 saving.
Net saving to other funds = $1,087,830 (reduced reinsurance payments)

The fund has saved a little over $160,000, but it has taken a significant gamble that investing in the alternative care would pay off. That gamble has, however, saved its competitors more than $1 million. Even though it has saved money, its competitive position has worsened.

If, however, the fund had been able to include the $550,000 cost of the program in reinsurance, it would, after reinsurance, have paid $217,250. Its competitors would have reduced their reinsurance payment by $332,750, so the net cost to the other funds would have been only $755,080. Both the fund embarking on the program and its competitors have saved significantly, so there is a clear financial benefits to both the receiving fund and its competitors in including the cost of a program which substitutes for hospitalisation in reinsurance.

There is a caveat to this, and that is that the alternative programs must be closely monitored and carefully administered to ensure they are limited to those patients that are most likely to benefit, i.e., avoid hospitalisation that would otherwise be necessary. As a general rule they should substitute for higher cost care, not merely supplement existing services. At the same time there is a strong case for insurers to be looking to support programs, which, though initially costly, may be less expensive in the longer term if they reduce the likelihood of readmission or further treatment in the future. At the moment one of the biggest disincentives for a fund to take a long term view is the fact that the members affected may, over time, choose to move to a competing insurer, and the investment in better care flows to someone else. Inclusion of such programs in reinsurance in part offsets this perceived problem. It should also reduce the cost of the reinsurance pool over time..

It is critical that any such programs be outside the current default benefit system and that rates contracted for the service are a matter between the fund and the provider, with provision for capping utilisation or ensuring adequate controls are in place. If these arrangements are subject to default or mandated payments by government costs will increase and the value and integrity of the programs be undermined.

Determining which programs should be included in reinsurance should be left to the health insurance industry, which can evaluate them on the basis of their attractiveness of the members and their cost effectiveness. Given the savings to both those funds that instigate them and those which would otherwise pay into reinsurance, it would be reasonable to allow the industry itself to determine which specific programs should qualify. To avoid any sense of exploitation of the system it would be appropriate to have a trial period—perhaps 6-12 months during which savings could be evaluated—before the program was eligible for inclusion in the pool unless, of course, the program or treatment was so clearly beneficial that all insurers agreed to its inclusion.

Dr Death

The recent Dr Death incident in Queensland, in which a surgeon who had been struck off the lists in the US, was able to operate—and injured—large numbers of patients highlighted the need for better credentialing of healthcare workers at all levels. Further, consumers should be able to obtain information about the performance of those who treat them. Unfortunately this is virtually impossible under current restrictions, including the way Medicare has been put together.

Performance varies widely in our healthcare system, depending on a number of factors. In the US consumers can review the Dartmouth Atlas, designed to illustrate how performance varies from state to state and region to region. Often it may be a function of the teaching facilities groups of doctors attended, but sometimes there may be other reasons.

While specific provider performance can't be compared in Australia, there are considerable variations in the likelihood of you having a particular operation depending on what State you're in. In its Report on Government Services 2005 the Productivity Commission, drawing on Australian Institute of Health and Welfare data, showed considerable differences in utilisation rates for various procedures throughout Australia.

This data shows you are much more likely to have an appendicectomy if you live in Western Australia than in New South Wales, i.e., in 2002-03 (the latest figures available) 1.61 people per 1000 had their appendix removed in Western Australia, while only 0.91 per 1000 enjoyed this experience in New South Wales. Even when this is adjusted for age there is still a marked difference: 1.19 per 1000 in Western Australia compared with 0.91 across the continent.

ON the other hand, coronary artery bypass grafts were far more common in New South Wales - 0.84 per 1000 compared with 0.54 in WA. Even when adjusted for age the difference remains - 1.07 per 1000 in New South Wales and 0.68 in Western Australia.

Angioplasty is most popular in Victoria - 1.6per1000 compared with 1.1 per 1000 in Queensland. Age adjustment makes little difference - 0.82 per 1000 in the north, 1.19 in Victoria. Queensland is, however, the home of caesareans 3.96 per 1000 compared with 3.03 in the ACT. Perhaps that has something to do with the attractions of the outdoors to obstetricians/gynaecologists in the Sunshine State. If you live in Victoria you have a very good chance of experiencing a diagnostic endoscopy (said to be the equivalent to swallowing a snake) but a much less likelihood if you are Tasmanian. The list goes on:

Separations per100	Highest	Lowest
Diagnostic gastrointestinal Endoscopy	Victoria 32.14	Tasmania 19.81
Hip Replacement	Tasmania 1.82	Queensland 1.12
Revision of Hip replacement	Tasmania 0.21	Queensland 0.14
Hysterectomy	W.A. 1.88	Victoria 1.38
Lens Insertion	W.A. 8.27	Tasmania 5.62
Prostatectomy	Victoria 1.41	Queensland 1.04

These are not trivial procedures, and although on a per 1000 basis the differences may not seem great, when one extends them there are obviously far different decisions being made between States on whether to perform these operations or not. It may be there are more surgeons of a particular specialty in one State than another, it may be that the hospital system has better facilities for these procedures than another, it may be that teaching and training methods differ between States, or it may simply be that people do things different round here. Nevertheless, one would expect that in a population as relatively homogenous as Australia there would be far more consistency in decisions about surgery than the above figures indicate.

Where's the evidence?

Variations in performance are one thing, but failure to provide treatments which have been proven to work is another, yet repeatedly we find despite the best efforts of researchers and others, evidence based medicine fails to be provided.

The National Institute of Clinical Studies (NICS) established by the Federal Government as Australia's national agency for helping close the gaps between evidence and practice in healthcare has published two reports on the differences between evidence and practice since 2003. They make gloomy reading.

Whether it be advice on stopping smoking, using ACE inhibitors and beta blocker therapies in heart failure, prescribing antibiotics, managing acute and cancer pain in hospitalised patients, NICS found considerable differences between what evidence showed was the right treatment and what was taking place in the healthcare marketplace.

First, do no harm does not seem to have been practiced extensively based on much of the evidence now available. Even such things as prescribing antibiotics for the common cold, which may seem trivial enough, can have the potential for significant adverse side affects. As NICS says for the majority of patients presenting with these problems (the symptoms of the common cold) antibiotics will provide little or no benefit and may cause side effects such as nausea, vomiting, diarrhoea and rash not to mention the likelihood of promoting anti biotic resistant strains of bacteria.

A 2000 survey of 80,000 post menopausal women with hip fractures showed that less than 20 percent were receiving anti osteoporotic treatment, treatment which is much cheaper, and less traumatic, than hip replacement surgery.

NICS has done valuable work in exposing the difference between what evidence says works and what is applied, or not applied, in daily practice, both in our GP surgeries and our hospitals. But while highlighting these problems is valuable, it does not necessarily translate into practice at the coalface. The most effective inducement to good practice is, like it or not, financial incentives.

While individuals may choose to pay for treatments which are not supported by evidence there can be no argument that the community, whether via taxes or insurance, should be required to provide financial support. Health funds should have the right to refuse payment for medical treatment that is inconsistent with evidence of best practice. This would make it possible for health funds to achieve best use of their members funds by being able to reward those practitioners who do, in fact, provide treatments which are supported by evidence.

Performance Review

Medicare's introduction saw the Health Insurance Commission take over the responsibility of payment of doctors, both in and outside hospital. This made it difficult for insurers to link medical treatment with a specific hospital episode. Later provisions allowing funds to provide gap cover have made it possible for this link to be resumed, but funds can only review (if they wish to) matters relating to their own membership base. Even the biggest fund (Medibank Private) only pays for 30 percent of total hospital services, and in some States much less. So while health funds can and do capture considerable data about provider performance—both as it relates to hospitals and doctors no fund has a database large enough to be convincing or comprehensive.

If consumers and the funds acting as their payment agents are to be able to benefit from this information insurers should be permitted (or required) to pool it so that proper assessments can be made. Unfortunately the capacity of funds to do so is inhibited by the possibility they may offend Privacy Laws.

While Australians receive little or no information about provider performance other countries take a distinctly different view. In the United States, for example, a number of agencies and State Governments provide web sites detailing the performance of surgeons and hospitals, including their names and their risk adjusted mortality rates. For example the New Jersey Department of Health Services publishes a Cardiac Surgery consumer report, which allows consumers—and their family doctor— to evaluate hospitals and doctors before deciding where to go for surgery. The information is risk adjusted to overcome any bias against doctors and hospitals who treat sicker patients.

These reports are not just intended to provide salacious reading for consumers, but also aim at encouraging hospitals to improve the quality of their care and patient outcomes. As a result of publication mortality rates for by pass surgery in New Jersey decreased by 14 percent between 2001

and 2002. Evidence from other States that publish similar reports also shows that mortality rates have declines and the overall quality of by pass surgery care has improved considerably.

In the absence of such reporting, doctors and hospitals have no reason to believe there own performance is less than adequate. Only when they can see how they measure against other institutions and peer groups can they see the need for improvement. In many US hospitals where such reporting takes place positive steps are adopted to ensure the facility ups its act.

Some Australian States have attempted to develop reporting systems, but have been hidebound by privacy considerations. In Western Australia a report on cardiac surgeons performance could only be undertaken on the condition doctors involved remained anonymous. When completed the report showed one doctor had a much higher mortality rate than others. But because of the conditions of anonymity even the head of the State's Health Department could not find out who the doctor was!

In this case anonymity achieved the worst of all worlds. Not only was it impossible to take corrective action, but the whole of the profession was damned. Had the identity of the doctors been known it would have been possible to probe more deeply into the incidence and it is quite possible the surgeon concerned may have been handed the hardest cases. We will never know.

Health funds should be able to use their own databases, including but not limited to, information from the Hospital Casemix Protocol, on a pooled basis to review provider performance and this information, on a risk adjusted basis, should be made available to the profession and the public. Any privacy or trade practices legal impediments should be removed as a matter of urgency, in the interests of better informed consumers and a safer healthcare system.

Incident Reporting

Hospitals are not safe places. According to one expert on patient safety (Dr Bill Runciman, Iatrogenic Injury in Australia) simply being an inpatient in an Australian acute-care hospital is 40 times more dangerous than being in traffic, and only 10 times safer than parachute jumping.

Not all adverse events in hospital are caused by negligence or even accidents on the part of medical and nursing staff. The growth in technology means many new pieces of equipment are being introduced into our hospital system on an almost daily basis. While most of this equipment has been carefully tested to ensure it is unlikely to create problems, this is not always the case. And many people have difficulty coming to grips with the demand of modern technological equipment as most older Australians faced with the need to adapt to computerisation can testify.

Before one can be sure, or even aware, of technological or systemic problems one needs to see significant numbers of incidents occurring. Otherwise an adverse outcome may be blamed on all the wrong things—including the patient (I did everything right but the patient didn't respond as expected!). In a single hospital a faulty device may result in only one or two identifiably adverse events per year, but taken collectively it may be found to result, across a large hospital system, in hundreds.

For example, in a 250 bed hospital, the normal number of adverse events might only be about 1500 a year, and assuming a reasonable number of doctors were working there they and nursing staff would only be personally exposed to a very small number, if any, in each category. This low individual exposure may go some way to explaining why most clinicians were very surprised at the

scope and cost of adverse events when the figures (in a quality and safety survey) were extrapolated to provide national estimates.

These faults can only be detected if a system is in place for all adverse incidents to be reported and reviewed to assess whether there is a pattern arising either from faulty devices or inappropriate use of devices, etc. As Dr. Runciman said "although individually rare, these (adverse) events are collectively important, as many may quite simply be designed out of the system once their true nature has been understood. This may require no work at the individual hospital level, as generic solutions can be applied across the entire healthcare system for certain problems. For example, getting ride of all Seldinger wires with one sharp end will remove all cardiac tamponade arising from inadvertent insertion of a share end…all deaths resulting from the inadvertent intravenous administration of concentrated potassium chloride solutions could be eliminated if this preparation was simply removed from the inventories of hospitals, as has been done in the veterans' Administration hospitals in the United States of America."

A new and safer healthcare system would make incident reporting to a well funded central agency mandatory for all hospitals, with a speedy system in place to identify systemic or device faults and failures and allow mandatory recall or cessation of their use.

Rewarding specialisation

Practice makes perfect, and all the literature suggests this is as true of healthcare as any other endeavour. Unfortunately our current funding system means that every participant is guaranteed the same basic reward regardless of competence or experience. Hospitals which may carry out a particular operation once a year can get the same default benefit as those which carry it out a 100 times a week…indeed, provided they meet criteria which have no bearing on their experience in that particular procedure can achieve 85 percent of the rate paid the best most experienced hospital.

Nor does the Medicare Benefits schedule reflect experience or competency. This flows through into healthcare gap benefits. The provision of more information to funds as outlined above would help determine which providers did achieve the best results, and therefore were entitled to the greatest rewards, but this is difficult when benefits are set as add-ons to the MBS. Hostility from the AMA to the idea of individual contracts between funds and doctors has prevented the best performers receiving higher benefits than those lower down the scale. As a result benefits are tied to mediocrity.

Health funds should be encouraged to provide higher benefits to those doctors who, on the evidence, achieve better outcomes than others, and any legislative inhibition be removed. This should flow down to the 25 percent Medicare gap benefit and benefits paid above the schedule i.e., why should a health fund be compelled to pay 25 percent of the MBS for doctors whose performance is significantly less than others? If the evidence shows a doctor's outcomes are consistently below those of his peer group, a health fund should be able to decide it will not pay any benefits. This may help provide a signal to patients that it might be wiser to go elsewhere.

Cancer Care

Cancer directly affects nearly a third of all Australians before they reach 75 years of age. According to a consultative report from the Clinical Oncological Society of Australia, the Cancer Council, and the National Cancer Control initiative paper *Optimising Cancer Care in Australia February, 2003* Australia's performance is relatively good, but "we could do much better by routinely applying what evidence shows is best practice, that is, by treating people appropriately all the time using currently available knowledge."

"Survival does not equate with quality of life. Cancer reform is also necessary because the treatment can be complex, involving many disciplines and therapies, and there are many opportunities for someone to become lost in the system, causing unnecessary morbidity and personal distress. The experience of treatment and quality of life for the person living with cancer would greatly improve if the deficiencies and inequities were addressed" the paper said.

Consumers interviewed for the report expressed concern that obtaining effective care was a lottery, depending very much on where their GP sent them once the initial diagnosis was made. In cases needing difficult surgery the evidence showed better outcomes depending on volumes—i.e., surgeons who performed the operation regularly were less likely to make errors or have problems than those who did not. Sub-specialisation is becoming increasingly important, but this is not recognised in the Medicare Benefits Schedule, nor, as health fund gap benefits are tied to the Schedule, is private sector remuneration. Nor does the MBS, or fund benefits, provide proper payment for multi disciplinary teams, though this is considered to be more likely to achieve an effective outcome than hoping an individual surgeon will take an interest (and know) the best downstream providers.

The availability of a care co-ordinator, which applies in breast cancer via specialist nurses, is regarded by consumers as a valuable part of the overall treatment.

In the public sector patients have a reasonable chance of receiving integrated multi-disciplinary care which provides greater continuity of care, both during the first treatment and later stages. The team confirms the diagnosis and plans the primary intervention, and subsequent treatment. But the problems of funding arrangements in and out of hospital, plus the fact that private hospitals are themselves not well geared to provide such team approach, make it less likely in the private sector.

Government and insurers could take a lead in encouraging improved cancer services in the private sector both by benefit and contract arrangements and accreditation systems. This would be consistent with the National Cancer Control initiative paper *Optimising Cancer Care in Australia February, 2003* which argued "knowing a centre is an Accredited Cancer Centre would give consumers confidence that fundamental, cancer oriented quality mechanisms were in place. A similar set of guidelines (to those in the US) could be developed by cancer practitioners…."

Providing support for such centres would lead to evidence based therapy—using protocols developed by experts and overseen by multi-disciplinary teams. It would be important that such centres were agreed by the health insurance industry. It would not be appropriate for individual funds to go around establishing their own as this would only reduce the benefits of volumes. There is, however, no reason why the health insurance industry or at least several funds should not be able to establish such a centre provided their own membership base provided viable utilisation.

This could also encourage the development of multi-disciplinary teams. While public hospitals can require participation in meetings to assess how best to deal with a patient, private funding mechanisms do not. If a group of private medical, surgical and radiation oncologists each see a patient—individually or together—they can claim an MBS item, but if they meet without the patient they get nothing. It should be possible to develop payment structures (not necessarily fee for service) which reward (or require) participation on a team basis for those patients who require it, either in or outside the hospital setting.

Funds could also provide differential rebates for sub specialisation where the evidence shows outcomes are better. At the moment, this is not provided for: a gynaecologist gets the same rebate as a gynaecological oncologist, for example. However, the 2003 paper argued that there is an

increasing body of evidence that sub-specialists, individually or within specialist units, achieve better results for some procedures and this merits a greater reward…and a disincentive for others.

Over time the industry (and government) could aim at seeing the development of specialist centres with demonstrably good outcomes providing comprehensive courses of treatment. It would, of course, be a condition of recognition that any such centres provide information to allow their performance to be compared with other providers to ensure that any higher rewards were justified. funds should have the option of providing products which limited benefits to best practice providers, and consumers should be able to choose between products which offer access to all providers (at a price) and those which only cover certain providers (with proven track records), ideally at a lower price.

Continuity of Care

The current system means payers and to some extent providers play pass the parcel with the patient, moving them from one setting to another and once they have moved out of their direct responsibility cease to be concerned about the outcome.

Discontinuity of care comes about largely because of discontinuity of payment. As illustrated earlier, a patient whose condition requires treatment in a variety of setting a GP one day, a specialist another, a day surgery or outpatient on another, a two day private hospital admission, an emergency presentation—has their bills reimbursed or paid by a variety of different agencies depending on just where they go. This is not only confusing for the patient, it also makes it impossible for any payer to maintain an oversight on what may be happening to the person for whom they have assumed financial responsibility.

Financial tracking of a patient can have positive quality outcomes. In the United States Kaiser Permanente, due to the nature of its operation, can monitor every treatment a patient receives, in any setting. If it discovers a member is attending Emergency on a regular basis Kaiser will contact the patient's primary care physician and advise them that the patient is obviously not being managed effectively, and please correct. This is not possible in Australia because their health insurer, for example, does not know whether a member is undergoing avoidable hospitalisation until they receive the bill, after the event.

Health funds should be able to provide comprehensive cover for their members, including, in the case of those whose condition may require both in hospital and out of hospital treatment as part of an episode of care. Such coverage arrangements should be a matter for the fund (or funds) to determine in consultation with providers, individually, collectively or within a commercial entity.

Risk Sharing

Effective management of a patient, which reduces hospitalisation, and therefore costs, should be able to be rewarded. As well as allowing health funds to pay doctors for treatment outside hospital, either on a capitated or other basis, funds and doctors (and hospitals) should be able to enter into risk sharing arrangements, e.g., whereby a doctor who provides long term care for patients with particular illness can demonstrate, to the satisfaction of the fund, that their treatment has saved $x in hospital costs, the fund and doctor should be able to agree on sharing the saving so achieved.

Disease Management

Disease management arrangements should not be a competitive issue. If there is an acknowledged best practice treatment for a particular condition funds and medical organisations should be able to

agree that this will be provided and rewarded without any legislative barriers, including Competition legislation. At the same time doctors and funds wishing to innovate should be free to do so, with an expectation that successful innovation will, if successful, be progressively taken up by other payers and providers over time.

Efficiency of Capital Investment?

Australia has 1286 hospitals, 80,064 beds. Almost seven million people are admitted each year and take up 23.6 million bed days. 55 percent of all elective surgery is provided in private hospitals.

In 2003/04 the Australian Bureau of Statistics private hospitals survey showed that private hospital operators had gross capital expenditure of $307 million much of this is state of the art technology and while some resources may be duplicated as a result of the hospital arms race (in which hospitals compete for doctors by offering them access to the latest medical innovations and devices) it represents a very sizeable investment.

Paradoxically, however, in both the public and private sectors this capital investment isn't worked on a 365 day 24/7 system. Cost restraints in the public system lead to bed and ward closures at certain times of the year—December and January, due to the Christmas and summer holidays, Easter and towards the end of the financial year when budgets run out. Private hospitals minimise their overall costs by trying to maximise occupancies (and theatres) on a Monday-Friday basis and closing as many beds/wards as possible on the weekend to avoid penalty rates.

This is in marked contrast to most other industries involving large capital investments, where logic says it is better to keep the capital working as much as possible. Airlines and hotel industries, which are also capital intensive, strive to fill empty seats and beds during low utilisation times by providing special offers, discounts and other devices to attract customers. Federal Government industrial relations reforms should provide some capacity for operators to negotiate around the limitations of penalty rates, and consumer demand could also help secure more efficiency of this capital investment.

In virtually all states of Australia consumers are able to enjoy seven day a week retail shopping and, in many cases, 12 if not 24-hour access to supermarkets etc, yet, except for emergencies (and maybe not even there) healthcare is largely a five-day a week business. Day surgeries at least could be encouraged to provide their services on the weekend allowing patients to undergo procedures without being forced to take a day off work.

Under the existing regulatory system, however, any such action would be of concern to insurers who would fear that it would simply lead to more activity rather than more efficient activity. The existence of minimum default benefits—i.e., those which force health funds to pay a fixed amount for every admission—limits the incentives insurers might have to come to working financial arrangements for those providers willing to use their capital investment to optimum capacity. Removal of the default would mean insurers would be able to choose to not pay for admissions to those facilities that did not, in their view, meet the requirements of efficiency, consumer demand, or appropriateness. It would also mean the private health dollar could be stretched further, and encourage more competition based on outcomes at the level where competition really matters—at the point of delivery.

Technology

One of the greatest drivers of health costs has been the development of new, improved technologies, which allow treatments to take place that would, even a few years ago, have been

unimaginable. Because they are safer they make it possible for patients who would, in other circumstances, be placed at excessive risk, to enjoy far greater quality of life than hereto; and in some cases save life itself. There can be no doubt about their benefits to society.

Not all technologies necessarily provide these benefits, however. Some may provide vastly superior benefits to others, though there is not always much difference in price. Innovation means new versions of equipment can come on stream before most practitioners have become accustomed to their predecessor. Consumer desire for the best and latest, and media focus on the sensational, exacerbates this situation. The problems that are caused, however, are significant both in costs and outcomes.

Joint replacements are one of the fastest growing areas of healthcare expenditure, driven by the demands of an ageing population and the introduction of new and better prosthetics. In 2002 more than 50,000 hip and knee replacements were carried out in Australia at an estimated cost of more than $500 million, and the rate of this surgery has been growing at between five and 10 percent per year, and sometimes more. And although this form of surgery was once regarded as applying mainly to older people joint replacements, particularly knees, are increasingly being provided to younger persons. If patients are to receive the greatest possible benefit from these treatments (and if the cost can be contained to ensure the service is affordable for all) it is essential that devices used are robust and long lived, and that revision (or replacement) is minimal.

To its credit the Australian Orthopaedics Association established a National Joint Replacement Registry in 1999 to provide demographic information on joint replacement surgery with a view to improving outcomes and establishing a mechanism for audit of hospitals and surgeons.

About 14 percent of hip replacements in Australia are revisions, compared with Sweden in which revisions represent only seven percent. In an article in the Medical Journal of Australia (Stephen Graves, David Davidson and Lisa Ingerson MJA vol 180 March 2004) members of the Registry pointed out that "revision operations are associated with less satisfactory outcomes and considerable morbidity and mortality when compared with primary procedures. Reducing re-operation is also associated with significant cost savings. A conservative estimate of savings accompanying a one percent reduction in the percentage of revision operations is $10 million."

The Registry has identified not only major differences in the practice of joint replacement surgery between Australia and other countries, but also significant variation between states. There are also considerable differences in the use of different types of devices. In Sweden more than 75 percent of hip replacements involve the use of five different prostheses. In Australia surgeons mix and match devices to the point where 600 different combinations of components have been recorded by the Registry.

This has significant implications for both cost and quality. The fact is some devices do not last as well as others, and it is debatable whether patients should be expected to suffer the subsequent revision operations and they, and their fellow fund members, should be required to meet the cost.

Of course, joint replacements aren't the only area where technological innovation needs monitoring. There is no doubt that many of the new treatments, and devices that make them possible, have significantly improved the quality of life for many, probably the overwhelming majority, of those who receive them. But they do have significant cost implications and the question that must be asked is whether our society will be able to continue to afford them. To understand the cost implications, consider this: In 1988 the then state of the art pacemaker cost the equivalent of 10 single premiums—today's state of the art pacemaker defibrillator costs 50 single premiums. There can be no doubt the new version is vastly superior to its predecessor, but whereas a fund

needed 10 no claimers to pay for one patient to receive a pacemaker, it now needs 50 to provide the same access to leading edge technology.

Not all new versions are necessarily vastly superior to their predecessors, however. For a variety of reasons many devices are brought to market as quickly as possible, under the commendable claim that it is important to provide people with the best and latest technological innovation possible. However this market imperative reduces the capacity of the suppliers, or regulators, or clinicians, to effectively monitor their safety, not to mention their efficacy. Over the last few years there have been a number of instances of individual pacemaker types failing, with extremely emotional, if not outright physical, concerns for those using them.

In most of these cases the supplier replaces the faulty item, although many patients (and their surgeons) may have lost confidence in that suppliers overall product range. As a result the patient undergoes further procedures—to remove the faulty product and then to provide a replacement, which may well be from another supplier. In this case the health insurer—or more accurately, their membership base—meets the cost.

Prostheses suppliers should be required to provide adequate warranty protection for consumers, including covering the total cost of removal and replacement of any device, which does not meet the warranty specifications. A commitment to this should be a prerequisite for allowing a device to be sold within Australia.

Prostheses purchasing arrangements

The Australian health insurance industry has achieved some progress in current arrangements, but the regulations applying to prostheses pricing must go further. Under current arrangements, prosthetic devices are, at last, subject to clinical evaluation and grouped according to their likely clinical effectiveness (and one might expect as time goes by this will increasingly look to the extent to which devices live up to their manufacturers' claims). Negotiations then take place with suppliers aimed at achieving the best possible price within a group, and those prostheses that are clinically similar but whose supplier demands a higher price may have an uninsured co-payment. The intention behind this system is twofold: to create some market tension between payers and providers, and to introduce a price signal which may encourage specialists and their patients to opt for the clinically suitable, but lowest priced, prostheses. Theoretically, and to some extent in practice this should encourage suppliers to minimise their margins to maximise market share rather than risk patients (and doctors) opting for the lowest priced clinically appropriate device.

Nevertheless the system has some faults, especially if a device lacks a competitor, in which case the supplier can effectively demand whatever they believe the market will bear. And even in a competitive environment, suppliers are free to reduce their price at any time. This means that if a supplier finds themselves undercut they can simply reduce their asking price to the generic level. Obviously knowledge of this arrangement means that suppliers need not feel much pressure to cut their margins when negotiating prices until they see what the market situation is. In some markets this may be a reasonable way of doing business, but it is unlikely to lead to much containment of healthcare costs. Just as health funds only get one chance a year to set their price, so should suppliers…i.e., if they charge higher than the minimum, then the resulting co payment should apply for 12 months. As this could reasonably be expected to impact on a supplier's market share one would expect it would encourage suppliers to go for the lowest possible margin to avoid being left on a co payment list and risk losing market share..

Technology should be our friend

In most industries technological innovation improves quality or reduces costs or both. This rarely seems to be the case in healthcare, although there is no inherent reason why it should not. Certainly, technological innovation can be a cost driver in that it allows more things to be done for more people, but that is equally true of other sectors.

Electronic information systems are one area of potential enhancement of both quality and costs, (although one should be wary of the latter, especially in complex systems). The capacity of existing health system technology to provide the same level of information as the financial system is markedly deficient. If banks, credit agencies and other financial institutions can develop ways of establishing an individual's credit worth, there is no inherent reason why the health system cannot establish their health risk and basic health needs. The privacy lobby has a lot to answer for in its on going opposition to electronic health record information based on a unique identifier.

One of the compounding problems is the division between Medicare information and health insurance information. By virtue of being a comprehensive payment system Medicare collects an enormous amount of data related to individual use of the health system and individual risks. Combined with the Pharmaceutical Benefits System data which it also collects Medicare can, if governments and society wish, identify persons at greatest risk long before that risk turns into hospitalisation. But the system divorces Medicare data from health fund data, which, also claims based, can assist in identifying high and low risks. It is in the interests of individual patients and the overall healthcare system to use every possible technological asset to identify those at greatest risk and allow them to be offered treatments and interventions which lower that risk. When will the Privacy and other lobbies start to demand that be done?

New technology (robotic surgery, monitoring devices, anaesthetic machines) can provide both safer and cheaper healthcare, but it can also proliferate in inefficient and uneconomic ways, especially if used as an incentive to encourage doctors to move from one hospital to another. However, health funds should be able to enter into partnerships with providers, and facilitate their investment in cost saving technology, which reduces costs for both parties. This is inhibited by the existence of default minima, which in effect dissipate the value of the private health dollar.

Commonsense Competition

Health funds are expected to compete aggressively with one another, and in the current marketplace they do within the limits of the legislation. However at times this competition gets in the way of an efficient and effective healthcare system. Competition is important, but there are some areas where brand differentiation creates its own problems, and this is particularly so in relation to disease management programs. Doctors will NOT like to have to deal with different care regimes demanded by 25 different funds, and nor should they. While there is a case for experimentation of different ways of providing and funding services which reduce hospitalisation the aim should be to develop common ones which can be adopted across the industry rather than individual funds seeking to have different programs just because this makes it easier for the marketing department. Just as politicians and bureaucrats like to deal with divided industries, so can providers avoid participation in a multiplicity of schemes by pointing to the fact that they are too confusing, but if health funds come up with a single defined standard across the industry it is a lot easier for providers to fit in. For consumers and health funds and those providers smart enough to work out how to participate, it's a win-win situation.

Any legislative barriers which prevent the health insurance industry collaborating together and with the profession on the establishment of mutually agreed standards for disease management or other care management programs should be removed. At the same time funds should be free to innovate if they wish, and not be prevented from introducing new and better standards, and reward them appropriately.

Supplementation, not substitution

The extension of health fund activities outside hospital will only work if fund investments in these activities makes commercial sense: in other words, it must lead not just to better patient outcomes, though that is of primary importance, but should also be more cost effective than the patient remaining in, or being admitted to, hospital.

This cost effectiveness may not, of course, be a direct correlation between the costs of admission and those of avoiding admission: longer term costs for the insurer, better outcomes for the patient, reduced chances of readmission or further care being needed are all important. These are best judged, however, by clinicians on clinical grounds and insurers on commercial grounds. They should not be determined by rigid regulation, nor the financial aspirations of providers.

As we have seen with day surgery, with medical gaps and with many other attempted reforms of the private health funding system, the establishment of ministerially determined default payments does nothing more than create new opportunities for healthcare entrepreneurialism which does not necessarily improve patient care or outcomes and certainly forces costs up. Wherever possible we should be trying to achieve fewer interventions rather than more, and the emphasis should be on lower cost treatments wherever possible, or, at the very least, more cost effective ones.

In any new environment health insurers, individually or collectively, should be free to enter into commercial arrangements with providers, either individually or collectively, on mutually agreed terms. If the two parties cannot agree on terms the fund should not be required to pay a service fee on the basis of any willing provider but rather those that meet its (or the industry's) requirements for price, service, quality and outcome.

Involving GPs

The Medicare monopoly on medical benefits for services outside hospital has led to a relative disinterest on the part of GPs and other sections of the profession as to a patient's insured status. This can, at times, add unnecessarily to pressure on the public system as well as unfairly treating patients. At a recent House of Representative committee hearing a hospital witness reported a conversation he had had with a young man in Darwin some time ago. The young man complained about pain in his knee, which, he said, would last for more than two years before he would be able to have a knee replacement. "Why don't you take out health insurance…you'd only have to wait 12 months and then you could have it done in my hospital" the witness said. "But I do have insurance" the man replied, "but I didn't know I could use it for that. The doctor sent me to the public hospital and they told me I'd have to wait two years"

The ban on health funds providing adequate medically based programs to help keep their members from suffering a sudden acute attack from a chronic illness puts added strain on public hospital emergency departments. It is difficult to quantify how many people could avoid these presentations, often with admissions, but there are good grounds to believe thousands of presentations, and tens if not hundreds of millions of dollars could be saved by better primary treatment. Thus State Governments (and taxpayers) would be better off, and their emergency departments better able to deal with genuine, unavoidable emergency patients.

Public hospital casualty/emergency departments

More than four million Australians go to public hospital emergency departments each year. Of these 32 percent are regarded as urgent, and of these about 40 percent are admitted to hospital. This is expensive medicine, for an emergency department requires a range of skills from its doctors, nurses and other workers. It is a 24/7 operation, which is an essential part of our health system.

While it is difficult to determine the cost per attendance at casualty, the Productivity Commission Report on Government Services estimates the cost ranges between $174 and $772 per patient. Even those who present, but decide not to wait, involve a cost of $74 per person to the system. The 3.64 million admissions the Productivity Commission quoted cost taxpayers almost $1 billion! Obviously anything that can reduce the need for people to go to emergency will save the health system money, money that can be better spent on other things.

Emergency departments are essential but expensive services, and it is best for those patients who do need urgent attention and for taxpayers to reduce the numbers needing emergency care. Apart from accidents and injuries, many public hospital emergency presentations come about from people with chronic conditions, which become acute. These include asthma, diabetes, heart complaints etc… Proper management of these conditions could not only improve the quality of patient care but also reduce avoidable demand on the emergency room, making it possible for this vital service to be more freely available to those with unavoidable problems.

Mental Health

Mental health represents a $3 billion industry in Australia and is growing. Just as private hospitals moved into the provision of elective surgery as a market reaction to queuing and capping in the public hospital system, so did the private sector move towards the provision of private hospital mental health services as governments reduced their own institutionalised mental health arrangements and shifted the provision of public mental healthcare into the community (or onto the streets).

Private health funds pay more than $130 million per year for private hospital mental health services, and this figure has been growing. For health insurers the provision of appropriate benefits represents a significant challenge, for, unlike surgical hospitals, they are dealing in an area which is very difficult to cost or project, and therefore difficult to adequately insure. In pure actuarial terms, mental health patients often represent long-term liabilities, outcomes are difficult to measure, and it is an area, which, it can be argued, is very much prone to supply induced demand, especially if treatment can be provided at no direct cost to the patient.

In general terms insurers are willing to pay for mental healthcare but, on behalf of their overall membership base, pose the question: are they getting value for money? While providers—both psychiatrists and hospital operators—vehemently argue that funding is inadequate for what is delivered, it remains to be seen whether this is the case. One of the most unfortunate aspects of mental healthcare is the capacity of providers to play the patient when trying to secure higher income from third party payers, whether they be health insurers or governments. This was evidenced quite poignantly before a recent hearing of the House of Representatives Committee inquiring into healthcare in which a leading psychiatrist said he had closed his public practice as he was not paid enough to look after public patients!

Fee for service payments for psychiatric care lend themselves to abuse by providers who can (especially if there are no co payments) extend periods and sessions of care for their own financial

benefit rather than the patients well being. While one has no doubt they would violently dispute any such suggestion, the fact is the payment system creates the potential for such abuse. While surgery is a relatively clear cut affair—it happens or it doesn't—a course of psychiatric treatment can be as long as a piece of string, especially if the cash flow is coming from someone other than the patient.

With a view to trying to ensure both reasonable costing and better patient outcomes, health funds in South Australia have, in cooperation with the principle psychiatric hospital provider, Ramsay Health Care(RHC), a prospective payment system which aims at satisfying the needs of payers, patients and providers, and should become the basis for future payment systems in the private mental health area.

Per-diem based and other similar funding arrangements for mental health services in the private sector focus upon payment for in-patient psychiatric services retrospective to their delivery. There is little incentive for providers to invest seriously in a range of alternative programs or to provide non-inpatient services that are true substitution for, and not an add-on, to the cost of inpatient care.

At the time major objectives of *The National Mental Health Strategy* included establishing the greater part of psychiatric services in non-hospital settings, the development of innovative funding models and partnerships, and consumer and carer participation. The Federal Government demonstrated a commitment to *The National Mental Health Strategy* and to private health funds and hospital providers working together. This set the scene for the introduction of the Prospective Payment Model.

The objective was to jointly establish a payment model facilitating the provision of a continuum of care for members requiring psychiatric care, and an increased choice of services available to both members and clinicians

As part of the Model RHC is paid an agreed annual figure spread over 12 monthly payments of equal value within each year. Hospitals are therefore assured of a known and regular income and able to plan for financial investment in alternative services. The Model included mechanisms for addressing issues such as new members under LHC, compensable claims and an approved method of reinsurance reporting, while in no way interfering with the decision making process of clinicians over admission and treatment options. In fact, the Model creates an environment conducive of a greater choice of alternative services available to both consumers and clinicians.

Progressively health funds in S.A. agreed to support the model, and at least 80percent of RHC's work in South Australia is now funded under the Model. Since inception the Model has seen more members cared for with a greater range of services, and with the following changes in RHC service profile in South Australia:

- 36 percent reduction in total in-patient beds, RHC has commented that "bed occupancy has reduced as our new services are clearly seen as a substitution for in-patient admission."
- Opening of Fullarton Day Hospital in May 2002.
- Subsequent conversion of Kahlyn Hospital, closure of Fullarton Day Hospital, and transfer of all day programs to Kahlyn Day Hospital from October 2003.
- Opening of a day program (Bridges Program) at The Adelaide Clinic for acute Elderly Program patients.
- A statistically significant increase particularly in community (Outreach) psychiatric home visits run from both The Adelaide Clinic and Fullarton Private Hospital.
- Out-patient based Assessments for patients attending Elderly services.
- Introduction of Pre-Admission Assessments where appropriate for other Programs.
- Introduction of family counselling and telephone counselling services within the Model.

The above is in stark contrast to the continued reliance on in-patients and in-patient funding in other states and hospitals where numbers of private psychiatric beds continue to increase, and with no or minimal replacement by alternative services.

The model has also served to reduce hospital administration time, with the invoicing process being replaced essentially with activity reports, and the chasing of forms from doctors unnecessary. All parties have benefited from streamlined administration compared with a fee for service system. Since the introduction of the new funding model the focus of care has become more tuned to the individual, with staff taking more time to determine what is the best treatment option for each person. With a variety of services now available, staff are able to recommend the treatment approach that is most suitable.

The model also provided for the establishment of a Quality Committee to oversee the changes and outcomes. A Consumer and Carer Advisory Committee has also been formed and continues to meet.

The Prospective Payment Model in South Australia has been the subject of two favourable external and formal evaluations conducted with the participation of the Commonwealth Department of Health and Ageing.

The model has proven that prospective payment arrangements can, and do, work in areas such as mental health, and should be extendable to rehabilitation and palliative care. Significantly, much of the South Australian experiment has involved the development of out of hospital care based on the provider's decisions about what will achieve best practice and best outcomes.

The success of such systems depends very much on the willingness of providers to accept them, and is much more difficult to apply in states where there are a multiplicity of hospitals offering mental health services, able to rely on default benefits, portability arrangements and other devices (including emotional blackmail) to maximise their income without necessarily providing appropriate or adequate patient care. **Any new arrangements should allow health funds to opt out of paying for all providers and instead concentrate benefit structures on those providers willing to accept prospective payment arrangements, subject to the insurer providing a sufficiently broad based panel of providers to allow their membership base reasonable access.**

Working with Providers on Better Care

Individual health funds and hospitals have for several years been developing mutually agreed methods to providing rewards for quality improvement, meeting quality controls, etc. These tend to be fund-hospital and, for competitive reasons usually do not extend to the broad insured population. While these are commendable initiatives there are problems particularly in scale and risk.

Australia's private health sector should be encouraged and allowed to work together to develop ways of improving value not just for individual members but for all patients. This could include, for example, initiation of experiments such as those conducted overseas whereby hospitals, which provide significant improvement in outcomes, receive appropriate rewards.

In Ohio several years ago the then major health plan, Anthem Blue Cross and Blue Shield, became concerned about the cost of cardiac care. After investigation it also became concerned about the number of members dying or suffering complications from heart procedures. The plan decided to develop a coronary services plan in which 16 hospitals providing cardiac services agreed to provide data on a uniform format, allowing a risk adjusted evaluation of outcomes to be undertaken. Those hospitals that had the top results were rewarded with special bonus payments.

As a result of the experiment overall length of stay in the network decreased by 2 percent for cardiac by pass surgery, and severity adjusted mortality rates decreased by 7.3 percent. And not only were patient outcomes much improved, the health plan saved a significant amount of money.

To be effective any such experiments in Australia would require pooling of both hospital and health fund resources and participation, and this would inevitably involve agreement on reward payments. Again this is an area where competition laws need to be reviewed to ensure they do not prevent such positive collaboration in the commercial healthcare world.

Conclusion

It is quite clear from the foregoing analysis that Australia's health system, both in the public and private sectors, would be improved by sensible reform of the regulations governing health insurance to bring them more into line with contemporary medical practice and the demands of 21st century Australian society. This reform will also make it possible to adapt the healthcare system to the demands of an ageing population without bankrupting the nation. It is also in the interests of all people needing healthcare, regardless of their choice of treatment site.

The private health insurance rebate, Lifetime Health Cover and the Medicare surcharge have all played their part in increasing and sustaining health insurance membership. However it is impractical, and not in the nation's best interests, to see health insurance main function as being the payment of the costs of hospital care.

Contemporary practice and community desire is emphasising the importance of prevention of illness wherever possible and the maintenance of the best health practical. Reductions in the need for people to go to hospital not only reduce the cost of health insurance itself, they also reduce demand for public hospital beds, and can significantly reduce demand for that very expensive part of the public sector, the emergency or casualty ward.. In an ideal health system emergency departments will be used by people facing real and unavoidable emergencies, not by those who, with proper management, could either remain well or be able to be treated in their own homes. Each privately insured patient who can be provided with better primary care avoiding hospitalisation is one less needing admission to Casualty, and therefore one extra place opened up for someone who desperately needs that form of care. Reform of the National Health Act and Health Insurance Act is, therefore, not only valuable to the private health sector but has potentially life saving benefits for the public sector as well.

To achieve these reforms it is recommended that the government take the following actions as a matter of urgency:

- Repeal section 126 of Health Insurance Act
- amend the National health Act and related regulations to expand the coverage of health fund hospital tables to include preventative care activities and allow to be included in reinsurance
- allow funds to offer products which limit benefits to limited numbers of providers (with or without defaults in other circumstances)
- allow health funds to enter into risk sharing arrangements with providers in which savings can be shared by both fund and provider, subject to satisfactory outcomes for patients (and patient satisfaction with the services provided).
- allow funds to offer a product with varying contribution rates depending on providers which are fully covered (Healthpartners Ultimate Choice).
- funds to be able to contract with Divisions of GPs or other medical or non medical group arrangements to provide non hospital care for members. (and include in reinsurance)
- enter into reward partnerships with providers similar to that in Ohio
- permit preventative activities supported by funds to be included in the reinsurance pool once evidence has established they improve outcomes and reduce costs.

The provision of more appropriate healthcare for privately insured persons funded, in whole or part, by their private health insurance will not only ensure that patients are treated in the best setting by most appropriate providers, but will also ensure better health outcomes for those patients. The reforms discussed above will also reduce pressure on public resources, including, but not limited to, public hospital emergency departments and lead to a more efficient use of overall private health sector resources, both inside and outside hospitals

Consultation

The successful implementation of reforms to the private health system will require serious discussion between those who draft the enabling legislative changes and the health insurance industry, which has to administer them. This consultation has rarely taken place in the past, and the term has usually represented departmental officials outlining their plans to industry and noting the comments. As a result legislation has often created more problems than it solves. There are very few officers in the Department of Health with any extensive experience in the private health sector, or even administering policy dealing with the private health sector.

The fact is public servants are very good in the development of policy but lack the experience needed to determine precisely how the rules of administration could best be enacted. As a result the legislative and regulatory environment in which health funds operate lacks a sense of corporate history or an understanding of the importance of specific regulations and clauses within the legislation itself. Equally there is little understanding of how the health insurance marketplace works at the coalface. The outcome—legislation which does not achieve the purpose it set out to achieve adds to costs and reflects badly on the extent to which the private health sector can assist in achieving government goals.

There is inherently no reason why bureaucrats should not sit down and work through the details of legislative proposals with their equivalents in the health insurance industry, many of whom work within the constraints of the Act every working hour of every day (and often have a better understanding of its practical effect on day–to-day business activities than departmental officers. Just as we need to minimise avoidable errors in healthcare, so should we strive to do so in healthcare legislation?