Health at a premium

With health care services in greater demand and costs rising, private health providers are divided on the way forward. Chris Uhlmann reports.

Former NSW Premier Bob Carr is credited with saying history is an argument. If the parliamentary inquiry into health care is anything to go by, so is the present and the future.

One point of agreement is that health costs will continue to rise, but the key players are sharply divided on whether the bill is reasonable and who should pay.

Inquiries into health care are like cricket games in summer—there always seems to be one going on somewhere. The most recent is being undertaken by the House of Representatives Health and Ageing Committee. In March last year the committee resolved to examine how the Commonwealth can take a leading role in "improving the efficient and effective delivery of highest-quality health care to all Australians".

That covers a lot of ground, so this article will focus on the committee's last two terms of reference: how best to ensure a strong private health sector; and how to make private health insurance more attractive.

Private health insurance isn't looking all that alluring at the moment. In December, insurance funds again asked the federal government to approve premium increases of between five and seven per cent, their fifth successive rise at double the inflation rate.

However, health insurance is not just our ugly step sister. Around the developed world health care inflation is running at twice the normal inflation rate with costs driven by advances in technology, spiralling drug prices, ageing populations, increasing utilisation and the rising cost of prostheses.

So, just what kind of money are we talking about? Well, Australian Institute of Health and Welfare figures show total health expenditure grew from $692 million in 1960-61 to $78.6 billion in 2003-04, which is 9.7 per cent of Gross Domestic Product (GDP).

In raw figures, health care costs grew by $575 million in 2003-04. Expenditure on hospitals was $26.4 billion, made up of $19.8 billion on public non-psychiatric hospitals, $6 billion on private hospitals, and $534 million on public psychiatric hospitals. Health expenditure as a proportion of GDP more than doubled over the last four decades, from 4.1 per cent in 1960-61 to 9.7 per cent in 2003-04.

If all that makes your head hurt then think of it this way, spending on health increased from $65 per person in 1961 to $3,931 in 2004. That is not a beautiful set of numbers and, if it bothers you, it has an even more sobering effect on policy makers and health insurers.

Bruce Harrison is national manager of provider relations for the Australian Health Service Alliance, which represents 25 health funds. At an inquiry roundtable in Sydney, Mr Harrison said health care costs would continue to rise at four per cent a year for the foreseeable future. Add on an average three or four per cent a year in increased hospital costs and you have a seven

to eight per cent rise, each year, and a corresponding increase in premiums.

"These figures are somewhat scary from my perspective and do little to ease the minds of governments and health administrators," Mr Harrison said.

One of the scary things is that those calculations are based on the assumption membership will stay about the same. But policy holders are actually extremely price sensitive.

Bruce Levy, group manager of health services for Medibank Private said there was substantial evidence to show that when premiums increase at two or three times inflation, customers change funds or dump insurance entirely. That creates a vicious cycle: less money to cover more costs means even steeper premiums.

Faced with a membership haemorrhage in the late 1980s and early 90s—and politically committed to the private health industry—the Coalition stemmed the flow with a carrot and stick approach. It introduced a 30 per cent tax rebate on private health insurance and "Lifetime Health Cover", a scheme that financially penalised people who delayed taking out hospital cover. For example, a person who delays joining a private fund until the age of 40 pays 20 per cent more than someone who joined at the age of 30.

The idea was to encourage more people to take out health insurance, to do so earlier in life and to maintain their membership. According to a submission from the Australian Private Hospitals Association (APHA) the policy has been a success. When the scheme was introduced in 1999 the number of Australians with private health insurance peaked at 45 per cent of the population (up from 30 per cent) and the latest figures show it is now 43 per cent, despite years of premium increases.

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There is a fierce public debate over the value of the 30 per cent rebate for private insurance, with many arguing it would be better spent on the public system. Not surprisingly that view was not in evidence at the inquiry roundtable in Sydney, which drew together a panel of private health insurers, private hospitals and health professionals. The strong opinion there was that the public health system could not survive without the private system.

APHA says there are 296 private hospitals in Australia, 25,000 beds (approximately 32 per cent of all hospital beds) and 248 free standing day hospital facilities. They treat four in every 10 patients (39 per cent of all separations) with 2.5 million separations in 2002-03. Latest figures show private hospitals now perform 56 per cent of all surgery, most of it elective.

Private providers argue they represent value for money. A study by Professor Ian Harper of the Melbourne Business School maintains that the government's investment of the 30 per cent tax rebate of $1.8 billion in 2000-01 leveraged $4.3 billion in services from the private sector.

But the clubby agreement between private hospitals, insurers and health professionals ends when the discussion turns to their relationship. In short, everyone is unhappy with the way the system is currently working and each blames the other (and, of course, the government) for its shortcomings.

The point where the rubber hits the road in the private health spending debate is contract negotiations between hospitals and health funds.

Private hospitals receive the bulk of their money from health insurance funds under Hospital Purchaser Provider Agreements that operate within the regulatory framework of the *National Health Act 1953*.

The purchaser provider agreements date back to 1994-95. In a bid to try and bridge the ever-widening gap between what hospitals were charging and what health funds were prepared to pay—costs that had to be covered by increasingly disgruntled consumers —the two were legislatively required to negotiate contracts.

Photo: AUSPIC Continued page 24 ▶

Continued from page 23

Since then insurers have been using the contracts to muscle down private health costs or, increasingly, have been refusing to give hospitals contracts. Patients in hospitals without contracts are still covered by their insurers but only at 85 per cent of the going rate, under a system known as the Second-Tier Default Benefit. Neither hospitals nor insurers are happy with the outcome.

The outgoing chief executive of the Australian Health Insurance Association, Russell Schneider, told the inquiry health care funds had to balance the needs of members who were sick with those who were well and against the demands of health care providers whose interest was "to maximise their income".

There was a cargo-cult view every provider was entitled to a contract. "This is not the case," he said, "because the concept of a contract is to allow a proper negotiation—a commercial negotiation—between the person who is paying the bill and the person who is providing the services with a view to providing a mutually acceptable relationship.

Insurers were increasingly freezing hospitals "out of contracts.

"I say 'mutually acceptable', not necessarily liked by both sides because everyone who is paid believes they are underpaid and everyone who is a payer believes they are paying too much."

The executive director of the Australian Private Hospitals Association, Michael Roff, made it abundantly clear to the inquiry his members believed the critical issue in private health care was the badly flawed regulatory arrangements underpinning the "unfair contracting environments" between hospitals and health insurance funds.

As evidence of its flaws, he cited an average fall in private hospital margins from nine per cent to six per cent since 1995.

"Health funds might say that is a good thing," he said, "we say it jeopardises the industry, training and capital investment."

He said insurers were increasingly freezing hospitals out of contracts. One hundred and thirty had been forced on to the second-tier arrangements and another 60 were in jeopardy of going the same way. This, he said, proved the second-tier default system was a necessary safety net.

Not so, according to Angus Norris, general manager health and benefits management for MBF. Mr Norris said the second-tier arrangements were "perverse" and should be withdrawn. Contracting was about achieving change, not arguing over unit cost increases.

"We must find efficiencies within the system and reward and penalise with our contracting arrangements," he told the inquiry.

Hospitals made their money through admitting as many people as possible, so there was no incentive for them to change their behaviour. But in order to cut the cost of health care the in-patient-centric model had to be challenged. Some hospital operators understood that and were working with insurers on alternatives to acute care. That behaviour should be rewarded, but the second-tier safety net put a significant barrier in the path of change.

"A strong private sector can only be sustained into the future when health funds, private and public hospital operators, medical practitioners and all other stakeholders finally realise they are all part of the same industry and that they need to work together to deliver quality health care services at an affordable price in the most appropriate setting," Mr Norris said.

"The private health care sector comprises three distinct, significant operators: health funds, hospitals and doctors. The relationship between health funds and hospitals, whilst at times tense—as it should be in any commercial arrangement—ranges from minimal to extremely positive.

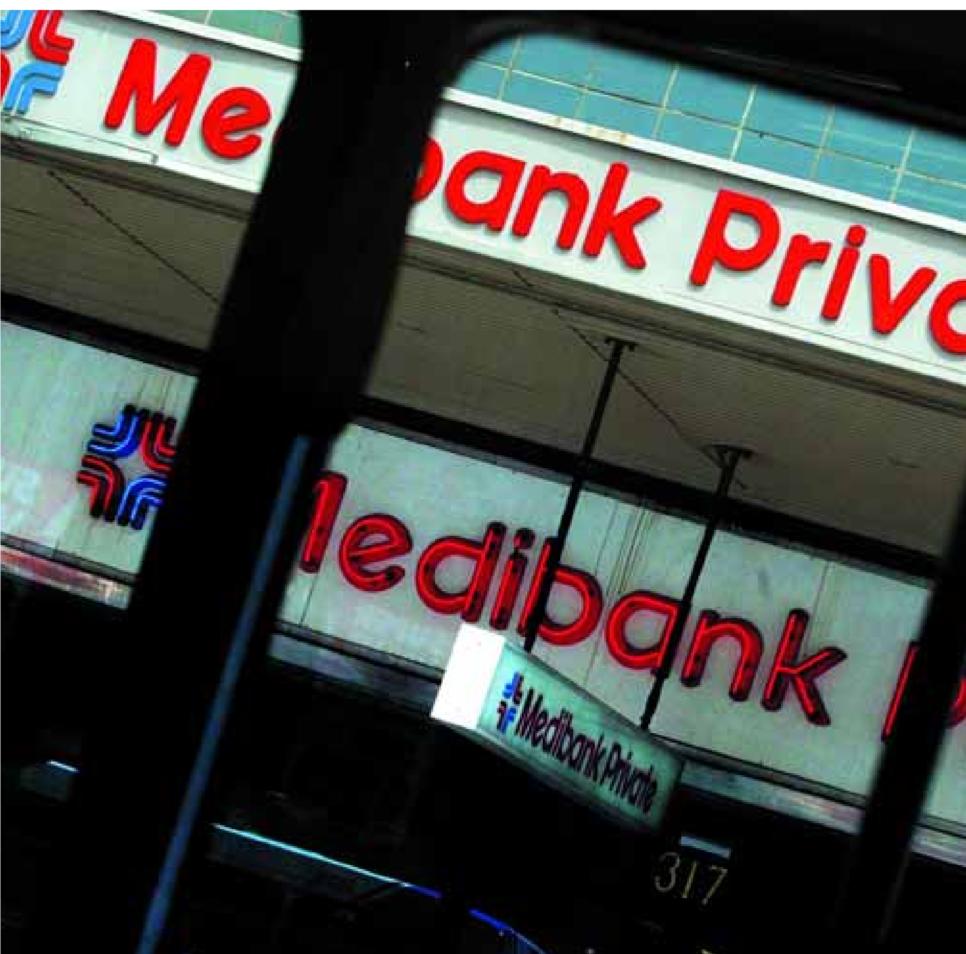
"The relationship between health funds and the hospitals with the medical profession on matters of sustainable affordability is almost nonexistent. It is the relationship with the medical practitioners that

holds the key to a vibrant, quality, focused sustainable private health sector".

So to the doctors, and at first blush their argument seems the purest. They say their key concern is simply good health care outcomes. However, the words "sustainable affordability" do not appear to be in their lexicon.

The Australian Medical Association's submission to the inquiry rejects scary projections about the future saying much of the sustainability debate has been driven by the 2002 Intergenerational Report. This, it says, addressed the problem in a partial way, placing focus on budget-funded health spending. There was a prior question, "how do we reconcile growing demand with capacity of community to pay".

The AMA says the capacity of community to pay is not in question. Australia is a wealthy country and it will be wealthier in 2040. "It is a question of choice," the AMA says.



Private hospitals now perform 56 per cent of surgery. Photos: Mick Tsikas, AAP

Dr Dana Wainwright, chair of the AMA Council, reinforced the message in evidence to the inquiry, saying the overall cost to GDP is relatively modest. "We believe we have under-invested in health care and we continue to under-invest," she said.

Alas, there is not an interest group alive that believes it gets enough money. The pull on the public purse has to be regulated somehow. There is little evidence to suggest throwing ever-more money at health delivers better outcomes.

The United States pays significantly more for health care than any other country (US$1.9 trillion in 2004, or 16 per cent of GDP) yet a recent *Wall Street Journal*/NBC poll put health care costs just behind the Iraq war as the nation's stickiest problem. France has better health outcomes than the US and, in dollar terms, spends half as much per head.

As for the observation by the MBF's Angus Norris that the private health care sector was made up of three distinct, significant operators: health funds, hospitals and doctors. There is, of course, another player: consumers, or as they were once known, patients.

Eventually it is patients, either through their taxes, health insurance or direct payments to hospitals and doctors, who fund 100 per cent of the growing health bill. As the House Health Committee Chair, Alex Somlyay noted, there are precious few submissions from consumers to the inquiry.

This is a pity because there is ample evidence to suggest consumers are just as anxious about the state of health care. Their patience with apparently endless public/private, Commonwealth/state blame-shifting may be running out. ■

For more information on the health funding inquiry by the House of Representatives Health and Ageing Committee visit www.aph.gov.au/house/committee/haa/healthfunding or email haa.reps@aph.gov.au or phone (02) 6277 4145.