
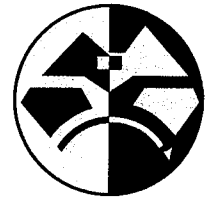


5th May, 2005

SUBMISSION NO. 5
AUTHORISED: 11/05/05. 



ACN 062 860 584
ABN 75 062 860 584

**AUSTRALIAN HEALTH
SERVICE ALLIANCE LTD**

Mr. James Catchpole
Committee Secretary
Standing Committee on
Health & Ageing
Parliament House,
CANBERRA, ACT, 2600

Dear Mr. Catchpole,

Re: Standing committee- Inquiry into health funding

Attached please find a submission from the Australian Health Service Alliance (AHSA).

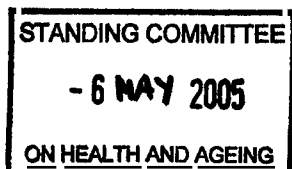
AHSA is a private company owned by 26 health funds and acts as an outsourcing company for these funds in regards to a numbers of areas including hospital contract and doctor negotiations, data compilation and industry analysis. Attached is a paper in which AHSA discusses some of the issues contained in the committee's Terms of Reference. The paper covers what AHSA considers to be key issues that relate to health funding in the private sector and draws heavily on AHSA experience and analysis of these issues. Some of these issues will affect both the public and private sectors; others are specific issues for the private sector. There are other relevant issues that have not been addressed in the interests of brevity."

The contents of this submission have been deliberately limited to address some of the key issues that relate to point (d) of the committee's Terms of Reference viz , *"how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in the various levels of government"*.

Yours sincerely,



David J. King
Chief Executive Officer



Head Office
979 Burke Road, Camberwell,
Victoria. 3124
Phone: (03) 9813 4088
Fax: (03) 9813 4099

NSW
26b 446 Pacific Highway,
Artarmon, NSW. 2064
Phone: (08) 9427 3444
Fax: (02) 9427 1155

South Australia
133 King William Road,
Hyde Park, SA. 5061
Phone: (08) 8272 0344
Fax: (08) 8272 0544

<http://www.ahsa.com.au>

AHSA Briefing Paper - House of Representatives Standing Committee on Health and Ageing – May 2005

1. Private Hospital Demand Projections – a major issue facing the private sector

AHSA made a series of hospital demand projections since 2000 following the increase in fund membership. The full details of the methodology were published in the August – September 2001 issue of the publication Healthcover (1).

The basis of the method is to project growth in cases, beddays and costs in each DRG for each five-year age cohort for the private sector in each state. Same day and overnight cases are projected separately and the average charge to AHSA per case for each DRG (same day and overnight case charges distinguished) in each state is used as the basis of financial projections. A factor is also built into the projections to include the effect of age standardised utilization changes for each DRG.

These projections suggest that demography and utilization will increase fund costs by ~4% per annum in the foreseeable future. While projections beyond five years are subject to increased uncertainty, they indicate the rate of increase in hospital charges due to demographic change will steadily accelerate. Combined with an assumed average ~4% increase in hospital charges, the effect is a ~8% growth in fund expenses per year for the foreseeable future and therefore an 8% increase in premiums. This further assumes the membership age structure that exists with the higher membership levels remain. The AHSA projections have been checked against PHIAC data and to date the actual increases and projected increases are similar.

The above projections indicate a major issue facing the private sector. Private health fund premiums are being driven by factors related to demographic change and age standardised utilization that compound the effect of increased provider charges. The combined effect of these factors results in health fund premium increases well above CPI. It is a major concern of health funds that this will lead to a major reduction in health fund membership and those remaining members will be those with above average utilization resulting in a “second round” of premium increases.

It should be noted these factors are not limited to the private sector. As an example in the Victorian public sector’s case mix model the number of funded units (expressed as WIES - Weighted Inlier Equivalent Separations) rose by about 13% between 1999-00 and 2004-5 and the average payment per WIES by 32% nett of “efficiency gains of ~1.5% pa” over the same period, an average compound increase of 8.3% per annum over this period.

Demographic change and increase in age standardised utilization rates are driving the cost of health in both the public and the private sector. What will assist the private sector to dampen down these cost increases?

2. Private Hospital Efficiency

In recent years there have occasionally been often heated debates in the context of whether private hospitals were efficient or not. The basis for comparison is usually the public sector. AHSA considers such debates to be of minimal assistance in relation to private hospital efficiency. The cost structures and services provided by the two sectors are very different and it is not really comparing like with like. AHSA is much more interested in comparing private hospital with private hospital as there is compelling evidence of very **marked differences in financial efficiency between private hospitals** and has developed a method of comparing charges per unit of casemix adjusted work load as a byproduct of developing a DRG based payment model. Details are:

- ♦ ARDRGv4 facilitates meaningful comparisons of casemix between hospitals provided psychiatry, rehabilitation and non-theatre error DRGs are excluded i.e. they are limited to acute caretype cases.
- ♦ A relative weight is given to each case based on the DRG, the LOS and whether ICU care has been given as indicated by the use of Mechanical Ventilation (MV).

- ◆ The National Hospital Cost Data Collection (NHDC) – Private sector is used as an appropriate clinical costing basis for deriving relative weights.
- ◆ By using the NHDC data and the LOS parameters within the AHSA dataset a relative weight was derived for each case using a process analogous to the Weighted Inlier Equivalent Separations (WIES) model used in Victoria.
- ◆ Differences from WIES include exclusion of prosthetic and medical staff costs from weights, the use of the Median LOS and some differences in setting of trim points.
- ◆ Similarities to WIES include separate weights for same day and overnight cases in some DRGs, weight reduction for low outlier cases in some DRGs, added payment for high outlier cases in all DRGs and added payment when MV occurs.

Hospital charges (ex prostheses charges) for acute caretype cases are divided by total weight units to derive an average charge per unit weight. This gives a method of comparing the relative cost of hospital output on a casemix-adjusted basis. The following table shows 2002-2003 relative charges per weight for large (1,000+ acute cases from AHSA funds) metropolitan private hospitals in AHSA's main states (2).

State	Average AHSA Charge per weight – all Private Sector	Lowest large metro Hospital AHSA charge per weight	Highest large metro Hospital AHSA charge per weight	Ratio Highest to Lowest
NSW	\$N	\$0.87N	\$1.15N	1.32
QLD	\$Q	\$0.95Q	\$1.23Q	1.29
SA	\$S	\$0.92S	\$1.12S	1.21
VIC	\$V	\$0.94V	\$1.12V	1.19

Historical factors, particularly geographic cost variation and the differing economics of each state market, may in part explain any variation in charges between states. On the other hand large casemix adjusted variation in charges per weight between large private hospitals in the same metropolitan area are more likely to reflect significant differences in clinical and financial efficiency between such hospitals.

The actual dollars involved are not included due to commercial considerations. The results suggest that there would be significant savings if those hospitals above the state average charge reduced their charge per case to the current average charge. Part of the reduction in charge per case lies in reducing Length of Stay as many of the high charge hospitals have long casemix adjusted LOS.

It is assumed in the above analysis that charges reflect hospital costs and profits. However it is difficult to assess the accuracy of this assumption due to factors that will be discussed in the following section.

3. Availability of Hospital Data - Transparency & Efficiency

- **Financial Statements – Not for Profit Hospitals**

An inequitable situation currently exists in that private health funds are required to be transparent in regard to their financial position but no such requirement is placed on private hospitals – particularly Not for Profit hospitals.

The Not for Profit private hospitals do not have any obligation to provide financial statements but the private health funds have their annual accounts published by PHIAC. This leads to an information asymmetry that invariably disadvantages health funds when negotiating charge rates with Not for Profit private hospitals. Requests for such information are routinely made and almost invariably refused. For profit hospitals on the other hand have to routinely publish such information and this permits informed debate leading to increased efficiencies and lower price increases. It is difficult to understand why one group of hospitals in the private sector has such a significant advantage in negotiations compared to the other group.

The introduction of a measure that requires the Not for Profit private hospitals to provide financial statements to the Commonwealth similar to that required of health funds may well lead to significant savings. These savings will occur both naturally as a result of inter-hospital benchmarking process and also due to the negotiation process with health funds.

- **Occupancy Statistics**

Occupancy statistics are an important way of determining whether hospitals can accommodate extra patients at marginal costs or whether the capital needed for extra capacity is necessary. There are a number of ways of deriving occupancy statistics and some of these are misleading. Any reporting of occupancy statistics should begin with a clear understanding of the basis underpinning the derivation of such statistics.

Same day and overnight cases should be considered separately. This is because in many situations such as endoscopy couches multiple patients can be put through the same "bed" in a day. The cost functions and clinical usage of overnight and day beds is also quite different. Mixing overnight and day cases can distort calculations of both numerators and denominators.

In some cases occupancy statistics are derived by inconsistent mixing of total bed days (overnight and same day case bed days) and day only and overnight beds. For this reason it is suggested that the best measure of **overnight bed occupancy is derived by dividing the actual number of overnight beddays in a period by the available number of overnight beddays in the same period.** This avoids the issues related to mixing day and overnight cases and incorporates issues such as holiday bed closures into occupancy calculation.

A further refinement of this process would be the calculation of the casemix adjusted LOS of a hospitals compared to that expected based on an appropriate set of private sector norms. The Australian Institute of Health and Welfare (AIHW) data on private sector LOS could be the basis of such a set of norms. This would enable casemix adjusted LOS to be compared in a meaningful fashion and encourage further efficiency within the private sector.

- **Caveat**

It should be noted that the gains in efficiency from the above measures will be at the margin. While helpful they will not be large enough to total offset the other factors driving health fund costs.

4. Private Health Fund Overheads

It has been suggested in some quarters that Private Health Fund overheads are excessive and that if funds were to merge there would be large cost savings and these could be passed on to members as significant premium reductions.

The strategy to achieve overhead reductions through mergers is very effective in industries (e.g.: automotive manufacture, hospitals, banking) where fixed costs are high (e.g.: over 30%). Merging can also be an effective strategy where fixed costs are low (e.g.: retail, insurance) provided the merger increases buying power or helps share unpredictable risks. Health funds however have low fixed costs (below 5%) and good buying power through "outsourcing/merging" of their buying function (though AHSA and ARHG). Health fund risks are reasonably predictable even for small funds.

This suggests there is little commercial advantage in merging funds and the attractiveness of merging is therefore more apparent than real. An examination of PHIAC data reinforces this view.

Fund overheads are substantially driven by claims experience and that would not change if funds amalgamated. There may be some savings in senior staff, rent etc. However it is unlikely that any plausible set of fund amalgamations would lead to more than a once off reduction of 2.5% reduction in premium rates. Such a saving while worthwhile is not large in the context of 8% growth in costs per annum for the foreseeable future (3).

According to the PHIAC reports, Operations of Registered Health Benefit Organizations overheads were 13.6% of total expenditure in 1999-2000 and 11.2% of total expenditure in 2003-4, a significant decrease and evidence funds are increasing their internal efficiency. A reduction of 8.9% in overheads will have had the same effect as a 1% increase in premium income. Improved fund efficiency offers only marginal benefits in relation to reducing health fund premiums premiums.

5. Effect of 30% Rebate and LHC on Public Hospitals

One of the benefits anticipated when Lifetime Health cover (LHC) was introduced was a reduction in demand pressure on public hospitals. It was anticipated that many people would have elective surgery as private patients in the private sector rather than as public patients in the public sector as a result of taking up Private Health Insurance (PHI).

It should be noted that AHSA disagrees with the view that the introduction of LHC was in itself the major factor causing the significant increase in fund membership in mid 2000. AHSA considers the increase was the result of the combined effects of the 30% rebate and the new LHC conditions. Neither of these measures would have caused the large membership increase experienced if only one had been introduced. It was the synergy of these two measures that resulted in the large increase in membership. It is likely the extensive media campaign about mid-2000 contributed to the large increase in the uptake of PHI about that time.

The results of recent research by TQA Research should be noted. TQA Research is the only organization that conducts regular surveys of consumer attitudes in this area in Australia. It has stated that "for every 1% increase in the price of private health insurance, a corresponding proportion of consumers are "very likely" to drop their private health cover." This is consistent with view that price remains a very important factor determining the extent of the uptake of private health insurance despite the introduction of LHC. The implication is that the reduction in the nett cost of private health insurance is the major factor underpinning member retention not the just the age related premium increases under LHC. It is also highly plausible to assume that if the nett cost of PHI had not already been reduced by the 30% rebate, the increased uptake of PHI under LHC would have been much lower.

AHSA is of the view that the cost of the 30% rebate in relation to hospital tables is less than the cost of undertaking the same work in the public sector at public sector payment rates (4). It bases this view on studies showing that if the rebate had not been introduced it is likely PHI uptake would have continued to fall to levels below that of 1998-9. This would have led to a situation in which either people clinically assessed as needing care would not have been able to access such care or there would have had to have been substantial additional public sector recurrent expenditure. It should also be noted than this takes no account of two very pertinent issues – whether the requisite clinical staff can be recruited and whether the funds are available for what would be very substantial capital expenditure.

6. Change in technology and Clinical practice

There have been substantial changes in both clinical practice and technology which have driven up the cost of health fund hospital tables.

Some of these relate to improved clinical practice particularly in relation to then elderly. Better surgical and anaesthetic techniques have lead to some of the more complex and expensive procedures becoming appropriate to utilize in relation to the elderly. The result has been an increased utilization cost of health for these age groups. The decision of whether or not to make clinical interventions has become increasingly based on biological rather than chronological age. In addition improved clinical techniques have significantly reduced risks associated with many procedures and thus increased the frequency with which they are performed.

New technology has also had a significant effect. One example is the new imaging technologies (e.g. CT scans, Digital Subtraction Angiography) although these should be considered in the context of replacing older, less effective and less safe technologies. Another example is new prosthetic technology (e.g. intra-ocular lens, joint replacements and arterial stents). These have often replaced older and less effective clinical modalities but at a price.

In the private sector there is open access to any approved technology and there is no ability to ration e.g. in relation to expensive new drugs and prostheses. While in one sense this is of value to those with PHI it also creates a significant cost driver within the private sector. There is no simple solution to this dilemma for private health funds. However two points should be noted. There is skepticism that many of the new approved technologies have been rigorously evaluated against current technologies and it is noted that prices charged in the private sector for many prostheses are well above that charged in the public sector e.g. the cost of Automated Implantable Cardiac Defibrillators (AICDs) cost approximately \$28,000 in the public sector and \$48,000 in the private sector. This statement is based on the comparisons of invoices received for the same device when private patients have been treated in the public versus private sector.

While there is no simple solution to this issue its reality and its effect on health care costs should be clearly understood. Understanding the reasons for these changes is an essential pre-requisite to appropriately addressing them.

7. Conclusions:

The contents of this submission have been deliberately limited to address some of the key issues that relate to point (d) of the committee's Terms of Reference viz , "*how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in the various levels of government*". AHSA believes some of these issues, particularly demographic change and changes in technology and clinical practice, will affect the provision of health services across all Australia regardless of whether they are provided in the public or private sector. A strong private sector is necessary to ensure a strong public sector.

References:

1. Hanning B 2001, 'Assessing the effect of Lifetime Health Cover (LHC) in South Australia and Victoria', *healthcover* vol 11 no 4 pp 33-38
2. Hanning B 2004, "How can the Financial Efficiency of Private Hospitals be Compared?", *Proceedings Dimensions in Health Care Conference incorporating the 15th Casemix Conference*, 10-13 October 2004, Sydney CD ROM.
3. Hanning B 2003, "Will health fund rationalization lead to significant premium savings? *Australian Health Review*, vol 26, no 3, pp139-46.
4. Hanning B 2004, "Impact on public hospitals if private health insurance rates in Victoria declined?, *Australian Health Review*, vol 28, no 3, pp 330- 339