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Hon. Alex Somlyay M.P.
Chairman
Standing Committee on Health and Ageing
House of Representatives
Parliament House
CANBERRA ACT 2600
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Dear Mr Somylay

I appreciate the opportunity to make a submission to the *Commonwealth Parliamentary Inquiry into Health Funding*. I will address the Inquiry's task to 'report on how the Commonwealth Government can take a leading role in improving the efficient and effective delivery of highest-quality health care to all Australians.'

Karen Davis, president of the Commonwealth Fund in Manhattan (http://www.cmwf.org/), an agency strongly committed to improving health services worldwide through research into health policy and practice, nominated from her observations ten steps that health services can take to control costs and improve efficiency. Because Davis is fully informed about international trends in health care, her observations are relevant for Australia as well.

First, Davis argues that many patients - between one quarter and one half - admitted to hospital, for example with heart failure, could be better and much more cheaply treated with proper monitoring and care at home. She quotes a study that found that annual health care costs for frail elderly people could be cut by 36% if they and their families were visited regularly by nurse practitioners. In Australia, health service financing is not yet tuned to the needs of the growing numbers of people with serious and continuing illness. Medicare does not generally reimburse nurses. Adjusting these arrangements would give better care and save money.

Second, Davis found in the US that the costs of care for patients with the same condition varied widely from place to place, with no relation to outcome. The question for Australia is this: do we match the institution to the patient? The answer is: not all of the time. Patients with severe conditions requiring special care do not always receive it because they go to a small hospital while others who do not need the firepower of the teaching hospital nevertheless receive it. We need to get mobile: notions of all health care needing to be within a stone's throw of where patients live are highly inefficient. We need two or three major institutions in each State in each specialty that compete to provide excellent care. We should not expect to get it at a dozen corner stores.

Third, by informing patients about costs and benefits of medical treatments, such as surgery versus medical care, overuse of dubious interventions might be reduced. Doctors should, but often do not, review patients' medications every few months. It is common for older patients to come to hospital

receiving a dozen medications, half of them given for forgotten reasons, which do no good, may do harm and waste money. Patients should be encouraged to ask their doctor regularly, "Do I need all these pills?".

Fourth, Davis argues, we should put a financial sting in the tail of efforts to reduce medical error. In the US insurers have been forking out for the care of patients who suffer as result of medical mistakes. It is fashionable to ascribe these errors to 'the system' to reduce blame on doctors and nurses. The system, though, is built and maintained by accountable humans. The institution that houses 'the system', and the people in it, is responsible for its form and function. In the US between 44,000 and 98,000 people die each year of medical errors and proportionately Australia is not far behind. These errors cost the US $9 billion a year. Financial incentives should be built into hospital funding to impel them to fix 'the system,' cut the error rate and save money.

Fifth, we must retain our capacity to control pharmaceutical prices. Australia has done well, especially compared with the US where most medications cost twice what they do here. The risk in the US-Australia Free Trade Agreement is that drugs that the pharamaceutical industry says are innovative, but which the PBS says are only a little bit different, will be put on the PBS whereas before they were rejected. This will allow the marketing systems to encourage people to switch medications for no good reason.

Sixth, the judicious use of evidence from clinical studies can save money. A recent study by several of my colleagues reviewed evidence about the appropriateness of the use of blood transfusion. They found that in NSW hospitals approximately one third of the patients were given blood probably inappropriately and causing unnecessary risk of complications. Cheaper and safer ways of treating these patients effectively could have been used.

Seventh, every person deserves and needs a doctor who knows them, sees them regularly, helps them with prevention and manages their long-term serious and continuing illness. This efficient use of a continuing general practitioner is often missing in the US. The drift to impersonal corporate panels of doctors in Australia, excellent for coughs and cuts, is no substitute for such a person. This drift has occurred in Australia almost without comment. Much of it has to do with pathetic payment arrangements for GPs. We need to find new ways of assuring patients of a continuing reference doctor who helps prevent illness where possible and who prevents expensive and unnecessary flare-ups in those suffering from serious and continuing illnesses.

Eighth, if patients had their own readily accessible electronic medical records, in which were stored all their medical data, ridiculous duplication could be avoided. Too often - perhaps in as many as 25% of cases - patients moving from one doctor to another have their tests repeated because the results cannot be transferred on time or get lost. We should recognise a patient's clinical record as his or hers and make it accessible so that he or she obtains optimal benefit from it wherever and whenever the need arises.

Ninth, and as an extension of eighth, the introduction of modern, efficient IT systems, although expensive, can cut medical error, improve care and reduce costs. Many health professionals worry about the prospect of IT-informed clinical care, while happily using hand-held devices for their music or for managing their investments. They need to get with it. On-line prescribing can identify drug incompatibilities before disaster strikes. Puzzling clinical information, including video, ECGs and x-rays, from an acutely ill patient seen in one hospital can be reviewed on-line by experts elsewhere as though they were present. This is superior care without the cost of unnecessary patient transport by ambulance or helicopter.

Finally, administering complex private health insurance plans in the US, according to Davis, creates overheads of 12-15%. In Australia, the price of administering Medicare, even when the hidden costs of raising money for it through tax and the Medicare levy are added, is lower than those of

private health insurance. As Australia moves backwards towards the US, with a greater dependence on private health insurance, the costs of administering health care financing will rise. Ways need to be found to hold down these costs, which siphon money from the provision of clinical care.

Rising premiums have again shone a spotlight on private health insurance. It is only unexpected to those who believed that rising membership rates would stabilize or even reduce premiums. But there is no cap or control over private health care costs to justify such a claim. Consumer whim is unchecked.

A central ambiguity resides at the heart of the health insurance debate and it is this: Australia has a universal public health insurance system, Medicare, underpinning the majority of health care. Yet $2.3 billion of public money is now spent subsidising private health insurance. This ambiguity expands when private health insurance is commended to the electorate, who demand Medicare's continuation, as taking "pressure off the public system". If that were the intention the $2.3 billion would have been used to better effect by direct investment in the public system.

The publicly funded system, which covers the bulk of consumers, is also the "no frills" system, catering for the vast proportion of emergency care and chronic illness services. The private system predominantly manages elective and day-only surgery, with additional business class comforts. Fair enough, too: if people wish to pay for frills, fine, but should other tax payers pay one third of those costs?

The ambiguity has grown because of confusion around the nature of Medicare. However much some may wish to rewrite its original purpose to be that of a safety net, Medicare was introduced to be universal. The idea that, unless young people "run for [private] cover", they will have no health insurance in the future is true only if Medicare is not there or is turned into a charity system for the indigent. If that is not the intention, the advertising for lifetime cover was disingenuous.

Fortunately, for the sake of equity, there is no convincing evidence that care in the private system is superior to public system care in health outcome or financial efficiency. Heart patients, who get more procedures in the private hospitals, have no better outcomes. Comparisons of the administrative costs of public and private health insurance administration reveal a three or four fold higher cost than for Medicare in the smaller multiple private health insurance companies. The administration cost of private health insurance is now over $700 million per annum. The lie that somehow private care is efficient and public care wasteful is another furfy.

The government subsidy for private health insurance has had a paradoxical consequence. The portion of total health costs ($72 billion in 2002-03) paid by government has risen from 65.5 % in 1997-98 to 67.9% in 2002-03. If pressure has been taken off anything as a result of the private health insurance supplement it is the private contribution to health care!

Further there is a problem because Medicare does not cover allied health services (physiotherapy, speech therapy) and dentistry in the community. These services are now only met by private insurance or out of pocket payment and are not equitably available. This creates an inequitable and artificial niche for private insurance. Currently, by subsidising private health insurance, which covers dental services to some extent, the government provides a 30% rebate for dental care only to private health insurance holders. In a study commissioned by the Australian Health Policy Institute, Professor John Spencer, Professor of Social and Preventative Dentistry at Adelaide revealed that the Commonwealth subsidy for public dental care for adults is about $75 million while the private dental insurance rebate is around $262 million (http://www.ahpi.health.usyd.edu.au/pdfs/colloquia2004/spencernarrowing.pdf).

The private health insurance subsidy along with health financing arrangements in general, as recommended by the Productivity Commission, deserves seriously to be reviewed. This country is

affluent enough, and once had sufficient social goodwill, to introduce Medicare. It is time to reaffirm that commitment.

Sincerely

Stephen Leeder

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CC Mr Mohit Kumar, Senior Executive Officer, Australasian Faculty of Public Health Medicine