GAP Taskforce on Hospital Funding

Third Meeting
Tuesday, 28 March 2016, 10:30am to 12:00pm
Ernst & Young Centre, Level 34, 200 George St, Sydney

PREAMBLE

The third meeting of the GAP Taskforce on Hospital Funding was held on Tuesday, 28 March 2017, from 10:30am to 12:00pm, at Ernst & Young Centre, 200 George Street, Sydney NSW.

The Taskforce brings together senior executives from Commonwealth and State health departments and associated agencies, hospitals, private health insurers, private healthcare providers and specialist medical practitioners. The group will consider the structural redesign of the Australian Government Rebate on Private Health Insurance under the Federation reform, focusing on the proposed Commonwealth Hospital Benefit as a new funding model. The Taskforce is an initiative of the institute for active policy Global Access Partners (GAP).

The GAP Taskforce on Hospital Funding operates under the Chatham House rule of non-attribution and in accordance with the principles of the 'Second Track' process. It is currently chaired by Mr Peter Fritz AM, Group Managing Director of TCG and Chairman of GAP.

DISCLAIMER

This document represents a range of views and interests of the individuals participating in the meeting. Statements made during discussions are the personal opinions of the speakers and do not necessarily reflect those of Global Access Partners and its sponsoring organisations. Given the different perspectives of meeting participants, it should not be assumed that every Taskforce member would agree with every recommendation put forward.

PROCEEDINGS

Welcome & Introduction. Review & Approval of Minutes

The Acting Chair welcomed participants to the meeting. A new member introduced himself to the group.

The minutes of the previous meeting were adopted unchanged.

Summary of the Commonwealth Hospital Benefit (CHB)

Forty-two billion dollars will be spent on public hospitals this financial year, with $17 billion contributed by the Commonwealth, $24.8 billion by the States, and $193 million from other sources. Public hospital funding agreements typically run for five years, but current arrangements will be extended by three years[1] while the government works on broader, long-term reform.

Four new health ministers attended the COAG[2] Health Council meeting on 24th March[3]. The Commonwealth Hospital Benefit (CHB) was not discussed, but the $300 billion cost of the next five-year agreement, starting in July 2020, was outlined. State and Federal governments therefore share an interest in controlling health prices and demand.

The CHB concept sprang from work begun by the Department of Prime Minister and Cabinet in 2015[4]. The CHB would combine three current sources of Commonwealth funding: the $17 billion Commonwealth contribution to State governments for public hospitals, the $6 billion private health insurance rebate, and $3 billion in MBS payments made to private patients for medical services in public and private hospitals (*see Slide 3 in Appendix*). The CHB would use IHPA[5] expertise to create a private sector analogy to the National Efficient Price (NEP) in the public system. The CHB would be paid when a patient enters the public or private hospital system, with State governments covering the balance in the public system, as they do now, and co-payments, private health insurance or new forms of private insurance making up private sector costs.

1 Hospital funding and health reform - COAG Meeting Communiqué, 1 April 2016; https://www.coag.gov.au/meeting-outcomes/coag-meeting-communiqu%C3%A9-1-april-2016

2 Council of Australian Governments

3 COAG Health Council Meeting, 24 March 2017; http://www.health.gov.au/internet/main/publishing.nsf/Content/mr-yr17-dept-dept005.htm

4 Reform of the Federation Discussion Paper 2015; https://federation.dpmc.gov.au/sites/default/files/publications/reform_of_the_federation_discussion_paper.pdf

5 Independent Hospital Pricing Authority

The CHB is not government policy, and there is no intention to formally progress the idea, although Global Access Partners is welcome to undertake informal analysis.

The Taskforce was briefed on a range of policy options being developed by the Department of Health over the next 18 months. COAG should agree the parameters of the next five-year funding agreement by September 2018, with the agreement taking effect in July 2020.

Discussion

Hospital benefits are a political 'hot potato', and members were asked to seek consensus on proposals for change. Although medical practitioners remain significant opponents of reform, private and non-profit hospital sector are more amenable to change. Private hospitals cannot control the prices charged by specialists, while public hospitals have some measure of control over surgeons' fees. Surgeons may try to charge private health insurers or consumers more if private hospitals are able to cap their prices. Metropolitan centers have more competition than the regions.

Private insurers are concerned by the removal of the ancillary rebate, which supports a range of extra services valued by some customers. Australia's fee for service model encourages expensive in-hospital care, rather than cheaper out-of-hospital treatment, and an outcome-based model would be more efficacious.

While IHPA sets prices and data requirements for treatment, State governments still manage the system. IHPA does not direct or plan the type, location or volume of services provided by the States. Outcome-based funding models could compliment fees for service, but broader reform is inhibited by the traditional activity-based approach.

Opposition from medical professionals is real, but can be overstated. Ninety per cent of in-hospital medical services appear to be 'no-gap' or 'small-gap' in the private sector; however, there are many unreported charges to patients which are not passed on to health funds, notably in obstetrics, pediatrics and urology. 'No-gap' payments charged to insurers in the private sector can be twice as much as the NEP, and this issue must be addressed whatever reforms are pursued. The NEP reduces costs in the public sector, but may not have the same effect in private hospitals powerless to control the fees charged by clinicians. New terms of contracts will require a different culture in private hospitals, as senior doctors have no experience of negotiating fees, although they negotiate operational parameters such as theatre access. Such cultural change would take years to prepare, but larger hospitals, particularly in rural markets, realise the need for change to ensure long-term provision of sustainable services.

Reform may be achieved by convincing those most amenable to change and building momentum from their example, rather than immediately targeting the most intransient objectors. Private hospitals may be the most amenable stakeholders to reform. Consumers want access to high-quality care, which is affordable in the private system and timely in the public sphere.

The private insurance industry claims that some consumers are concerned by the removal of the rebate on ancillary services as they do not use other services, such as hospital stays, covered by private insurance. Such consumers may drop private insurance as a result, increasing the burden on the public sector. However, the rebate only covers 27% of the cost of insurance, and this will continue to dwindle. Private health insurance is a complicated product, bedeviled by complex regulation and diminishing affordability. More citizens may accept a greater health risk and drop private insurance due to higher costs and falling product satisfaction. A suite of reforms to reduce major cost drivers and improve efficiency is required, rather than any single solution.

Reform is hampered by cultural inertia, but new technology offers scope to change clinical work practices. Most stakeholders, from governments to hospitals, consumers and insurers, share an interest in reducing costs. Technology can drive reductions in health costs as well as increases, but the complex trade-offs and relationships in the system as a whole make individual impacts difficult to model or quantify. A simpler system which reduces, rather than merely shifts, costs and focused on outcomes rather than processes is easier to agree in principle than achieve in practice.

Self-interest is the common driver of change. The government has long tried to encourage the use of electronic health records, but subsidies given to clinicians and general practitioners to install technology proved ineffective. Payments for generating and using electronic records would have been more effective. Private hospitals and consumers both want to reduce their costs, but private insurers do not want to shrink their revenues, and clinicians will need incentives to embrace reforms which affect their revenues. Specialists will oppose any model which inhibits their power to set their own fees, but are indifferent to changes which do not affect them financially. Once the points of stakeholder resistance are identified, measures to buy acceptance can be planned.

Federal reform proposals of any kind are vulnerable to an opportunistic 'no' campaign, but opposition would be undermined by Labor and Coalition-controlled States supporting changes which reduce their costs and demand and increase their bargaining power with health workers. Bipartisan support in the States could reduce opposition at the federal level. The States have discussed these issues at a high level, but successive hospital agreements have increased costs to avoid political conflict. The

States would be reluctant to forego revenue, and agreements tend to rely on assurances they would not lose out.

Health costs must be tackled, as they might otherwise absorb 60% of total expenditure by 2056. Fundamental reform of the funding system is achievable, but judicious steps must be taken to assure stakeholders and manage the political debate.

Outcome-based or blended payments should be pursued alongside incentives for treatment in appropriate community settings alongside national efficient prices for hospital care. Most stakeholders agree that fee for service is inefficient, and positioning reform as a better way of paying for the health system could increase support.

Members were asked to outline the one-time incentives they would need to back permanent change.

While most specialists do not set their own fees, they want to retain the right to do so. Some peak bodies, such as the Royal Australasian College of Surgeons (RACS), support giving consumers more information about health outcomes to empower better choices and allow top surgeons to charge higher fees. While doctors do have altruistic motivations, Australian surgeons charge higher fees than their OECD[6] peers, with 17 of the top 20 taxable professions held by surgeons. A thoracic surgeon, for example, might earn $3 million a year. Consumers should therefore head the list of stakeholders to co-opt for change.

Many not-for-profit private hospitals are run by doctors, and these interlinked relationships will complicate reform. The open negotiation of contracts by private hospitals might be problematic, but private insurers could undertake this role. A model of contestability, as examined by the Productivity Commission[7], would see multiple funders and create pathways between the public and private sphere.

The Taskforce might usefully unpack stakeholder interests in more detail to understand the 'showstoppers' proclaimed by each interest group. The insurance industry has a formal position, but different companies within it have equally diverse levels of interest in reform. The States and private hospitals are not opposed to reform, and consumers support a better, more affordable system. Picking a path through political opposition will be complex, but can be managed through normal channels of discourse. The status quo is always a short-term alternative to action, but will become increasingly unsustainable for both consumers and the government. If more consumers drop private health insurance to rely on the public system, waiting

6 Organisation for Economic Co-operation and Development

7 Productivity Commission (2017), Reforms to Human Services preliminary findings report; http://www.pc.gov.au/inquiries/current/human-services/reforms#draft

lists will increase and the quality of public care will decline, which may in turn restore demand for private provision.

The models used in nations such as the Netherlands and Germany could also be instructive, as Australia's system will be unsustainable in 30 years if current trends continue and no reforms are achieved. Ideally, a well-informed consumer cohort would demonstrate in support of the reform proposition, and although this is unlikely, well-informed consumers could be mobilised for change.

Consumers are not a monolithic block, and different types have different interests. Many consumers do not fear falling sick and have different attitudes to those who do. Fifty per cent of consumers buy cheap insurance because they do not think they will use it, while only 5% of the half which buys more expensive cover lodges a claim for hospital expenses in a year. Despite paying more for insurance, these consumers are also hit by additional out-of-pocket demands. People who now pay $1,200 for the cheapest insurance would gladly pay $800 if costs could be reduced, as they will not use it anyway, while consumers who buy insurance because they know they are likely to need it would support steps to reduce additional out-of-pocket costs.

The Australian Healthcare and Hospital Association is concerned by out-of-pocket costs, the removal of ancillary rebates and how the Commonwealth will cover its 35-40% share of costs. Giving more power to private hospitals to negotiate lower costs may not work, given the market power of doctors. The medical professional is a historically powerful lobby, which has succeeded in protecting its interest over time. Greater transparency about health outcomes as well as costs would inform better decision-making, but surgeons in one Canberra hospital relocated to New South Wales, rather than agree to fixed fees. Anesthetists and obstetricians in another hospital with a 95% no-gap ratio refused to agree to 100% because they did not want to be told what to do, or for the public to know what they charged. Specialists want control even more than they want to protect their income.

Private and not-for-profit hospitals are a promising place to start, but the way in which the reform message is delivered will determine its success. The CHB reform proposal offers benefits to efficient providers; however, efficiency tends to be a product of technological innovation, and changing processes is more difficult in established facilities than new ones where technical provision can be planned around the patient journey. Retrofitting new technology into old facilities tends to incur high capital costs and falter on the complex pyramid of sub-tenancy and commercial arrangements, which have accreted over time.

Members discussed whether hospitals could be incentivised to voluntarily accept reform proposals. While piecemeal hospital adoption would prove impractical, insurers could opt in on a voluntary basis to secure rebate incentives. Consumers

could be educated about the true value of ancillary insurance, although members disagreed about the value it offered, with one member pointing to high administrative costs and out-of-pocket expenses.

As a next step, stakeholder mapping could be carried out in a few States, perhaps NSW, Victoria or Queensland, to build bureaucratic consensus over the facts and encourage consensual and detailed analysis. Health reform is a long-term project, and momentum for change requires robust data and agreed bipartisan approaches.

The 2018 hospital funding agreement offers an opportunity to consider ambitious reform, but stakeholder consensus remains elusive. Members offered to discuss the issues offline to concentrate on the most promising areas to progress.

Everybody wants a better health system, and a safe space to debate radical options for systemic change is valuable as many proposals are strangled at birth. Seven broad areas for possible reform will be researched by the Department of Health over the next 18 months, and Health ministers will explore these options further in August.

Next steps

GAP will produce a final report based on Taskforce discussions, having identified key stakeholders, opportunities for improvements, and barriers to reform. However, more work must be done before the private health insurance industry would back the CHB model for change, although they are not opposed in principle. The GAP report should therefore not claim a consensus for change and outline steps for implementation.

There is no 'burning platform' to drive change in private health insurance. However, young people are not joining health schemes, which will increase premiums for older people more likely to require healthcare. 'Business as usual' is not an option, and insurance companies could look to provide new products, but health insurance is so heavily regulated in Australia that change is difficult to pursue. By contrast, the IT industry embraces a new paradigm shift every five years, showing the benefits of brand new approaches.

Current standards and prices of care are unsustainable, and a series of reforms are required. Merely tinkering with the existing system will not create progress, and the intellectually easy, but politically difficult, option of increasing the Medicare levy will not suffice.

If the right incentives are given to institutions, they will embrace reform.

While discussions of reform envision gradual transitions, sudden disruptions may transform healthcare as they have other established industries. Stakeholders should not be seen as monolithic, homogenous blocks, as they are all segmented in different ways, and understanding stakeholder segmentation would help reforms to progress. Little attention is paid to shades of stakeholder opinion in the broader discussion, and more sophisticated consideration of variation within groups could inform the debate.

The health system should encourage more care in the community and at home, rather than hospital, but paying hospitals to become more efficient will only increase patient churn, rather than making the health system more efficient overall. The CHB, or similar proposals, will only work as part of a broader set of reforms to address systemic problems. If CHB was a pathway to blended payments, for example, it would be a more attractive proposition than merely a way to service more patients in hospital. Instead of paying hospitals $1,200 per patient per night, a blended payment system would offer a set payment for chronic patients and encourage health authorities to treat people at home.

Half the Australian population has some form of chronic disease, but only a million receive extended primary care. Most people manage their conditions themselves and do not visit hospital. The Taskforce brief focused on hospital funding, and though a wider consideration of issues is useful, it is beyond the immediate remit.

Next Meeting

The next meeting will be arranged for June-July, after the Federal budget is published.

ACTION POINT SUMMARY

Members to submit material for the draft report (contact Emma Johnson)

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Group, NSW Treasury

Australian Government
Department of Health

COMMONWEALTH HOSPITAL BENEFIT

Australian Government
Department of Health

Commonwealth hospital benefit

- Pooling Commonwealth public hospital funding, in-hospital Medicare benefits, and the private health insurance rebate
- Using this funding to pay a Commonwealth hospital benefit for services provided in both public and private hospitals
- Objective is to improve technical efficiency and competitive neutrality
- It is not intended to address allocative efficiency

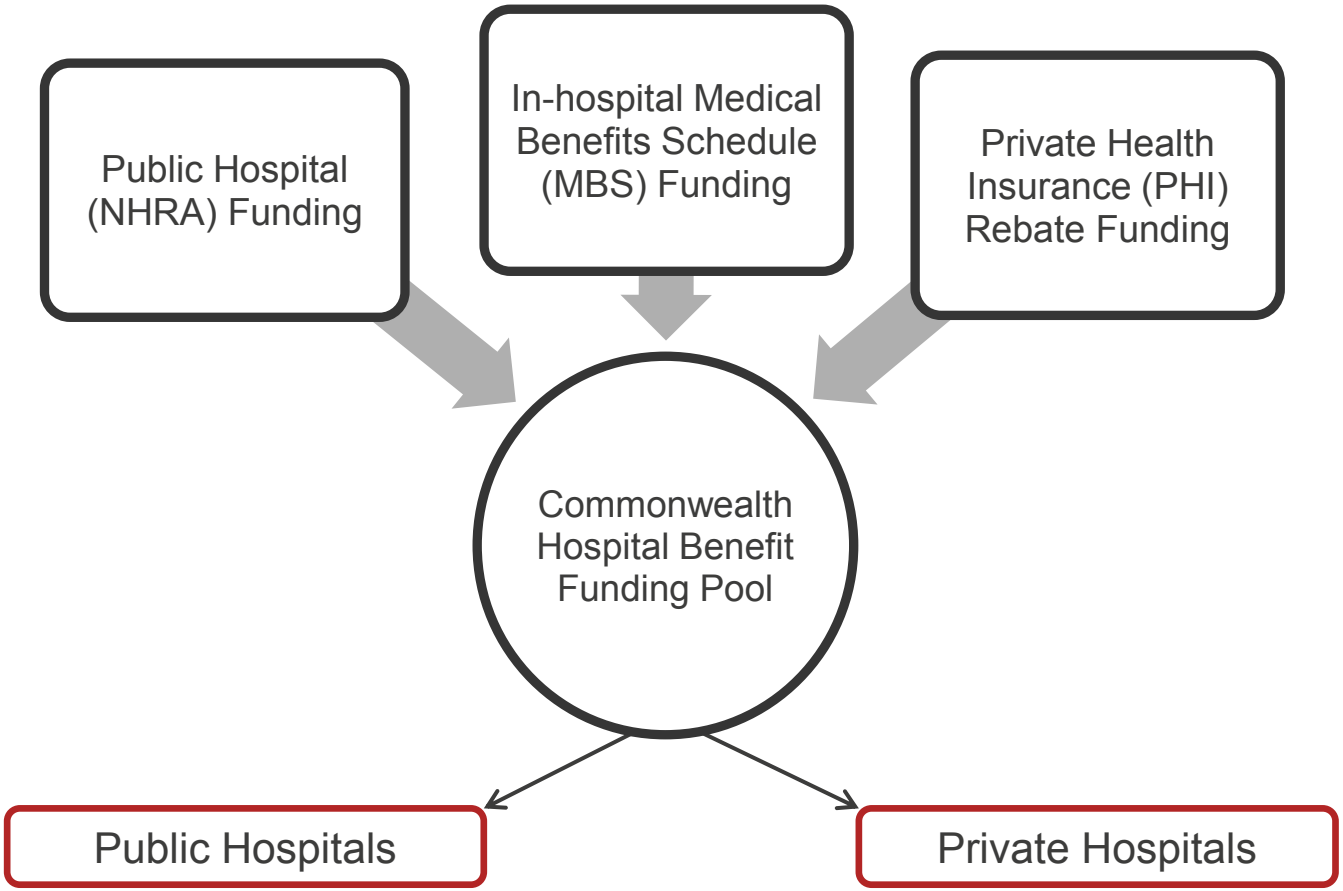
Australian Government
Department of Health

Commonwealth hospital benefit

- The Commonwealth pays a case-mix adjusted hospital benefit for all hospital services regardless of setting or insurance status
  - (other than veterans and compensable cases)
- The benefit would be set as a proportion of the national efficient price of delivering hospital services
- States would be required to meet the balance of the cost for public patients (thus maintaining free public hospital services)
- Private patients could take out insurance, or meet the balance of the costs themselves

Australian Government
Department of Health

Commonwealth hospital benefit - funding



Australian Government
Department of Health

Commonwealth hospital benefit - scope

- Commonwealth public hospital funding is currently paid for the scope of services determined by the Independent Hospital Pricing Authority
- In the private sector Commonwealth funding is largely limited to admitted patient services and does not cover services such as emergency departments
- The new benefit would begin by applying to all services included in the IHPA's scope, regardless of whether they were in a public or private hospital

Australian Government
Department of Health

Commonwealth hospital benefit - mechanics

Setting the benefit

- Benefit indexation – in line with the national efficient price set by the IHPA
- Benefit relativities – determined by the IHPA
- Scope of services – determined by the Minister only after advice from the IHPA

Private doctors' remuneration

- Currently doctors are paid with funds from MBS, insurers and patients' pockets
- It would be open for hospitals or insurers to negotiate a single payment for doctors

Australian Government
Department of Health

Commonwealth hospital benefit - benefits

- Improves equity of Commonwealth funding and competitive neutrality between states and sectors in the delivery of services
- Paying a benefit directly to hospitals would reduce administrative costs associated with administering the premium rebate and improve efficiency
- Basing benefits on a National Efficient Price would ensure continued pressure to improve technical efficiency in both the public and private sector
- Removes the Commonwealth's exposure to cost shifting activities involving reclassification of patients as private patients
- Potentially simplifies experience of private hospital patients in paying doctors' bills

Australian Government
Department of Health

Private Hospital Episode Indicative Example

CURRENT (Private Patient)		FUTURE (Private Patient)	
Medical		**Episode**	
MBS	**$600**	**Hospital benefit** [Note 1]	**$1,750**
PHI		**PHI**	
PHI rebate	$60	PHI premium	$2,550
PHI premium	$140	**Total PHI Benefit**	**$2,550**
Total PHI Benefit	**$200**	**Out-of-pocket** [Note 2]	**$700**
Out-of-pocket	**$200**	**Total Episode Costs**	**$5,000**
Total Medical Costs	**$1,000**		
Hospital			
PHI			
PHI rebate	$1,050		
PHI premium	$2,450		
Total PHI Benefit	**$3,500**		
Out-of-pocket	**$500**		
Total Hospital Costs	**$4,000**		
Total Episode Costs	**$5,000**		
Total Commonwealth	$1,710	Total Commonwealth	$1,750
Total Premiums	$2,590	Total Premiums	$2,550
Total Out-of-pocket	$700	Total Out-of-pocket	$700

Note 1: Assumption that the Hospital Benefit is 35% of the National Efficient Price (NEP).

Note 2: Assume total out-of-pockets are unchanged.

Australian Government
Department of Health

Commonwealth hospital benefit - issues

- Does not directly address problems arising from the division of responsibilities between the Commonwealth and the states
  - (Although it would assist in setting a common currency for hospital services to underpin funds pooling in coordinated care models).

- Removing the in-hospital MBS would require insurers or hospitals to reach agreements with the medical profession on the fee levels that would be reimbursed by insurers or bundled into a hospital episodic charge

Commonwealth hospital benefit – issues (2)

- There would no longer be any Commonwealth support for “general treatment” insurance products covering dental, physiotherapy, podiatry etc.
  - (However, over 90% of people with general treatment cover also hold hospital cover, and would be no worse off in aggregate if the existing subsidy was redirected from general treatment to a hospital benefit. It is important to note that this figure is an average and does not reflect the range of individual experiences.)