Committee: CA Leg. Committee

Tabled Document

Inquiry: 2017-18 Budget Estimates

Date: 29 May 2017

Witness: Senator Watt

Organisation: .....

GAP Taskforce on Hospital Funding

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

AGENDA

10:30am **Welcome & Introduction**
Acting Chair - Peter Fritz AM, Chairman, Global Access Partners

Review and Approval of Minutes *(attached)*

Summary of the Commonwealth Hospital Benefit (CHB)
Department of Health

Group Discussion

- Impact of CHB on the following stakeholders:
  - Consumers
  - Insurers
  - Hospitals
  - Healthcare Providers
  - State Government
- Any potential changes to the model to achieve stakeholder consensus
- Alternative models to consider

New Members Perspectives

Recommendations for Final Report

Timeline for release of Report

Next Meeting

Other Business

12:00pm **Vote of Thanks & Close**

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PROCEEDINGS

Welcome & Introduction. Review and Approval of Minutes

Members were welcomed to the meeting.

A permanent chair for the Taskforce is still being sought. Members were reminded of the group's main topic of discussion. Attendees represent themselves and should pursue self-interest to achieve results. Discussions are noted under the Chatham House rule of non-attribution. The GAP process allows different stakeholders to discuss mutually beneficial solutions in an informal setting and pursue concrete outcomes.

Members introduced themselves to the group.

The minutes of the inaugural meeting were adopted unchanged.

Commonwealth Hospital Benefit (CHB): Presentation *(slides attached)*

As a steward of the health system, the Federal Health Department must look at all policy options to improve outcomes. The possibility of a Community Hospital Benefit (CHB)[1] was raised in the Federation debate in 2015[2] and has been discussed at GAP meetings and elsewhere.

A CHB would have a significant impact on the whole industry, given the importance of private and public hospitals. There is a separate process around private health insurance, with an independent committee chaired by Dr Jeffrey Harmer AO[3].

The Council of Australian Governments (COAG) met in early December 2016 and approved public hospital arrangements up to 2020.[4] These will be revisited in 2018 to plan future changes, and if the CHB was to gain traction, then it could be incorporated in future reforms.

The CHB would be an exercise in **technical efficiency**, rather than reducing demand or broader population health planning. The private health system accounts for a third of activity and so should be included in discussions of improving healthcare overall.

1 A working title

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

3 Private Health Ministerial Advisory Committee; *http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac*

4 COAG meeting Communiqué, 9 December 2016; *https://www.coag.gov.au/meeting-outcomes/coag-meeting-communiqu%C3%A9-9-december-2016*

The Commonwealth funds hospitals in three ways. It currently gives public hospitals $20 billion a year, which will grow by 6.5% a year through the next three-year agreement. Three billion dollars in MBS[5] benefits are used to pay private sector doctors, and $6 billion is spent on private health insurance rebates.

A CHB would blend these streams together, paying for treatment regardless of whether patients go to a public or private hospital. This would improve technical efficiency and competitive neutrality, but is not designed to address allocative inefficiencies.

The Commonwealth would pay **a case-mix adjusted benefit** to all hospitals regardless of setting or insurance status. The citizen could take their benefit to a private hospital, with an arrangement in place to cover the gap between what a private hospital charges and the benefit allowed. Citizens could insure themselves for any shortfall through a private scheme.

The benefit would be set as a proportion of the **National Efficient Price (NEP)** as set by the Independent Hospital Pricing Authority (IHPA). The setting of a NEP has driven significant improvements in technical efficiency over the last five years in the public hospital sector, saving billions of dollars. Extending these arrangements to the private system should have similar results. State governments would cover the gap between the benefit and costs in their public hospitals. Patients would still be able to access public hospitals without paying fees, while the subsidy for private hospitals would be taken from their insurance.

The current range of in-scope and out-of-scope public and private sector activities would be covered by the proposed CHB. The indexation of the CHB would move in line with the NEP set by IHPA, with the scope of services controlled by the Federal Minister for Health based on IHPA advice.

The CHB would **change the remuneration arrangements for private doctors**. Private doctors are currently paid with funds from the MBS, with insurers covering a range of gap payments and out-of-pocket expenses paid by the patient. The new system would have **a single payment**, as in the public sector, with **the doctors' payments rolled in** to the total amount.

The costs of **private sector prosthesis** would also be treated in the same manner as the public sector.

As well as improving equity and competitive neutrality, the new system should **reduce administrative costs** and **remove layers of complex regulation** for private health insurers. A CHB would reduce the Commonwealth's exposure to cost-shifting activities by the States, as the States now seek to maximise the revenues they can generate from patients in public hospitals. The CHB would also **simplify the paying of private doctors' bills for patients**. The Department's working hypothesis is that the CHB should have no

5 Medicare Benefits Schedule

net effect on the expenses paid by individuals,[6] as it recycles the same money for payments while reducing the administrative burden to private health insurers. It would not directly address the problems which arise from the division of responsibilities between the States and Commonwealth, but it would set a common currency for hospital services in other care models.

Removing the hospital MBS would be a significant change requiring new agreements with medical professionals; however, public hospitals have successfully negotiated these for decades. The medical labour market is changing rapidly with a much greater supply of specialists.

Group Discussion

- ***Benefits and impact of CHB on various stakeholders***
- ***Any potential changes to the model to achieve consensus***
- ***Alternative models to consider***

Members debated the proposal. A better allocation of funds should lead to better health outcomes, although there will be an inevitable argument between stakeholders which benefit or lose as a result. Policy makers should 'take care' of the losers, to secure their support, as the winners will take care of themselves.

One member praised the effort to think about the future and adopt a more holistic approach, but warned that significant hurdles would have to be overcome, including **opposition from private doctors and medical specialists**. More care should be provided outside hospitals, and market dynamics should not be eliminated in the quest for a uniform NEP. The CHB could lead to cost inflation, unless very strict definitions were set.

The economic circumstances were different when the private health insurance rebate was set, and the policy has evolved over time. Press reports regarding the size of the rebate can be misleading, as it is means-tested and multiple clawbacks are made. The $6 billion PHIR[7] allocation does not equate to the actual spend. **The empowering of consumers to make better choices should be applied across the system**, as some people are unable to find a good family doctor in their area.

In answer, it was underlined that the CHB would not take money out of the private health system.

6 It was later noted that the CHB will have an effect on individuals' expenses. Currently, the CHB proposal is to cash out the rebate for hospital and ancillary products and use the money to pay for a proportion of all hospital treatment. As a result, either individuals will miss out on ancillary cover (which covers the costs of dental, optical, physiotherapy, etc.), or there will need to be additional costs charged to individuals to continue cover for ancillary treatments.

7 Private Health Insurance Rebate

Another member clarified the average individual figures involved and stressed that the CHB would be **a long-term project**. Reforms should lead to better outcomes, rather than more 'churn' of fee-based services. If specialists agreed to the proposal, they might also encourage hospital admissions, as this would guarantee them a payment. **A value-based, capitation or blended system**, where payments are received for outcomes, could reduce this risk.

The Dutch system proves that outcome measures and a NEP are not mutually exclusive. The Netherlands has compulsory private health insurance, a government contribution to a risk pool of just under 50% of the total, competition between providers, and a blend of fee-for-service, capitation and bundled payments.

Members were invited to submit comments on the proposal to GAP. This could inform a map of the ecosystem and highlight its costs and benefits from a range of stakeholder perspectives.

Many private hospitals would welcome the ability to be more competitive and may also want to provide out-of-hospital services. Questions around **medical remuneration in private hospitals** will be difficult to address, as self-employed specialists will oppose change which appears to threaten their income or independence. However, **partnerships can be developed between various services**, as they have been in Western Sydney between the public and private health sectors. The proposed model would shift risks, and the benefits it creates should be shared among stakeholders.

Members were asked for **solutions to reduce the tension between public funders and private providers.** Transparency is vital in the process.

The States would also need to understand the proposal's impact on them, their activities and primary care. Reforms should improve outcomes while controlling costs, and more **outcome-based funding** should be supported.

The CHB proposal has **a 10-year outlook** and should be seen **in the context of broader health system reform**. Spending increases are now capped at 6.5% in the public hospital sector, and State projections have overestimated their needs in recent years. The Department of Health is working with the States to offer more treatment for chronic and complex diseases outside hospitals. Although it would be beneficial to transfer 10% of hospital funding into other forms of care, this is not a practical possibility, and so other avenues to get people out of hospitals are being explored. The risk of States 'cashing out' of hospital provision, then spending the money anyway – doubling the bill for the Federal purse – must be managed properly.

Other members were interested in how the proposal would sit in the wider health system, **the balance of risk** it would create, and **the changes in behaviour** it might drive. **Treasury modelling** of likely outcomes would be required, if the proposal is to be developed further. The Department of Health must examine options for reform, as the

current system will run out of money in the future. The States already spend almost a third of their budgets on healthcare, and while NSW and Victoria have limited this growth, all States will face problems as it grows over time.

Members were urged to support reform, rather than merely consider it. A holistic and mutually beneficial solution must be sought, particularly in the context of outcome-based funding.
Overseas experience shows that general practitioners (GPs) are more likely to support approaches which avoid hospital costs, such as house calls, if they receive **a share of the savings**.

Data mining can inform more efficient ways to manage **chronic patients**; however, hospitals are concerned that embracing improved management methods would impact on their funding. Hospitals therefore need incentives to embrace, rather than reject, such innovations. Another example of perverse incentives is ambulance services which could lose funding if they introduce more efficient triage methods. That could reduce the number of emergency responses to calls, and thus the funding which is linked to the number of calls they respond to.

The CHB would be a part of an overall and much broader effort to improve care.

While perverse incentives to put people in hospital should be considered, the CHB would ensure greater efficiency once they are there. The public and private hospital sectors consume a significant proportion of overall health spending. **Cost-shifting** from the States to the Commonwealth, for example, is a major problem. The Department of Health has detailed figures regarding spending in public, although not private, hospitals, and greater use of this data is being made in primary healthcare. More data can be presented at the next Taskforce meeting.

Members agreed that **reforming medical fees** would be a major obstacle. Over-utilisation can be controlled through pricing. The NEP has brought stakeholders together in the public sector, but **the isolation of hospitals, insurers, doctors, prosthesis and other stakeholders in the private sector remains a major problem**. A population-based health model is likely in the long term, as measures to remove perverse and inappropriate incentives must be found.

Next Meeting

The next meeting will be held at a mutually convenient time in the New Year.

Other Business

Reference - Capital Markets CRC (2016), "Flying Blind: Australian Consumers and Digital Health" Report, *https://flyingblind.cmcrc.com/*

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Vote of Thanks & Close

Members were thanked for their contributions, and the meeting was brought to a close.

ACTION POINT SUMMARY

- Members to submit their written comments on the CHB proposal to GAP (contact – Emma Johnson)
- More detailed data on government spending in public hospitals to be presented at the next meeting (Mark Cormack, James Downie & Dr Ian Smart)
- The Department of Health to provide a stocktake of all the stakeholders relevant to CHB discussions (Mark Cormack)

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