Private Healthcare Australia
Better Cover. Better Access. Better Care.

Unit 32, Level 1, 2 King St, Deakin ACT 2600
T (+61) 2 6202 1000
F (+61) 2 6202 1001
www.privatehealthcareaustralia.org.au
ABN: 35 008 621 994

Dr Rachel David
CHIEF EXECUTIVE OFFICER

5 March 2018

Senator David Leyonhjelm
Chair, Senate Red Tape Committee
Department of the Senate
redtape.sen@aph.gov.au

Dear Senator Leyonhjelm

Further to our testimony to the Senate Red Tape Committee Inquiry on 9 February this year, Private Healthcare Australia (PHA) is pleased to provide the attached supplementary submission.

The aim of this supplementary submission is to provide additional information to the Committee regarding the potential benefits to patients and PHI members as well as the health system in the event that the reforms outlined in our initial submission were implemented.

This submission therefore focuses on those issues raised by the Committee, specifically the benefits that could be delivered from the:

- Introduction of better mechanisms to reduce fraud, waste and low-value care;
- Elimination of perverse incentives to use hospital care; and
- Building on the initial reform of the Prostheses List.

This submission explains the benefits that would accrue to both patients and the health system by removing the structural restrictions currently built into the system and enabling PHIs to undertake long-cost savings programs, such as wellness or preventative health programs.
These deliver positive benefits to patients by helping keep them healthy and out of hospital whilst also providing a positive return on investment via lower hospitalisations and other health care costs.

The need to continue reform in private health insurance is not to discount the significant steps taken in the last two years. These have been critical in helping put downward pressure on PHI premiums and in delivering in 2018 the lowest premium rises in a decade.

Ongoing reform is necessary however and this supplementary submission outlines the benefits the next wave of reform could deliver.

PHA would welcome the opportunity to further discuss the attached or the other recommendations made in our initial submission should that be of assistance.

Yours sincerely

Dr Rachel David
Chief Executive Officer

Private Healthcare Australia
Better Cover. Better Access. Better Care.

Senate Red Tape Committee – Supplementary Submission

5 March 2018

Better mechanisms to reduce fraud, waste and low-value care

Significant opportunities exist to improve how issues of fraud, waste and low-value care are identified and managed in the Australian health care context.

Increasing utilisation of services predominantly drives health system health increases with a large part of this related to population ageing and the growing burden of chronic disease in our community. Significant incentive also exists as a result of the MBS fee-for-service model of reimbursement as driving up procedure and consultation volumes under this system provides financial reward. Given the high information asymmetry between providers and consumers, provider-induced demand accounts for a significant proportion of services provided.

PHI's submission to the Committee recommended introducing a robust mechanism in conjunction with the Department of Health to manage compliance in the MBS program and to ensure the appropriate provision of services using modern data analytics. The resultant joint payment integrity program would deliver improved MBS and health fund benefit compliance that both assesses the validity of individual claims and acts to modify the claiming behaviours of both individuals and groups of individuals.

Impact for patients and the health system

This would:

- Ensure effective and appropriate use of health care services and dollars;
- Avoid payments for services that did not occur;
- Permit greater tracking of patient outcomes; and
- Help deliver appropriate care to patients whilst avoiding unnecessary costs.

Example – avoiding medical procedures that deliver low value to patients

The Australian Commission on Safety and Quality in Health Care found that between 1997 and 2006, there was a 2% increase in the number of spinal fusion surgeries undertaken in the NSW public hospital system compared to an increase of 167% in the private sector.

At the same time, only around 20% of patients are reported to be helped by spinal fusion surgery and some estimates suggest that 50% of the operations being performed are unnecessary. The Australian and New Zealand College of Anaesthetists have recommended that the procedure be added to a list of unnecessary procedures that is under development.[1]

A 20% reduction in hospital episodes for spinal fusion would deliver savings of $60 million per year to health funds who continue to promise to return those savings to customers in full as they have with savings achieved by reform to date.

Example – eliminating waste in post-surgery rehabilitation

PHA figures indicate that average annual utilisation growth for PHI funded separations related to a service related group of rehabilitation was 13% between 2011-12 and 2016-17 whilst average cost over the same time grew 11% (see table below). Thus, utilisation rates increased substantially during the period and total costs increased from $442 million to $754 million.

In terms of outcomes however, a 2017 clinical trial compared the mobility outcomes of patients who had undertaken a total knee arthroplasty procedure followed by home-based rehabilitation program with a group who undertook their rehabilitation as a hospital in-patient.

[1] Sean Parnell, Sarah-Jane Tasker, 'Health waste: spinal fusion added to list', *The Australian,* 14 February 2018. https://www.theaustralian.com.au/national-affairs/health/health-waste-spinal-fusion-added-to-list/news-story/ffba3301b3b78f59a864739e6b3304d9 Accessed 5 March 2018.

The study concluded there was "no significant difference" in outcomes and that "inpatient rehabilitation *did not* improve mobility compared with a monitored home program".[2]

With a typical length of stay in hospital of 7-14 days, inpatient rehabilitation adds around $9,500 to the median $22,000 bill for the surgery itself. This compared to the cost of outpatient rehabilitation of less than $400.[3]

The study reflects the substantial growth in the performance of total knee arthoplasties found in the PHA data: more than 49,000 of these procedures are performed in Australia each year and the incidence per 100,000 population has increased by more than 80% in the last decade.

Further, the KPMG study found that rates of inpatient rehabilitation for private patients are around double that of the public sector, "suggesting that factors other than need drive the high utilisation rate in the private sector".

Insurers are compelled by the current legislative framework to pay the costs of inpatient rehab whilst reports indicate that hospitals are gearing their operations to profit from these more lucrative arrangements.

Inpatient Hospital Rehabilitation

Source: Private Healthcare Australia

Financial Year	**Hospital Separations**	**Total Fund Benefits Paid ($)**
2011/12	155,287	$442,337,405
2012/13	182,697	$500,273,157
2013/14	207,889	$567,580,174
2014/15	236,507	$633,649,669
2015/16	263,453	$689,582,582
2016/17	284,327	$754,250,353

Example – enabling PHI funds to support more optimal care pathways

In a report commissioned by the National Mental Health Commission in 2014, *'Paving the way for mental health'*, KPMG considered the potential clinical pathways facing a 36 year old female with bipolar disorder. They identified that the optimal care pathway would deliver a decrease in acute inpatient days compared to the likely number under the current pathway. In addition, an increase in GP contacts and visits from community mental health teams would be involved (see the table below).

Enabling the female patient to access the optimal care pathway would also reduce her likelihood of severe illness by around 13 percentage points compared to the current pathway, and reduce treatment costs by $321,000 over nine years. The majority of this saving would be achieved through the patient experiencing fewer days as an inpatient in hospital.

Current regulatory restrictions preventing funds from covering medical services provided out-of-hospital and covered by Medicare preclude funds from covering most of the services in the optimal care pathway. As such, funds are unable to provide these optimal clinical offerings to their members.

---

[2] Buhagiar, M. *Effect of inpatient rehabilitation vs a monitored home-based program on mobility in patients with total knee arthroplasty* – JAMA, 14 March 2017

[3] Naylor, J. *Most private patients are wasting money on costly rehab after major knee surgery* – accessed 28 February 2018 at https://theconversation.com/most-private-patients-are-wasting-money-on-costly-rehab-after-major-knee-surgery-83958

Table 8.1: Severe bipolar disorder care pathways

	Units	Current	Optimal
GP	Visit	12	17
Psychologist	Visit	4	12
Psychiatrist	Visit	12	12
Endocrinologist	Visit	4	4
Dietician	Visit	12	12
CMHT	Visit	24	24
Acute inpatient	Days	60	30
Sub-acute inpatient	Days	30	15
Residential	Days	10	-
Ambulatory services	Visits	24	-
ED	Visits	10	6
Care coordination	Hours	100	100
Psychosocial support	Hours	100	100
SSRI/SNRI	Weeks	8	-
Benzodiazepine	Weeks	4	-
Olanzapine	Weeks	40	-
Lithium carbonate	Weeks	50	52

Source: KPMG's clinical expert survey.

Elimination of perverse incentives to utilise hospital care

Since the advent of Medicare as defined in the *Health Insurance Act 1983*, legislation specifically prevents private health insurers from covering medical services that are provided out-of-hospital and covered by Medicare. This includes GP visits, consultations with specialists in their rooms and diagnostic imaging and tests.

The intent of this measure was to prevent inflationary pressures from a second payor being involved in fee-for-service care in an environment marked by barriers to entry. Over time, this has however created a strong perverse incentive to default to more expensive treatments and the most expensive setting of care, i.e., in-hospital care. Increasingly, a number of procedures and treatments are occurring in hospital settings when they are, in fact, designed to be performed as outpatient procedures. This is clearly negative for patients' experience and is putting upward pressure on PHI premiums.

PHA recommends that the outdated regulatory restrictions on hospital funds funding care outside hospital are removed with a view to permitting negotiated agreements covering consumer out-of-pocket costs in community settings.

Impact for patients and the health system

This would:

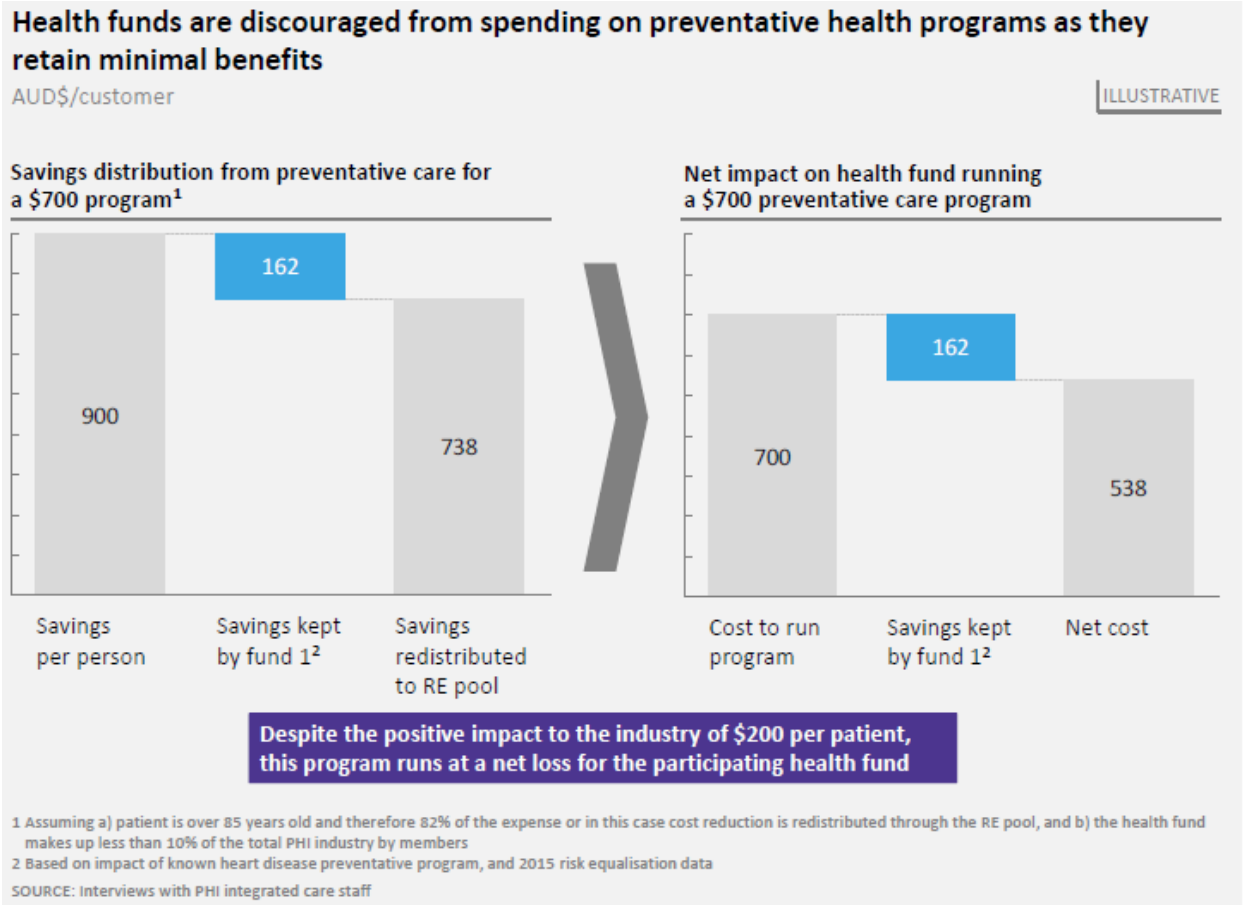
- Ensure that patients are treated in the most appropriate setting for the conditions or treatment they require – not only is this appropriate but is likely to enhance a patient's experience;
- In many instances, deliver savings to the patients via lower out-of-pocket costs;

- Avoid the current system whereby higher payments are being made for treatments delivered in hospital settings when those procedures and treatments could be delivered more appropriately in a lower cost environment; and
- Deliver cost savings and put downward pressure on premiums.

Example – preventative health

Currently, a health fund that invests in a preventative health program would decrease its benefit payments but, due to the cost of running the program, increase its management expenses. Since the former is used to calculate an insurer's risk equalisation transfers, health funds that invest in preventative or chronic care programs would reduce their 'risk' according to the current process and, therefore receive less funds from the risk pool. This means that health funds that invest in preventative health programs subsidise those health funds that do not invest in preventing the deterioration of their members' health.

The exhibit below demonstrates how this flows through in practice and the structural disincentive that therefore exists to funds' increasing their preventative health programs. This not only impacts the health fund but, should they not offer these programs, the health of their members and the overall cost to the health system as well.



Example – services provided to patients in specialists' rooms

Many medical practitioners can provide services in their consulting rooms that might otherwise require admission to a hospital. Provision of these services in a practitioner's room cannot be rebated by PHI funds despite the relevance of these services and the ease and convenience of these services being provided to patients outside a hospital setting.

Urologists can, for example, with the right equipment and set-up, perform cystoscopies (MBS item 36812) in their rooms. Where this is done in a hospital setting, it attracts a Medicare fee and PHI rebates (one large insurer apparently pays around $900) but also involves greater inconvenience for the patient as they need to be admitted, pay an excess and arrange time for a hospital visit.

This procedure can be undertaken in a surgeon's rooms but, where that occurs, there is no PHI rebate to the patient or clinician and the clinician or patient needs to pay for the consumables. Usually there would be an out-of-pocket expense for the patient as well.

Performing the procedure in a surgeon's room is quicker and can be done on the spot but, given the financial incentives and depending on the level of patients' excess, patients and doctors may choose for this procedure to be performed in a hospital.

Building on the initial reform of the Prostheses List

PHA has recommended a raft of structural measures that would extend the strong work begun on Prostheses List reform and capture both the savings and efficiency gains remaining in the system. Many of these reflect recommendations made by Professor Lloyd Sansom, Chair of the Industry Working Group on PHI and Prostheses List pricing in 2016.

Some of these measures include: regular benchmarking with the prices of older established products; the introduction of price disclosure; stricter controls on the support and other benefits provided by manufacturers and suppliers to providers; and a more rigorous evidence base, including an effective post-marketing surveillance on all implants with formal registry data required for new implants.

Savings achieved from these measures would not only flow through to consumers through their premiums but also the Federal Government via the procurement of medical devices by the Department of Veterans' Affairs and through lower prices achieved in the public sector.

Impact for patients and the health system

- Lower PHI premiums;
- Helping maintain the sustainability of Australia's mixed public-private healthcare model; and
- Achieving more appropriate prices for prostheses.

Example – impact of changes to date

In its submission to the Senate Inquiry into the Value and Affordability of Private Health Insurance in 2017, Medibank indicated the real difference that reform of the Prostheses List can make to premiums, commenting that their 2017 premium increase – the lowest in 15 years – was 35 basis points lower than it otherwise would have been due to reductions of some prostheses prices.

The company noted that, in the 2015-16 financial year, they spent $540 million on prosthetic devices and that the price reductions made resulted in $24 million of savings to their customers, all of which were fully passed on.

Medibank further noted that further regulatory reform of prostheses pricing was essential to keep private health insurance premiums affordable and that a reference pricing system – using domestic and international benchmarks – would assist in this.

Example – requirement for ongoing review

Bupa's submission to the 2017 Senate Inquiry into the Value and Affordability of Private Health Insurance also raised the issue of prostheses pricing and noted the changes made to that point.

Bupa further used the example of a standard branded ceramic hip to highlight the price differentials at play in Australia. This hip can be purchased by the Prince of Wales Public Hospital in Sydney for $4,900 whilst the private hospital nearby is forced to pay $11,000 for it – an increase of more than 224%.

Bupa also pointed to the example of their private hospital in London which pays GBP16,448, or the equivalent of A$27,000, for a St Jude Medical pacemaker. In Australia, the same device is listed at a mark-up of 95% or $52,750.

Like Medibank, Bupa has passed all savings achieved through prostheses reform to date back to their customers and highlighted the above as an opportunity to capture further savings in this area.