Inquiry by the Senate Finance and Public Administration Committee into the National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011

Submission by Medibank

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Medibank welcomes the Finance and Public Administration Committee's Inquiry into the *National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011* and the opportunity to provide this submission. Medibank supports measures that will deliver greater transparency and efficient use of health resources provided people's confidence in the system is maintained.

Australia has one of the best health care systems in the world, with quality health care being delivered at modest cost by comparison with some international health care systems. This has been achieved using a mix of interrelated public and private health care providers and funders. The private sector is an essential component of the Australian health care system and provides health care services through private inpatient hospital services and out-of-hospital medical practitioners such as general practitioners, specialists and allied health care professionals. The private sector also supplies pharmaceuticals, medical devices and prostheses.

Private hospitals provide high-end acute care services across all types of procedures. For procedures where public sector waiting lists are long, such as hip replacements, knee replacements and lens insertions, private hospitals provide the bulk of procedures[1]. In this respect, private hospitals substitute directly for public hospital services and deliver improved timeliness of patient care.

The 2009 Productivity Commission report into public and private hospitals noted that there are many instances where public and private hospitals offer substitutable services[2]. The most frequent types of same-day separations in both sectors are renal dialysis, chemotherapy, non-complex colonoscopy and lens procedures although the respective order of frequency in each sector varies slightly. The Productivity Commission noted that a number of private hospitals display features typical of larger public hospitals. In 2006-07, 47 private hospitals treated accident and emergency cases, of which 24 had formal emergency departments, and 47 provided teaching to medical staff and undergraduates.

The Productivity Commission also found that there were significant differences between public and private hospitals in the composition of costs. Almost 75% of surgical diagnostic related groups (DRGs) have a lower cost in private hospitals compared to public hospitals and nearly half of all DRGs investigated have higher average costs in public hospitals of greater than 10%.[3] The report also found that private hospitals had lower infection rates and lower rates of adverse events together with leaner staffing levels and shorter lengths of patient stay.[4]

About Medibank

Medibank is Australia's largest integrated private health insurance and health services group.

We have been providing health insurance to Australians since our inception in 1975 and currently cover 3.4 million members, equal to 32% of the national private health insurance market. In addition to our resident members, Medibank also covers over 200,000 overseas visitors and students and provide access to life, pet and travel insurance.

In the last two years, we have undergone a significant transformation, growing the role we play in our customers' health and evolving into a provider of broad range of health services, including mental health services.

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[1] 'Performance of public and private hospital systems', Access Economics (2009)
[2] Productivity Commission research study into public and private hospitals (2009) pp.XXXVI
[3] The Report also indicated that around 20% of DRGs had a lower cost of at least 10% in public hospitals when compared to private hospitals.
[4] Productivity Commission research study into public and private hospitals (2009) pp.XLVII

In 2009, we acquired Wollongong-based private health insurer Australian Health Management (ahm) and merged with another Government Business Enterprise, Health Services Australia (HSA). Renowned as a leader in customer service and customer satisfaction, ahm introduced around 200,000 people to our customer base. More importantly, it also brought ahm's pioneering health coaching and disease management business, Total Health, into the Medibank family.

The amalgamation of Total Health and HSA, together with Medibank Private's legacy health and wellbeing programs, led to the creation of Medibank Health Solutions, energising our health services capability and marking our transformation into a health company.

Following this, in 2010, we acquired the telephone and online health service provider, McKesson Asia-Pacific, further expanding our health and wellbeing capability. As a result today, we offer one of Australia's largest range of telehealth programs, ranging from online health and wellbeing services to help individuals achieve their health goals through to intensive telephone based support services for people living with chronic disease and mental illness.

Medibank purchasing

On behalf of our members, Medibank purchases 670,000 overnight hospital procedures and 380,000 same day hospital procedures each year. We also pay $3.9 billion in hospital, medical and allied health benefits for our members each year – this involves the management of 1.1 million hospital claims, 2.7 million medical claims and 8.3 million ancillary claims on behalf of our members each year.

As outlined below, Medibank has undergone a significant journey in relation to achieving more effective purchasing from hospitals. This has involved developing holistic models that take into account how funding models drive certain behaviours and deciding whether those behaviours are ones we want to encourage. Medibank's experience would indicate that any attempted changes to hospital pricing and purchasing arrangements requires clarity of purpose, a significant investment of resources and an ongoing commitment of time and energy.

Medibank's comments

1. Pricing and efficiency

The key element in setting pricing is good data sets, not simply of pricing information but also clinical usage and clinical outcomes. It is not currently clear how the Pricing Authority will collect data or how it will test its efficacy nor is it clear if the Authority will be focused on encouraging enhancements in innovation or efficiency linked to good clinical outcomes. Currently none of the parameters which will guide price setting have been clarified or communicated whilst the Productivity Commission[5] has highlighted the real risk that the Authority may inadvertently drive inflation – through uncertainty about the flow on impact to private hospitals from price signals that will be set in the public system - rather than improve efficient resource usage.

Price and performance in isolation should not be the sole factors used to determine conclusions about hospital efficiencies. In its broadest sense, health care efficiency is a measure of the relationship between health care outputs and inputs. Outputs include health care services themselves and other health care system attributes, such as access to care, choice, and continuity of care. Inputs comprise resources used to produce health care services, such as labour (e.g. doctors, nurses, allied health care workers, administration staff, etc), infrastructure (e.g. medical equipment, and buildings), and land.

[5] Productivity Commission research study into public and private hospitals (2009) pp.XLVII

The Productivity Commission noted that hospital and medical costs for clinically similar procedures, based on the Australian Refined Diagnosis Related Groups or 'AR-DRGs', should be used as partial performance indicators for hospital services. They point out that a simple comparison of costs across selected ARDRGs does not however measure the relative performance of a hospital. Performance is determined by measuring the quality of services delivered for a given level of cost.

Misleading conclusions can be created by simply using cost measures when determining the relative efficiency of hospitals, for example, a more costly hospital may be deemed a poor performer when it is actually performing better than other hospitals measured against the quality of care delivered and the resulting health outcomes. Using a relative cost comparison to measure performance can bias decisions in favour of low-cost providers of hospital services, regardless of the cost effectiveness of those services.

Conclusions derived from cost indicators and all performance indicators are complicated by variations in the severity of conditions and co-morbidities within each procedure. Health outcomes depend on a multitude of factors in addition to inpatient care, such as the demographic and case-mix profile of the patient, and health behaviour after a hospital separation. These need to be considered when measuring the performance of a hospital. A hospital that is identified as high cost whilst delivering below average health outcomes may be performing well when proper account is taken of the complex case-mix in the population it services, such as a high number of chronic conditions or which exhibits a number of co-morbidities e.g. diabetes and obesity.

Measuring the performance of hospitals should be based on meeting society's health care preferences more broadly, including health outcomes and additional attributes of care valued by consumers, family and friends. Significantly there is no reliable Australia-wide data that allow direct comparison of non-health outcomes across hospitals.

Further work is needed to develop performance indicators that appropriately measure health and non-health attributes of care, along with investment in the collection, analysis, interpretation, and dissemination of hospital performance data for both public and private hospital systems.

2. Private and public sector purchasing of services

The process used by the private health insurers to purchase health care services from private hospitals and other health care providers introduces competition into the health care sector and generates an incentive for hospitals to reduce cost growth and improve health care quality. As such, there are broad indications that private hospitals are an efficient supplier of health care services when compared with public hospitals. For general hospital costs, public hospitals were estimated to have a higher cost per casemix-adjusted separation than private hospitals - $2552 versus $1953 at the national level. This was also the case with the experimental estimates of capital costs - $426 versus $230. Although conversely, average prostheses costs were estimated to be much lower in public hospitals - $131 versus $542. Average medical and diagnostics costs were also estimated to be lower in public hospitals - $798 versus $1346.[6]

There are significant differences in the comparability of cost data across public and private hospitals. Public hospitals and some charitable, not-for-profit private hospitals are exempt from State payroll tax and local government rates, as well as enjoying concessional fringe benefits tax arrangements, whereas private hospitals pay these taxes. The public system has significant management overheads because of the large administrative structures which oversee public

[6] Ibid pp.XLI

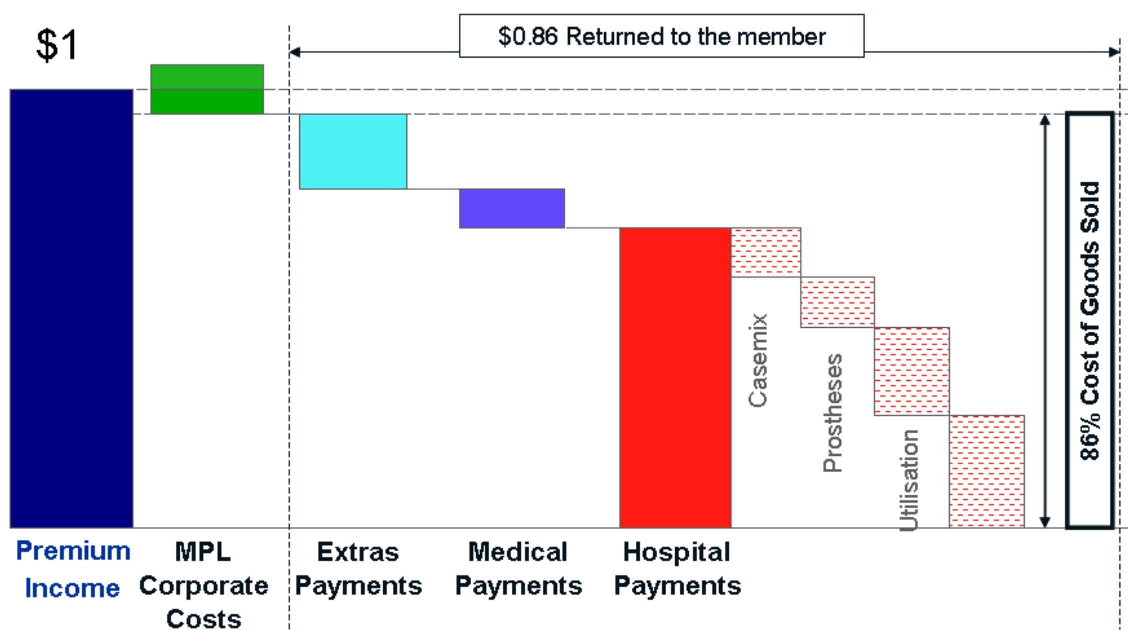
health care and the associated demands for information and accountability by central agencies at Commonwealth and jurisdictional levels.

Different jurisdictions have different arrangements in place for public hospitals to access capital. In general, public hospitals have favourable borrowing arrangements, underpinned by the debt ratings of the relevant jurisdictional government. Furthermore, most jurisdictions do not require public hospitals to account for the cost of capital or require a return on invested capital. Private hospitals explicitly incorporate the cost of capital within total cost. They also need to generate a return on investment commensurate with their market risk. Alternative measures of the cost of capital will affect the perceived level of relative efficiency within the hospital sector.

These issues complicate a direct comparison of technical efficiency between public and private hospitals, however the move, even if gradual, to full activity-based costing including capital expenditure should make comparisons easier.

3. Negotiating with hospitals
In 2003, Medibank started a journey to restructure its approach to hospital purchasing to maximise its purchasing effectiveness and control its growth in benefit outlays. At that stage, Medibank was a price taker with limited purchasing capability and understanding of the key drivers. Purchasing arrangements were disparate, state based, had large variations in price points and utilised predominantly per diem funding models which created perverse incentives for hospitals, particularly with regard to efficiencies. There was little consistency or coherency concerning the role of quality and safety.

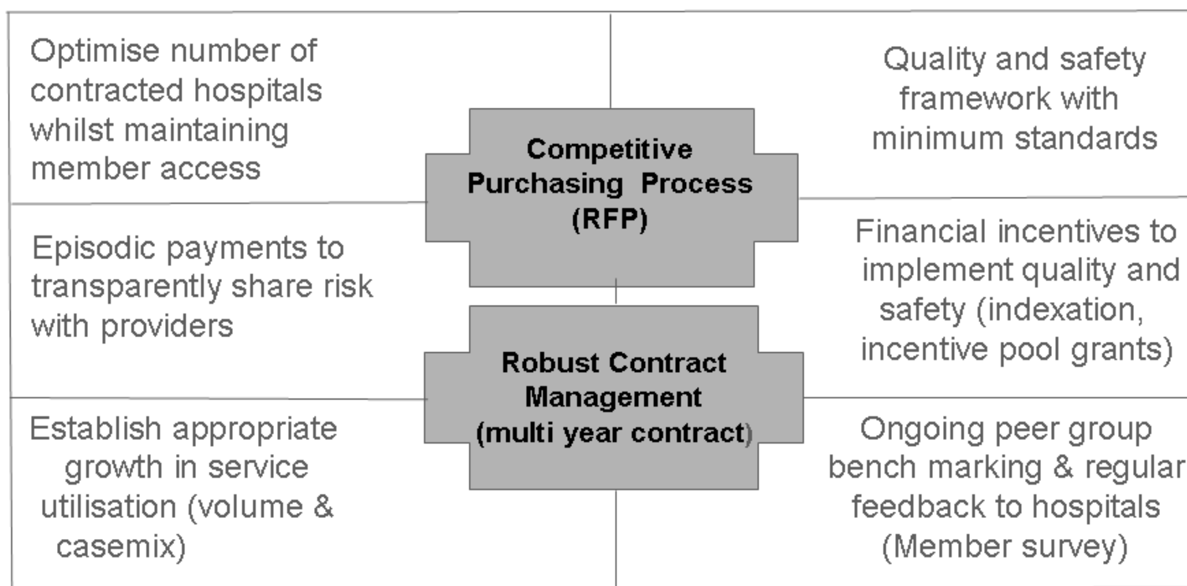
The importance of improving Medibank's purchasing effectiveness is clearly demonstrated by the following graph which highlights that 86% of Medibank's income is returned to members as benefit outlay. Key elements that contribute to outlays are price, utilisation, prostheses and casemix.



Medibank's aim in changing our approach to hospital purchasing was to reform our approach and become an effective purchaser whilst maintaining and enhancing the member value proposition. Improving member value through controlling price increases, maintaining appropriate prices and promoting improved quality and safety were all important and needed to be managed concurrently.

Medibank's Quality and Safety framework combined with funding for quality programs has been critical in driving better clinical outcomes for our members.

Elements of the purchasing framework included:



A key element of the new funding model has been the move to a case weighted episode of care. This is important as it provides a clinical link to patient care and means that one price point can be used for each provider and reflects their case mix. It also provides a funding mechanism that can easily be changed as new case weights are introduced or weights change as clinical care evolves. This recognition of the role of clinical care is critical to the model and to patient outcomes.

Significant gains can be achieved in purchasing by adopting a pricing model which allows for ease of comparators as it reduces the impact of "data" noise. As this adjusts for clinical case mix, price comparators can be used effectively.

<u>In conclusion</u>

Medibank employs an experienced and expert team that purchases hospital services with the utmost scrutiny and rigour. Its expertise extends to contracting for appropriate prices and services, controlling price increases and promoting improved quality and safety.

These matters need to be managed on an ongoing basis as this process is an evolving one that requires constant attention and resourcing. The key to effective price control is good quality data sets that are linked to clinical usage and clinical outcomes.

There are many instances where public and private hospitals deliver the same services. The key difference between the two is that the private system has much more complicated casemix systems in place and can control costs more effectively.

Medibank welcomes the opportunity to share our experience with both the Committee and the Authority and would be happy to discuss our submission further.