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Submission to House of Representatives Standing Committee on Health and Ageing Inquiry into Health Funding

The funding of Australian health care: modified payment systems and new economic incentives can reduce inefficiencies, promote safer and more appropriate hospital care, and reduce the future burden of major chronic conditions

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[1] Director, Institute of Health Economics and Technology Assessment, Australia, France and Greater China, and Honorary Professor, University of Hong Kong. Parts of this paper were included in an invited address at the Harvard Club in Sydney on 13 July 2005, and in a second invited address at the Parliamentary Library on 30 November 2005. Parts of this paper have been published in the *Sydney Morning Herald* on 9 June 2005, p 17; and in an op-ed piece in *Australian Financial Review* on 29 September, 2005. Parts 4 and 5 draw from a forthcoming book on the costs of benign policies for obesity in Australia.

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EXECUTIVE SUMMARY

Some evidence of inelegance in the current funding mechanisms

Anyone wanting to argue that the Australian health system is the best in the world or does not need restructuring is least guilty of ignoring the evidence, including the latest data of the independent Commonwealth Fund in April 2006, that there are serious unresolved problems in patient safety, clinical quality, efficiency and a chronic illness burden that is growing without effective policies.

In **PART 1**, I review data that have preceded this latest reminder of specific funding and payment issues to identify some issues that go to the heart of the Committee's terms of reference.

Some major conclusions relating to the five terms of reference

This submission makes the following statements about each term of reference of the Committee.

Term of Reference "a" (the overlapping roles of governments) and "b" (simplifying funding arrangements)

Structural solutions are often proposed to overcome the overlaps of three levels of government in healthcare. In **PART 2** I focus on two radical proposals that are non-starters as solutions to the health financing and efficiency gaps in Australia, viz., (1) proposals to create a fourth arm of government to exact efficiencies in health care, and (2) an vestige of the MedicareGold proposals that would move Australia towards a single payer government like the Canadian Medicare scheme before a pivotal 2005 Supreme Court decision.

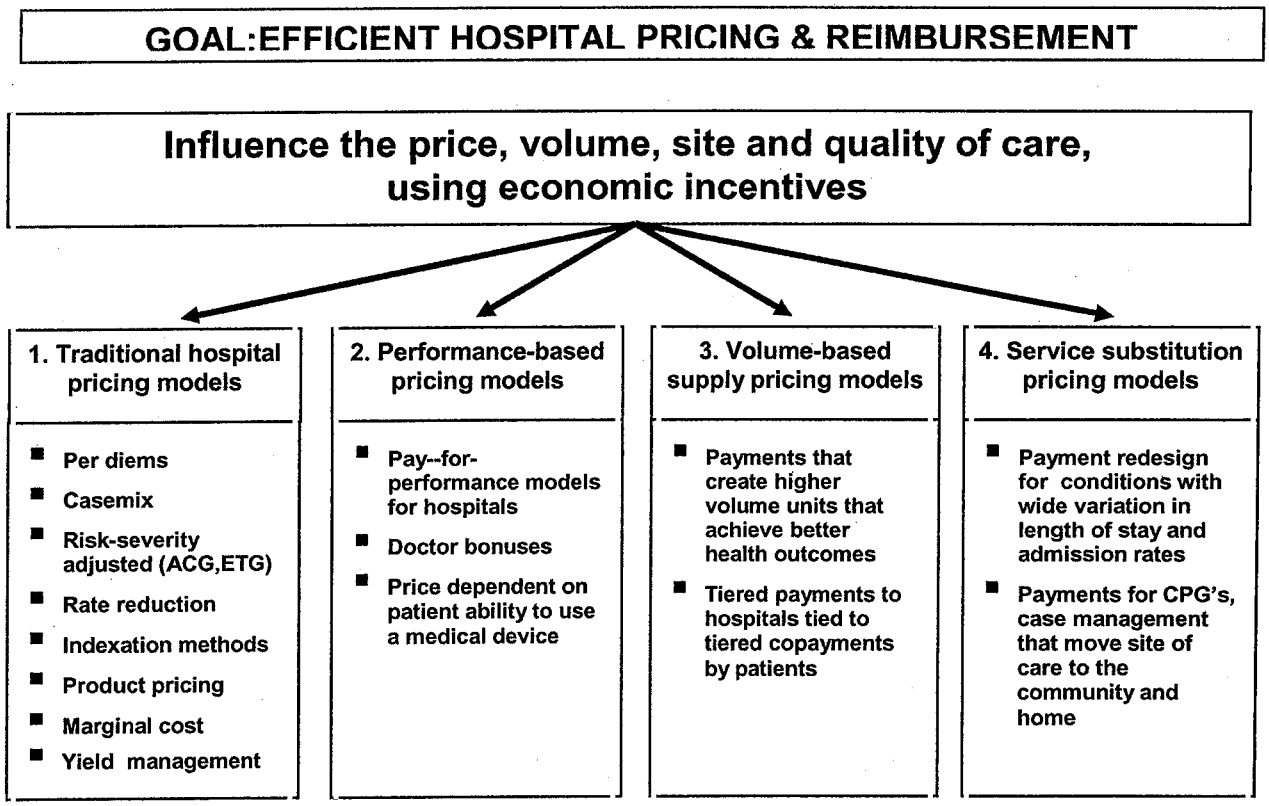
Terms of reference "c" (improving accountability for quality care in public hospitals and medical services) and term of reference "d' (enhancing strong positive relationships between major actors in the public and private health sectors)

In the absence of policies in force in other nations, I estimate specific inefficiencies consume at least 15 per cent ($12 billion) of the estimated $86 billion that will be spent on Australia's healthcare system this year.

I present evidence in **PART 3** suggesting that three sources of inefficiency and ineffectiveness need to be addressed by the Standing Committee:

- the inappropriate use of hospital care in an ageing society with a growing chronic care burden,
- the measured inefficiencies that exist in payment systems that pay for good and poor quality hospital care, and
- inappropriate regulatory constraints on the design of more appropriate health insurance.

I focus attention on one immediate reform, now underway in three nations and in our Department of Veterans Affairs, to enhance accountability in hospitals and medical care. A pay-for-performance addition to Australia's imperfect casemix payment of hospitals would pay more to high quality hospitals, and over time, it could change the price, volume, quality and site of care to ensure better use of scarce hospital resources. While the first column below covers today's most used hospital reimbursement models, the last three columns represent models that can help ensure a more efficient hospital system.



Listed in the newer provider payment currencies above (not just the pay-for-performance pricing models in column 2) are strategies that pay more for higher quality care, including, in column 4, care based on evidence-based guidelines that doctors and PHI companies develop together, and which are now being shared with patients so they can recognise "quality" and buy access to quality care. The criteria used to calculate the additional payment for higher quality include:

- measures of *efficiency* such as whether lengths of stay are in line with world best practice or within the 90th percentile band of efficient stays by similar hospitals;
- measures of *patient safety*, such as whether hospitals had in place protocols that prevent falls in the elderly or require prophylactic use of antibiotics before certain types of surgery whose infection rates are known to be reduced by antibiotic use;
- measures of *effectiveness of hospital care*, such as whether appropriate patients admitted with an acute myocardial infarction were given beta blockers within a certain time after admission, and made available at discharge;

- measures of the *patient satisfaction* with the care given during hospitalisation; and
- measures of *coordination of the care of patients with chronic conditions* that require close attention back in the community after discharge, and which require the patient to take appropriate drugs after discharge.

Those hospitals that achieved threshold levels on each criterion might receive a 2-4% increase in their case-mix payment (DRG in Australia) for all patients affected by the criteria. The measures require neither huge bureaucracies nor huge bands of travelling auditors checking medical records. They DO require intense dialogue between all actors, and they can, in time, educate consumers to be more astute payers for their care. In other nations, even in the free-market US health system, the medical profession in general and specialist practices have embraced them and are receiving higher payments based on measured quality of care.

Sadly, of all government departments in Canberra only the Department of Veterans Affairs (DVA) has any clear, practical strategy to lift quality and patient safety in hospitals offered DVA contracts. It has done so by leadership that says: we cannot go on paying the same dollar for good and poor hospital care, which is exactly what happens under the current funding by the casemix payment system.

Terms of reference "d' (enhancing strong positive relationships between major actors in the public and private health sectors) and "e" (making private health insurance more attractive to the uninsured)

In 2005, the Deputy Governor of the Reserve Bank warned the government that if we all live five years longer as a result of advances in medicine, we will need to save more during our working lives or earn 0.5-0.75% more interest each year on our savings over our working lives.

From whence can we achieve such a boost while improving the efficiency of health insurance? One alternative that could justify the 30% rebate as an incentive to increase the national savings ratio would involve an approved Medical Savings Account (MSA) that can pay for:

- a mandatory high deductible, minimum coverage health insurance plan that allows new incentives (including no-claim bonuses) to reduce risk factors and trivial claims;
- at the insuree's informed choice, an optional catastrophic plan that covers high-cost care at a lower premium than today's insurance; and
- the insuree's choice to meet copayments imposed at the point of service from the MSA.

If COAG is to have any credibility in the reform process, its members must offer visible leadership that affects both the government and private health sectors. That means embracing the private health system in a rapid review of alternative policies, having regard to collaborative review processes now underway elsewhere. The latest COAG Working Party report lacks credibility in its speed of analysis and its often piecemeal conclusions. The US Commonwealth Fund creation of a Commission on

High Performance Health Care might be a consensus-gathering model that is worthy of review by the Standing Committee.

In **PART 5**, I expand some of my arguments in **PARTS 3 and 4** to address the second last concern of the Standing Committee, viz., sustaining a strong private sector working with the Medicare system in which the economic incentives that currently drive patients towards expensive hospital care as a last resort are replaced by incentives to (1) reduce risk factors that cause hospitalisation and (2) seek more appropriate care outside the hospital walls. I outline

- the goals of a health system that provides new incentives for prevention and appropriate care; and
- a modified Medicare system, linked to private health insurance, which uses economic incentives to providers and patients to use care appropriately and efficiently.

FOCUS OF THIS SUBMISSION

Terms of reference of the Standing Committee

The House Standing Committee on Health and Ageing, in its inquiry into health funding, is required to "*...inquire into and 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*".

Noting Australia's "...strong mix of public and private funding and service delivery", the Committee will give particular consideration to:

a. examining the roles and responsibilities of the different levels of government (including local government) for health and related services;
b. simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;
c. considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;
d. how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government; and
e. while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

Because these roles have been traversed in many reports in recent years, I believe that there is no useful purpose in examining again the roles and responsibilities of governments if the over-riding concern of the Committee is with actions that the Commonwealth government should take to reduce the inelegance of the current health funding mess and the inefficient use of existing hospital resources.

Therefore except for my comment in **PART 2** on the concept of a Health Reform Commission as a solution to the role overlap problem, I focus mainly on the last four considerations (b)-(e) above.

Structure of this submission

I structure my major arguments in the following fashion

First, I summarise the problems not yet comprehensively addressed in the health system. I identify gaps and inefficiencies that should be the concern of the Committee before it asks what should be the role of any government, and how the private health sector should be engaged in overdue reforms that the Commonwealth can and should initiate (**PART 1**).

Second, I focus on two radical solutions that have been advanced to restructure government responsibilities and funding channels, viz., a fourth level of government in an independent Health Reform Commission, and a single-payer government-run (or controlled) health financing system. Since both create a greater role for governments, I reject both as solutions to the funding gaps even if they might tinker with some of today's inelegant funding overlaps. I draw on experience worldwide and

the impracticalities in the Australian health system where there is a large, growing and often-neglected private health sector that the Commonwealth government must involve in any payment and reimbursement reforms. The current structure of COAG, with no private health sector representation, is a vestige of another era, and we need a different approach to policymaking that harnesses the private health sector (**PART 2**).

Third, I summarise Australian and overseas experience in enhancing accountability by new strategies to increase efficiency and improve hospital quality and patient safety. I provide estimates of the share of total national health expenditures that are wasted in one of the highest use rates of acute hospitals and medical errors. I argue that it is benign neglect to allow such waste to continue when we have funding shortfalls and when leadership by the Commonwealth can embed new incentives in payment systems to all acute hospitals to reduce both forms of waste. I propose three actions for consideration by the Standing Committee (**PART 3**).

Fourth, I consider the inefficiencies that arise in private health insurance and identify ways by which the 30% rebate can be better targeted to attain better health outcomes while reducing our current over-reliance on hospital care. I draw on my recent experience in four nations that have restructured parts of health insurance to allow medical savings accounts, and I report some early results of these new health insurance plans on savings behavior, use of hospital and specialist medical services, and changes in patient lifestyles caused by the embedded economic incentives to reduce risk factors and chronic conditions. At the very least the Standing Committee should assess how such schemes can inform consumers about how to buy high quality hospital care (**PART 4**).

Finally I summarise my preferred route to gradual restructuring of, not dismantling, Medicare and private health insurance. I use obesity as an example to illustrate why such changes should not occur piecemeal (our long-held preferred strategy for most health-related policies- and a major cause of the current inelegance of healthcare funding), and why they should occur rapidly given my recent estimates that obesity and overweight are consuming at least 6% of national healthcare expenditures in 2006. At the very least, the Standing Committee might consider the hospital care burden that faces us if we allow obesity to go unchecked (**PART 5**).

1. HOSPITAL AND RELATED HEALTHCARE REFORM PROPOSALS: WE KNOW THE PROBLEMS BUT AVOID HARD SOLUTIONS

1.1 Is the healthcare system in crisis, or just inelegant in its funding?

Despite the many achievements of Australian health care and medical research, any parliamentarian wanting to argue that the Australian health system is the best in the world or does not need restructuring is at least guilty of ignoring the evidence that there are serious unresolved problems. Two reports by the independent New York-based Commonwealth Fund in 2005 and 2006 dispel any complacency.

On 4 November 2005, the Commonwealth Fund released yet another report based on its cross-national surveys of health systems.[2] An earlier report of the same Fund in 2003 had warned us that our care of the chronically ill was inefficient and worrying to the punters. This 2005 survey of about 700 adults in Australia tells us that things are no better. 8% had an infection while in hospital, 20% (the highest in the 6 nations surveyed) went to an ER or were readmitted to hospital as a result of complications during recovery, only 57% of the patients with diabetes had their feet examined in the past year, and 27% reported coordination problems when multiple doctors were involved in their care.

In April 2006, the Commonwealth Fund released its latest report[3] on the relative rankings of six nations using the following six criteria reported by the sickest in each nation.[4]

The Australia ranking (1= best, 6 = worst) is shown below:

- *Patient safety* (measured by the receipt of wrong medications or doses, incorrect test results and notifications about abnormal results): 4
- *Effectiveness of care* (prevention, chronic care, primary care and hospital care, and overall coordination of care): 4
- *Patient-centredness* (measured by patients rankings of the quality of their medical care along the dimensions of communication, continuity of care, patient engagement and responsiveness to patient preferences): 3
- *Timeliness of care* (measured by patients reporting the least difficulty in getting a specialist appointment or have emergency or elective surgery): 4
- *Efficiency of care* (measured by four questions on coordination of care): 4
- *Equity of access to care* (measured by nine measures that assessed whether patients did not receive needed care because of cost barriers): 2

Whatever else these data suggest, they render suspect any claims that we have a health system that is applauded by the sickest. Even on the equity of access criterion where we had an overall rank of 2 out of 6, we ranked 4 on the measure of whether

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[2] C Schoen, R Osborn, PT Huynh et al.," Taking the pulse of health care systems: experiences of patients with health problems in six nations". *Health Affairs Web Exclusive* 2005; W5-509 to W5-525, 3 November (downloaded 4 November 2005 from www.healthaffairs.org).

[3] Source: K Davis et al. "Mirror, mirror on the wall: an update on the quality of American health care through the patient's lens". New York, Commonwealth Fund, April 2006, 26 pages.

[4] The sample sizes contacted in a national telephone survey were 1,400 Australians in 2004 and over 700 in 2005.

patients did not get the recommended test, treatment or follow-up because of cost. The rising copayment burden in Australia may have been partially ameliorated by the 2005 safety net reforms for medical costs and by earlier PBS safety net provisions for PBS drug copayments.

However, this latest survey tells us that 1 in 4 of the sickest patients interviewed is not accessing needed care, with access barriers partly caused by copayments. These sick patients are also trying to warn us that we need to respond to the low rankings on other criteria.

The findings of these latest two Commonwealth Fund reports should be juxtaposed against

- the blow-out in the Medicare safety net payments within 1 year of the 2004 election, one small indicator of the hidden chronic illness burden;
- flaws and gaps in the mental health system reported in October 2005, and only partially ameliorated by strong Prime Ministerial leadership in April 2006 to add $1.8 billion over 4-5 years;
- ten years of delay in implementing patient safety measures in hospitals, confirmed by the first report by the Australian Council on Health Standards (ACHS) on 24 June 2005, and the May 2005 report by the Australian Institute of Health and Welfare showing that the reported medical error rates in public and private hospitals are 5.4 per cent and 3.6 per cent, respectively;
- the April 2004 report by the Royal Australian and New Zealand College of Radiology noting major gaps (still unfilled) in patient access to radiotherapy (RT) for cancer patients;
- the second report on *State Of Our Public Hospitals* in June 2005 showing that elective surgery admissions were low and waiting times were high in NSW, despite the state's higher than average bed-to-population ratio;
- the clarion call[5] in September 2005 by the Editor of the *Medical Journal of Australia* for reforms in patient safety that include the generation of national data on defined clinical outcomes;
- three newspaper reports on a single day in November 2005 telling us that fewer people were admitted to Queensland public hospitals but the mortality rates were rising as were the complication rates),[6] Hobart's major teaching hospital had lost its only neurologist (there is no stroke unit in the teaching hospital!),[7] and the CEO of this hospital was removed but the resource constraints and staff shortages remain untouched (is any federal politician asking what are the implications for the current health manpower shortages and for quality care if the clinical school deteriorates further?);[8]
- the public statement in December 2005 by NSW public hospital clinicians that the hospital system is seriously sick; and
- the revelation in January 2006 by the Australasian College of Emergency Medicine that 6 of the 15 public hospital emergency rooms were unsafe due to

[5] MB Van Der Weyden." The Bundaberg Hospital scandal: the need for reform in Queensland and beyond". *Medical Journal of Australia* 2005; 183 (19 September): 284-285.
[6] J Sommerfeld." Fewer hospital patients, more deaths". *The Courier Mail* 8 November 2005.
[7] M Paine." Loss of last key doctor a disaster". *The Mercury* 8 November 2005.
[8] M Paine." 'Scapegoat' Royal boss moved aside". *The Mercury* 8 November 2005.

a shortage of doctors, and that all 32 Queensland public hospitals except Princess Alexandria, Southport and Cairns had inadequate staffing levels.[9]

Clearly we have shortfalls in funding, serious gaps in services, and waste in the form of medical errors in hospitals.

1.2 What funding and related issues should the Committee address?

Across the continuum of Australian healthcare, there are many concerns that justify public debate and decisive political leadership. The Standing Committee can initiate the policy review process by a decisive report on these matters. For example:

- Many state/territory premiers, willfully ignoring their GST windfalls, are pleading inadequate funding by the Feds for public hospitals[10] but ignoring the real issue: how do the states propose to keep their citizens healthy in an ageing society with more chronic illness when the staff shortages noted in the Hobart and Bundaberg situations remain unsolved?
- Worldwide, the public-private divide in healthcare is closing. Even in the EU nations that go back to Bismarck, governments are making better use of public and private hospitals. The soon-to-be-revealed COAG Working Party report[11] on healthcare reform, arguing that private hospitals are growing because of supplier-induced demand and that the 30% PHI rebate "represents poor policy and bad economics", flies in the face of this trend, and by failing to harness the private sector, is surely destined to become another report that "*...lies dormant on shelves in the corridors of power*".[12]
- The new core role of governments, state and local in particular, is better purchasing to keep their citizens healthy, and COAG has a crumbling legitimacy for as long as its member governments ignore this core role and obvious inefficiencies in care that must be redressed.
- In 2006, healthcare is an inefficient, inelegant mess costing $85 billion, and as a result it is under-funded by at least $6 billion. Included in that estimate is a $100-300 million shortfall in PBS funding of cancer drugs, based on data from a new European Union study of similar expenditures in 2002/03. Life-threatening conditions that are under-funded deserve Parliament's attention.
- Some obvious inefficiencies cost at least $12 billion of that $86 billion (i.e., 15%), including adverse events in hospitals, hospital acquired infections, inappropriate use of hospital beds by the elderly and chronically ill lacking access to more appropriate care,[13] and regulatory overkill by governments in the whole of the health sector.
- With removal of some (but not all) of this waste, we will slow the growth of national healthcare expenditures, but never to zero. Medicare's promises and covered benefits, designed in another era 30 years ago, need restructuring for the 21st Century.
- The unconditional 30 per cent PHI rebate, plus the Reinsurance Pool that buttresses the community rating principle, both pre-empt efficiency gains in hospitals, and they need re-targeting to pay for more appropriate, safe, high quality care.

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[9] J Sommerfield, M Daly and R Barrett." Patients abandoned". *The Courier Mail* 14 January 2006.

[10] The latest concerted bid by the states asks for an additional $2.7 billion from the federal government for infrastructure for public hospitals-see A Stafford and L Allen." States want $2.7 billion to fix hospitals". *Australian Financial Review* 24 November 2005, 1,60. That estimate should be compared with my estimate of $2.5 billion presented at the National Health Summit on 18 August 2003. I am inclined to believe that the true figure is now closer to $3 billion just for public hospitals with another $4 billion for other shortfalls noted in my August 2003 paper.

[11] J Dwyer." COAG diagnosis needs positive response". *Australian Financial Review* 14 December 2005, 55.

[12] ibid

[13] The latest indicator that our health system does not work well for the chronically ill was released by the Commonwealth Fund in November 2005- see: C Schoen, R Osborn, PT Huynh et al.," Taking the pulse of health care systems: experiences of patients with health problems in six nations". *Health Affairs Web Exclusive* 2005; W5-509 to W5-525, 3 November (downloaded 4 November 2005 from www.healthaffairs.org). A summary of some major issues is included in: PF Gross, SR Leeder, MJ Lewis." Australia confronts the challenge of chronic disease". MJA 2003; 179 (5): 233-234, accessible at: http://www.mja.com.au/public/issues/179_05_010903/gro10737_fm.html

- National savings rates are low, provision for care in retirement is heavily dependent on government budgets and out-of-pocket contributions, and new savings vehicles such a Medical Savings Accounts are feasible, with New Zealand becoming the fifth nation to offer them in July 2005. They may not work for everyone, and we need to protect the sick and indigent.

Governments have chosen not to address these issues through COAG or any other national public pulpit. Whilst as a whole the above list does not constitute a national crisis in health care financing, politicians of all persuasions would be delinquent if they ignored them.

Because incremental change is most likely to change this situation, most of my submission focuses on incremental solutions that are feasible without causing organizational and political mayhem.

I now turn to the Committee's terms of reference in **PARTS 2-5** below.

2. TWO RECENT REFORM PROPOSALS TO REDUCE OVERLAPS IN GOVERNMENT ROLES THAT WILL NOT IMPROVE HEALTH STATUS OR FUNDING SHORTFALLS

Overview

Because structural solutions are often proposed to overcome the overlaps of three levels of government in healthcare, I focus on two proposals that are non-starters as solutions to the health financing and efficiency gaps in Australia, viz., (1) proposals to create a fourth arm of government to exact efficiencies in health care (**Section 2.1**), and (2) any vestige of the MedicareGold proposals that would move Australia towards a single payer government like the Canadian Medicare scheme before a pivotal 2005 Supreme Court decision (**Section 2.2**).

2.1 A Health Reform Commission on top of three existing levels of government is not a solution, nor is the current COAG process

At the April 2005 meeting of the Harvard Club in Sydney, Professor John Dwyer outlined his concept of an Australian Healthcare Corporation (AHC) that would be superimposed on the existing three levels of government,[14] the top two tiers of which represented in COAG have thwarted any real attempt to improve efficiency, quality and patient safety in hospitals, or sought to involve the private health sector in its deliberations.[15]

A sister concept is the Federal-State Health Commission proposed by John Menadue. It would act as an honest broker to remove the impasses, blame-shifting and cost-shifting that are endemic in Australian federal-state relations.

The two concepts, both emerging in 2004, are summarised under, together with some queries:

	MY QUERY
	Where is the private health sector in this concept? How will the AHC will reform all care? How?
	If the States hand over hospitals to the feds, can Canberra run hospitals and ensure access to qualified surgeons ? Is Bundaberg better than Queensland Health? With what reform priorities in aged, chronic illness, end of life, and other care? Where is the private health sector in this concept?

Recently, a third proposition that the feds should run hospitals was advanced by the then-NSW Opposition leader[16], echoing earlier thoughts of Health Minister Tony

[14] Lest we forget local governments, the reader should note the position of local government funding of healthcare in Australia, having particular regard to the submissions of local government bodies to the House of Representatives Standing Committee on Health and Ageing- see the Committee website for all submissions.
[15] The forthcoming report of the COAG Working Party apparently does not improve this situation-see Dwyer, op cit
[16] John Brogden. "Government club overdue for reform". *Opinion, The Weekend Australian*, 24 June 2005

Abbott. Mr. Brogden was right to argue that the "government club" in COAG was overdue for reform, but his "solution" (a 15-year program of reform, including the Commonwealth taking over control of hospitals) involves glacial speed. Moreover, if the scrutiny of the State health department in Brisbane left Bundaberg Hospital's patients at risk to unsafe surgery, it is unclear how substitution of more distant Canberra bureaucrats would avert any clinical management problem in any Australian public hospital.

The following testimony of a senior officer[17] of the Department of Health and Ageing to our House of Representatives Standing Committee on Health and Ageing on 30 May 2005[18] shows why:

*"**CHAIR**—Within our system of checks and balances and the information that we gather, if one doctor happens to lose 87 patients over an 18-month period, would the Commonwealth have any method to pick that up and say that is out of the norm?*

***Ms Huxtable**—The actual management of the hospital system is very much a state responsibility. Under the health care agreements, what the states agree to in accepting the Commonwealth's contribution is to adhere to some basic principles around Medicare, which is about providing services on the basis of clinical need in appropriate times, and to public patients free of charge. These are the principles that underpin the agreements, but the actual management of the hospital system itself is the responsibility of the states and territories under the agreements.*

***CHAIR**—Do you think what has happened in Bundaberg is consistent with the agreement?*

***Ms Huxtable**—To what are you referring?*

***CHAIR**—I am referring to the Bundaberg hospital, where these 87 patients have died as a result of one surgeon.*

***Ms Huxtable**—I am not aware of the details of the case.*

***CHAIR**—Right."*

While this vignette is not sufficient reason to summarily dismiss the Brogden-Abbott proposals, I briefly assess the other two proposals.

At its core, the two proposals are basically an organisational response to government overlaps in healthcare policy, much like the National Hospitals and Health Services Commission was in its 1974 genesis.[19] However, the proponents of the AHC have given it wider powers than its 1974 predecessor because it

- would not be owned by either state or Federal governments (to whom is it responsible at the ballot box?);
- would be a semi-independent statutory authority (semi-independent of whom and for what?);

[17] Ms Rosemary Huxtable is First Assistant Secretary, Acute Care Division, Commonwealth Department of Health and Ageing, Canberra.
[18] House of Representatives Standing Committee on Health and Ageing. Proof Committee Hansard, Monday 30 May 2005, page HE3.
[19] I served as a Commissioner of that Commission under both Labor and Coalition governments, so I have a biased view on its relevance then and now.

- would be a State/Federal initiative much like the Water Authority (that initiative was born of a crisis in water supply, and no-one wants to admit to a crisis in healthcare, just its messiness);
- would be a consolidator of all existing federal government payments, including subsidies to public hospitals and private health insurance funds, into a single financial "pot" (so going against world trends, the AHC would become THE single government payer for all Australian healthcare); and
- would distribute the "pot" to central services and areas (shorthand for state governments and regional health authorities).[20]

The purported advantages claimed for the AHC are listed below, along with my comments on each claim:

End to blame-shifting	The blame shifts to AHC, then back to politicians when AHC cannot solve the political mayhem that regularly pervades the health sector when resources get scarce in a federal system, as in Canada today
End to cost-shifting	True
No further Australian Health Care Agreements; separate hospital funding becomes an anachronism	True
Patient-focused	With no choice of care provider, except that offered by the funded organisations?
Cost savings	Ignoring the deadweight tax burden of a tax-financed healthcare system?
Improved workforce morale	With private sector subcontracting and continued nurse shortages?
Improved quality and patient safety	From a bureaucracy in a tax-funded system with the Australian Council on Quality and Safety in Health Care as the slow driver of safety reforms?

On the last claim, the AHC or HRC concepts are irrelevant if, knowing that inefficiencies and safety problems in hospital care have gone untouched in Australia since the 1995 landmark study on quality of care,[21] they do not propose a specific, costed 2-year action plan to replace the current deadline-free activities of the

[20] The AHC proposal is short on detail about the criteria that would be used to share the "pot", and so the role of the private health sector remains unclear.
[21] Wilson RM, Runciman WB, Gibberd RW, et al. The Quality in Australian Health Care Study. *Med J Aust* 1995; 163: 458-471. <PubMed>

Australian Council on Quality and Safety in Health Care,[22] now replaced by a new Australian Commission on Safety and Quality in Health Care.[23]

How can any serious healthcare reform agenda of the Commonwealth Parliament and its standing committees, with efficiency and effectiveness as the prime concerns, stay silent on delays in access, clinical quality and patient safety in hospitals in the face of two more reports in June 2005?[24]

The first report by the Australian Council on Health Standards (ACHS) on 24 June 2005 gave us yet another warning about quality, patient safety and queues in our hospitals.

- 51% of the 670 hospitals reviewed by ACHS had inadequate systems to prevent adverse events to patients and staff, identify the near-misses, or manage the risks of litigation.
- Private hospitals had better performance measures than public hospitals, a situation also observed in the May 2005 Australian Institute of Health and Welfare report on Australian hospitals for 2002/03, when the reported adverse event rate for patients in public hospitals jumped from 5.1% in the previous year to 5.4%, while the rate for private hospitals stayed at 3.6%.[25]
- The ACHS also reported lengthening public hospital queues. 36% of cancer patients waited 21 days for radiation therapy in 2003, compared with 10% of such patients in 1997.

Deficiencies in the services available to these vulnerable patients had been made painfully clear in the April 2004 report by the Royal Australian and New Zealand College of Radiology which found major gaps in patient access to radiotherapy (RT) services in 2002:

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[22] An accurate depiction of the work of ACQSHC and the resulting gaps is given in: Ross McL Wilson and Martin B Van Der Weyden. "The safety of Australian healthcare: 10 years after QAHCS". *MJA* 2005; 182 (6): 260-261. Perhaps the Council has been too preoccupied with abstractions that either do not require hard decisions or real budgets for hospital IT that helps reduce errors- see its diagrammatic vision of the health system at: http://www7.health.gov.au/pg/sq/qalhlth.htm , and contrast this vision against the well-funded action plans of US health leaders such as Kaiser Permanente, the US Center for Medicare and Medicaid, and states such as Pennsylvania.

[23] Despite assertions by the Council's chairman, that "dramatic changes for the better are already occurring", the replacement of a Council by a Commission might accelerate the reforms that other nations implemented years ago. Some of those reforms are summarised in: GL Rubin and SR Leeder." Health care safety: what needs to be done? *Medical Journal of Australia* 2005; 183: 529-531.

[24] Andrew Wilson's report to the Review Team conducting the review of ACQSHC rightly concluded that the matter was one for national governance- see: A Wilson." National governance for leadership and coordination for safety and quality in health care in Australia? Brisbane, University of Queensland, January 2005, 28 pages. His paper should be contrasted with the simplistic checklist of questions posed in: ACQSHC.*"Patient safety management systems: a checklist*", 11 pages.

[25] The adverse event rate in New Zealand is 12.9% (Davis P, Lay-Yee R, Briant R, Scott A, Schug S. 2003. Adverse events in New Zealand public hospitals: preventability and clinical context. *Journal of the New Zealand Medical Association* 2003: 116 (1183): U624), which is broadly comparable with the Australian rate of 16.6% (later adjusted to 10.6% to render its methodology comparable with the original Harvard study of 1986), the UK rate of 10.8% and the Canadian rate of 7.5%. See also: :PM Layde et al." Medical injury identification using hospital discharge data". In: AHRQ. *Advances in patient safety: from research to implementation. Volume 2; Concepts and Methodology*, Rockville, AHRQ, February 2005, 119-132.; and P Davis, R Lay-Yee, R Briant et al." Adverse events in New Zealand public hospitals: I. Occurrence and impact". *Journal of the New Zealand Medical Association* 2002; 115 (1167):URL http://www.nzma.org.nz/journal/115-1167/271

- 15,000 patients who would have benefited from RT did not receive any in 2002
- Over 50% of patients needing emergency care did not commence RT within acceptable times
- 40% of patients requiring curative RT did not commence treatment within acceptable times
- 30% of patients requiring palliative care RT did not commence treatment within acceptable times
- Overall, one in every four patients did not begin RT within acceptable times

The second report on *State Of Our Public Hospitals June 2005* was released on 30 June by the federal health minister. Elective surgery admissions were low and waiting times were high in NSW, despite the state's higher than average bed-to-population ratio.

Yet State and territory governments have delayed needed reforms. What new powers of an AHC or a HRC would change this situation, if (1) we are adding one more level of government oversight and if (2) the private health sector would be peripheral? How an AHC or HRC would cajole the extra taxes needed to pay for future healthcare needs has not been explained, or how they would enhance choice, private sector investment, clinical quality or patient safety. The AHC and HRC agenda is mainly about pooled funding, not about fixing inefficiencies using the evidence-based strategies now being fast-tracked in UK and USA.

Australia is lagging in policy reforms for almost all these problems, the public hospital queuing problem can be solved by more judicious use of available private hospital beds and smarter private health insurance, and we should recognise explicitly the human rights that are being infringed by queues, medical errors and diminished patient safety.

Public hospital queues, *per se*, have been a pivotal matter in two recent judicial decisions in the EU and Canada.

2.2 Removing European, Canadian and Australian public hospital queues: Australia's health insurance rebate looks like a sound investment alongside the Canadian and UK queues under single payer federal governments

The Supreme Court decision: universal access to a public hospital queue is an infringement of human rights

On 9 June 2005, by a 4-3 majority the Canadian Supreme Court ruled that the Canadian charter of rights and freedom cannot force an individual to endure poor quality healthcare or unreasonable waiting times for medically required services in Quebec.

The Court rejected Quebec's arguments that a ban on private health insurance for publicly insured services (such as those covered in Australia's Medicare) was connected to the maintenance of quality public healthcare. The Court said: "*It does*

not appear that private participation leads to the eventual demise of public health care".

In effect, the nation's highest court told Quebec to either deliver better hospital care or allow a private health insurance system to finance quality, timely access to hospital care. No politician can declare that all citizens have a right to medical care if that right is redeemable only by a long wait in a public hospital queue, an infringement of other human rights.

This Canadian decision (*Chaoulli v. Quebec (Attorney General), 2005 SCC 35*) came seven years after the European Court of Justice shocked EU member nations when it granted two EU citizens the right to claim reimbursement from their national system for treatment received in another EU nation.[26] This decision effectively drew a line between those who saw healthcare as a service subject to market forces, and those who saw it as something that should be provided and managed by national[27] and regional bureaucracies.

Public procurement in the EU now pays for access to private hospitals if the member nation is unable to offer equal treatment in a reasonable waiting time. As a result,

- the British NHS now pays for hospital care for Brits sent to contracted Belgian hospitals;[28]
- free choice of hospital will be entrenched in all four Scandinavian nations when Finnish law takes effect this year; and
- Europe is moving at flank speed away from the Bismarck and Beveridge models that equated solidarity with government-run healthcare.

If the Canadian decision is not reversed on appeal or if the other provinces do not now fix their public hospital mess, the numbers of private hospitals funded by private health insurance will grow in Canada.

Relevance of the Court decision to the Committee's brief

For four reasons, the decision is pertinent to the Committee's terms of reference and Australia's Medicare reform agenda for hospitals and related care.

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[26] A full text of one judgement, including the rationale of the presiding court, is given in: http://curia.eu.int/es/actu/communiques/cp05/aff/cp050031es.pdf

[27] Single payer systems are not on the nose everywhere. Driven to distraction by the 45 million uninsured persons across the USA, eighteen US state governments under Democratic control, supported by unions and some church leaders, have introduced bills that support a single payer model. When California in 1994 and Oregon in 2002 put forward such a bill, they were rejected by wide margins, and a Kaiser Foundation poll in early 2005 found that 55% of Americans rejected the single payer model-see: Associated Press. "Universal health care push being revived. *USA Today* 10 July 2005 (downloaded 12 July 2005 from http://www.usatoday.com/news/nation/2005-07-10-universal-health-care_x.htm)

[28] Starting in October 2002, ophthalmology patients who had been on London hospital waiting lists longer than six months were offered the choice of other providers. Other specialties (orthopaedics, ENT, general surgery, gynaecology and urology) were added to the scheme in 2003. A new report by RAND Europe and partners on the factors that lead UHNHS patients to accept hospital care outside their region indicates that about one-third of all patients on long waiting lists prefer hospital care outside the UK-see: P Burge, N Devlin, J Appleby, C Rohr, and J Grant. *London patient choice project evaluation.* Prepared for the London Patient Choice Project Team, Department of Health, 2005

First, the judiciary intervened in a policy space normally occupied by the legislature. Politicians delayed much needed reforms in public hospitals by clinging to ideological and theoretical defences that ignored the infringement of human rights inherent in the pain and diminished quality of life of patients in a public hospital queue. While I doubt that a similar legal route would succeed in Australia, some opinions expressed by the majority of judges about the injustices of long waiting times deserve attention by the medico-legal confraternity in Australia.

Second, the majority of judges rejected the opinion of Yale's Professor Theodore Marmor that private health insurance is unnecessary, or that it threatens the viability of a universal single-payer system in which governments are the most efficient operators of healthcare. The majority based its decision on evidence about how other industrialised nations pay for healthcare, rather than on academic theory. Some European academic observers, while agreeing that the European Court of Juctice rulings empower the individual patients, also note that "*...their positive impact on social objectives is much less clear (as)...they may also have a negative impact on cost containment, priority setting and solidarity on the national level, thus juxtaposing individual rights to free choice against collective priorities*".[29] In Australia, as noted above in **PART 1**, some similarly-minded advocates still believe that the inter-governmental dysfunctions that are responsible for inadequate finding of public hospitals can be removed by a fourth tier of government that would act as a single payer of pooled funds.

Third, by striking down a Quebec law that stopped the Quebecois from taking out private health insurance and thus opening up a flow-on of the decision to the other nine provinces of Canada if not reversed on appeal,[30] the Court may have negated the ban on private health insurance in all ten provinces of Canada, thus leaving Cuba and North Korea as the only nations still banning private health insurance. In Australia, there are still critics of the private health insurance rebate arguing that we should join Canada, Cuba and North Korea by wiping out the rebate and moving to a single payer model.

Fourth, in criticising the emotional reaction of two of her dissenting judicial colleagues, Justice Deschamps broke new procedural ground. At paragraph 85 of the majority judgement, she argued that it "... *must be possible to base the criteria for judicial intervention on legal principles and not on a socio-political discourse that is disconnected from reality*".

Her reality was the average 18-week queue that prolongs the pain of those waiting for medically justified hip replacements and causes the deaths of those denied reasonable access in a tax-financed, government-run health system. In Australia, those arguing for the insertion of "commutarianism" into health payment mechanisms tend to ignore these side-effects of a single payer model on human rights and the

[29] J Figueras, R Robinson and E Jacabowski (eds). *Purchasing to improve health systems performance.* European Observatory on Health Systems and Policy Series, 2005, 322 pages (at p.53).

[30] The court postponed the effective date of new private insurance until June 2006. In February 2006, Quebec decided to improve the quality of its public hospitals, announcing that it would also pay for surgery in a private clinic inside or outside Canada, and allow its citizens to but private health insurance to cover all relevant costs- see: R Steinbrook." Private health care in Canada". *New England Journal of Medicine* 2006; 354 (16): 1661-1664.

deadweight loss of the social insurance tax (as much as 12-15% of income if EU experience is a benchmark) needed for a single-payer model.[31]

Fortunately, Australia has avoided the long queues that caused the EU and Canadian judicial interventions because we have a safety valve called private health insurance (PHI) that can speed access to a private bed. PHI raises about $9 billion in premiums per year (and costs the government about $2.8 billion per year in the 30% rebate carrot). 43% of Australians have some PHI. There is a simple lesson here for Australian politicians ignoring the queues that will always form when there is no user charge is simple. Someone waiting for a year in a hospital queue for hip and joint replacement could sue a future federal government if their only other option – access to a private hospital using private health insurance cover - was beyond their financial means as PHI premiums move skywards. The smarter Australian states recognise that means testing of public hospitals and higher user charges are partial remedies, but intestinal fortitude is lacking to introduce such remedies. [32]

If public hospital budgets remain inadequate, critics of the 30% rebate argue that if PHI premiums are increasing (now about 5% per year) and there are still uninsurable gaps, and if people then drop PHI despite the 30% subsidy, then the rebate's $2.8 billion should be discontinued and any subsidies made directly (by a single payer) to private hospitals.

Apart from avoiding longer queues in Australia and offering faster access to hospital care, there are at least three other reasons to sustain the 30% PHI rebate:

- raising taxes to the necessary levels (12-15% of income) is politically unacceptable without prior improvements in the quality, safety and efficiency of public hospitals;
- restructuring Medicare and PHI to provide economic incentives to reduce risk factors that are pushing up expenditures at all levels of the health system; and
- the rebate can be easily restructured to encourage national savings, higher quality care and efficiency gains, desirable goals not all achievable with higher tax levies.

I return to these proposals below after summarising some related issues.

[31] These are now estimated to be between 20 cents and 100 cents of every dollar of tax raised-see comments by Chris Edwards, Cato Institute, at AEI Seminar in June 2005 at:
http://www.aei.org/events/filter.all,eventID.1091/summary.asp

[32] Queensland seemed to be now moving faster than other governments in recognizing this inevitability, spurred on by the final report on the Bundaberg fiasco released on 30 November 2005. But recent pronouncements by the Premier seemed to have killed any new user charges.

3. THREE HOSPITAL FUNDING INEFFICIENCIES THAT JUSTIFY DETAILED REVIEW BY THE HOUSE STANDING COMMITTEE [33]

Overview

The Standing Committee is charged with the task of commenting on the Commonwealth role in improving efficiency and effectiveness in the Australian health system.

I present evidence below that suggests that three sources of inefficiency and ineffectiveness exist in:

- the inappropriate use of hospital care in an ageing society with a growing chronic care burden,
- the measured inefficiencies that exist in payment systems that pay for good and poor quality hospital care, and
- inappropriate regulatory constraints on the design of more appropriate health insurance outside the hospital walls.

Three gaps are discussed briefly below: shortfalls in future funding needs of the chronically ill that should be anticipated (**Section 3.1**), current inefficiencies in hospital care that constitute waste (**Section 3.2**), and overcoming the limitations of the 30% PHI rebate to achieve more appropriate use of prevention and treatment, particularly hospital treatment (**Section 3.3**).

3.1 Future healthcare needs that require efficiency gains, new sources of funding and incentives for personal responsibility in funding and payment strategies

In Australia, many aspects of the current methods of healthcare financing are inelegant, and there are many gaps and inefficiencies in health care that still need to be addressed.

As pointed out three years ago,[34] these problems cannot be addressed by processes that ignore (1) a private health sector now providing 56% of all surgery, (2) the growth of the chronic disease burden, or (3) federal/state buck-passing before, during and after COAG meetings.

If COAG is to have any credibility in the reform process, the assembled politicians must offer visible leadership to solve a list of "wicked problems" that involve "*...complex tradeoffs between values, goals and resources, delivered in an environment of political contest*"[35]. viz.,

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[33] An earlier version of this section was published as: PF Gross. "Three bitter pills to cure health care". *Sydney Morning Herald* 9 June 2005, 17

[34] See for example: PF Gross. *"Some economic arguments for investing 10% of GDP in higher payments for high quality integrated care, demand-side incentives and public-private partnerships"*. Invited paper, National Health Summit, Canberra, 18 August 2003.

[35] This description of a "wicked problem: was proffered by Peter Shergold, Secretary of the Department of Prime Minister and Cabinet in 2004. I am grateful to Professor Stephen Leeder for the reference.

1. identifying *current* healthcare gaps requiring catch-up funding;
2. understanding *future* health care needs arising out of ageing and chronic illness;
3. assessing the likely *future* impacts of medical technology on healthcare expenditures; and
4. then- and only then- setting the policy framework for new funding and organisation policies that sustain BOTH Medicare and private health insurance in a safer healthcare system that deals with the chronic care burden.

To date, the federal government has splintered these four actions by throwing two separate references to the Productivity Commission to review limited aspects of Items 1 and 3, leading to two confusing reports in 2005 that tell us (1) ageing is the major driver of commonwealth government on health and welfare expenditures, but (2) medical technology has been responsible for 47% of total public and private healthcare expenditure growth.

We still lack any comprehensive insights into the gaps in risk factor reduction that are driving treatment prevalence, gaps in the diagnosis and treatment of chronic conditions that will cause higher prevalence of treatment and costs per treated case, or other gaps in care (mental health, indigenous health, cancer treatment, rehabilitation...) that need new sources of financing for new medical technologies. We remain oblivious to the future costs of Items 2 and 3 above.

Despite six reports since the 1997 report by NHMRC, the absence of funded, targeted national policies for obesity prevention in adults and children is another sign of national complacency. Why is this complacency a matter that should concern the Committee?

- Overall, during the 20-year period to 2004, the percentage of overweight males and females rose 17.5% and 18%, respectively, and the corresponding rates for obese males and females rose 10% and 12.5%, respectively.[36]
- About 60% of the Australian adult population is now overweight or obese, and the International Obesity Task Force estimates that by 2025, 1 in every 3 adults in Australia will be obese.[37]
- Adult obesity is rising at 1% per year, and over 60% of overweight and obese adults in the *ABS 2004/05 National Health Survey* considered themselves to be at a healthy weight. There is no reality check in a Medicare payment system that pays for non-specific medical services and bariatric surgery, does not record weight and height systematically in medical contacts, but will not pay for preventive activities that cause sustained weight loss.[38]
- Healthcare expenditures associated with the downstream effects of obesity - which means large shares of the costs of treating seven major chronic

[36] Australian Society for the Study of Obesity. "Obesity in Australian adults: prevalence data", 3 pages. Downloaded October 2005 from the ASSO website.
[37] ASSO, *ibid.*, 2
[38] I exclude here Medicare payments for some services connected to extended care plans and the recently announced proposed payments for annual checkups of persons over 45 years with at least one risk factor. If 60% of adults are overweight or obese, they already have at least one risk factor, and many are aged less than 45 years.

disorders - are rising at about 2% per year. Much of that care is in hospitals only because we refuse to think about policy solutions upstream.

It is not just adult obesity that is filling or hospitals. National data on obesity in children are incomplete and more recent, for reasons noted in a recent editorial: "*Rates of non-communicable health problems, such as obesity and mental disorders, appears to be rising, but lack of up-to-date national data makes it difficult to accurately assess the current rates*".[39]

- A new survey of schoolchildren in NSW, released in part at the NSW Diabetes Summit on 10 April, shows that childhood obesity rose at about 1% per year from 1987, with 26% of boys and 24% of girls now obese or overweight.
- Overseas data on hospital use suggest that the cost of hospital admissions by children with gall bladder disease, sleep apnoea and surgical needs tripled since 1987.

What is the cost of government complacency? Older studies suggest that obesity caused about 4-6% of national healthcare expenditures in the mid-1990's, mainly through its impact on six chronic diseases. By my calculations in 2006, the costs of obesity, overweight and physical inactivity are now 6% of national healthcare expenditures, fourth highest after heart disease, musculoskeletal disorders and injuries, and about equal with mental health.

Worse still, for a nation intent on improving national productivity, the costs to Australian employers of *presenteeism* (i.e., diminished performance while at work) swamp the costs of medical care and *absenteeism* (i.e., days of work lost), due to chronic conditions associated with obesity and inactivity could be up to three times these direct costs. Neither Medicare nor private health insurance have in place the economic incentives used elsewhere to persuade individuals to take personal responsibility for their lifestyle, including weight loss and physical activity.[40]

It is therefore very difficult to accept either the federal Health Minister's recent assertion[41] that many of the big improvements in private health insurance have already been made, or his unthinking inference that "only the small stuff" is left in the reform agenda. *Au contraire*,

- the copayment gaps in PBS, Medicare and private hospitals are growing at higher rates than in most other comparable nations, and the new Commonwealth Fund data referenced in **PART 1** show that access of the sickest is being compromised;
- risk factors to chronic illness, including an all-important measure of obesity such as the Body Mass Index (BMI= weight in kilos divided by the square of height in metres) remain mostly unmeasured by health insurers and by

[39] GC Patten, SR Goldfeld, I Pieris-Caldwell et al.," A picture of Australia's children" Editorial *Medical Journal of Australia* 2005; 182 (9): 437-438

[40] The concept once attracted criticisms that it was "blaming the victim" That lame rebuff has been blunted by new studies showing that health outcomes are improved by demand side education and by economic incentives, even the poor, and even those with pre-existing chronic illness.

[41] T Abbott. "Getting the smaller things right". Speaking notes for the Fourth Private Health Insurance Summit, Sydney, 6 June 2005.

Medicare, so we cannot target scarce resources to the high risk (=high BMI) individuals;

- the side-effects of payment systems that do nought about medical errors in public hospitals are visible on the pages of the morning papers and on shockjock radio programs, and
- improvements in mental health[42] as part of systemic reform of chronic care management are hardly among the "smaller things" yet to be done, and even the Prime Minister's decisive action in April 2006 to promise an extra $1.8 billion over 4-5 years is yet to be matched by funding promises from the states and territories, or by active case management using health fund benefits.

3.2 Current inefficiencies in hospital use under today's hospital payment systems- case study: medical errors in hospitals

Medical errors: how large?

One consequence of the current inactivity on patient safety reforms by the Commonwealth (one national committee that has not achieved change is NOT pro-active Commonwealth policy) is that public and private hospitals do nothing to reduce the consequent waste of resources.

The May 2005 report by the Australian Institute of Health and Welfare, *Australian Hospital Statistics 2003/04*, shows that the reported medical error rates in public and private hospitals are 5.4 per cent and 3.6 per cent, respectively. The extended treatment of patients affected by these errors increases private health fund pay-outs and public hospital costs by at least these percentages.

At the Council of Australian Governments (COAG) meeting in early June 2005, the assembled chief ministers found it impossible to fast-track solutions that other countries, facing similar inefficiencies, have already implemented by investments in

- patient safety improvements;
- new payment methods to pay for higher quality care by doctors and hospitals;
- expanded home care services to pull some of the load off hospitals;
- processes and new budget allocations that improve the inter-operability of information technology; and
- higher payments for disease management programs that empower the chronically ill and reduce the costs of future care.

[42] The latest report on deficiencies in mental health care in Australia, released on 19 October 2005, laments the tendency of state governments to invest in acute hospitals without providing the necessary funding for integrated mental health services in the community-see: MHCA. *Not for service: experiences of injustice and despair in mental health care in Australia: Summary*. Deakin West (ACT), Mental Health Council of Australia, 2005, 98 pages. The report argues *inter alia* that "...what's lacking is government co-ordination". The federal Health Minister responded the next day that Canberra's hands are tied, and that '*...we need the responsibility for mental health that we don't currently have*" -see A Stafford." Mental health services blasted". *Australian Financial Review* 20 October 2005, 8. His opinion that Canberra should control public hospitals and now mental health is at odds with practical common sense, political opinion in his own Party, and reforms in other nations that integrate health, housing and social services for the mentally ill under state or regional jurisdictions, not the national government. It might be more productive to fund some of the validated forms of integrated mental health care controlled by community organisations or delegated by the states to specialist disease management companies such as McKesson.

I estimate that in the absence of such investments, three broad types of inefficiency will consume at least 15 per cent ($12 billion) of the estimated $86 billion that will be spent on Australia's healthcare system this year, viz.,

- inappropriate use of hospitals by the elderly and chronically ill: 6 per cent of total spending;
- medical errors and hospital-acquired infections[43]: 3-5 per cent; and
- excessive government regulation: 6-10 per cent.

And these cost estimates ignore some new estimates[44] of the resultant legal costs summarized below, increasing from 1997 to 2001 in Australia at the frightening rate shown in the fourth column:

EXHIBIT 3
Malpractice Claims And Payments In Four Countries, 2001

Country	Claims per 1,000 population	Average payment per settlement or judgment ($PPP)	Average payments per capita ($PPP)	Average annual real growth in total payments, 1997–2001 (%)
United States	0.18	265,103	16	5
Canada	0.04	309,417	4	20[a]
United Kingdom	0.12	411,171	12	10
Australia	0.12	97,014	10	28

SOURCES: Australia: Australian Competition and Consumer Commission. Canada: Canadian Medical Protective Association. United Kingdom: National Health Service Litigation Authority. United States: National Practitioner Data Bank Public Use File (payments) and Physician Insurance Association of America (claims).
NOTES: PPP is purchasing power parity. Claims and payments are for cases against physicians only. For further details, see Note 19 in text.
[a]1998–2001.

Those malpractice payments feed into malpractice premiums, and new US data suggest that specific reforms can contain the loss of certain high-risk specialists

[43] For HAI's, any cost estimate in Australia should, ideally, estimate the number of all infected patients with each major type of nosocomial infection (bloodstream, surgical and respiratory) and their lengths of stay, but such data do not exist. My estimate of the costs of HAI's in 2005 assumes that they affect 7.9% of overnight separations (or 250,000 patients assuming about 3.1 million such separations), generating a cost of roughly $935 million, or 1.2% of estimated total healthcare expenditures of $80 billion in 2005. This estimate should be compared with five other estimates in earlier years: (1) McLaws (1988), assuming that 7% of patients acquired an infection while in hospital, estimated the costs at $180 million (1988 dollars); (2) *The Final Report of the taskforce on quality in Australian health care, Appendix 7*, in its June 1996 report, used estimates from the 1992 data used by Wilson et al (1995) to estimate the costs of AE's at $800 million per year, ignoring any readmissions, outpatient costs and longterm disability costs;(3) AICA .*National Surveillance of Healthcare Associated Infection in Australia: a report to the Commonwealth Department of Health and Aged Care*, April 2001, 232 pages, at p.71) summed the costs of six major sites of surgical infections , and the costs of SSI's alone were $268 million per year in 2001 dollars, with an additional cost of $108 million at a 3.2% rate for bloodstream infections; (4) Australian Patient Safety Foundation.*Iatrogenic injury in Australia.* Report for the National Health Priorities and Quality Branch of the Department of Health and Aged Care, 2001) estimated the potential savings in costs from the prevention of iatrogenic injury as $2.0 billion in 2001 dollars, assuming 80% preventability and bedday costs for iatrogenic cases as 1.5 times the normal bedday costs; and (5) ACQSHC."*National strategy to address health care associated infections 2003*") which assumed that there were 150,000 HAI's contributing to 7,000 deaths each year, generating a cost of $686 million in 2001 (i.e., $4,600 per HAI case). The APSF concluded that "*...the direct medical costs of iatrogenic injury consume over 5% of ...(expenditures)...each year, and...the costs of medico-legal claims filed consume a further 1%*" (at p.24). Allowing for the different year of each estimate and for the fact that some studies were of the total costs of AE's, not just HAI's, and adjusting for inflation, the five estimates are in the range $460-895 million.

[44] Source: GF Anderson et al." Health spending in the United States and the rest of the industrialized world". *Health Affairs* 2005; 24 (4): 903-914 (downloaded 12 July 2005)

facing higher premiums. Specific reforms might include payment methods that measure and pay more for quality care.

I note here that without a much larger investment in healthcare information technology (IT), it is unlikely that we will see significant changes in patient safety, operational efficiency or coordinated care in hospitals and between hospitals and care beyond the hospital walls. The central component underpinning each of these three developments is an electronic patient record. In the absence of rapid action and larger (at least an extra $2 billion over three years by my calculations) and a national Health IT czar with powers similar to Dr David Brailer[45] in the USA, we will

- still be talking about options in one ineffective national committee;
- still talking about partnerships between the government and private sector that can bring a working system online with appropriate incentives and a budget commitment;
- never achieve full interoperability of different legacy systems because of varying standards that can only be made uniform by national fiat or economic incentives to the IT industry, and
- never implement one fully automated clinic or hospital with the same enviable performance as the Rocky Mountains Kaiser Permanente clinics, with no paper record in sight.

Three Commonwealth initiatives that would improve hospital performance

Leaving aside the overdue tort reforms that might reduce the numbers in all four columns above, real leadership by the federal government to remove waste requires the federal government to lead on three fronts.

Reduce inappropriate hospital care: Australia has an enviable supply of acute hospital services. Yet, among industrialised nations Australia has the highest admission rate to acute hospitals (22 per 100 population), with over 40 per cent of public hospital beddays taken up by the frail elderly.

Four recent reports on reviews of healthcare in the Labor states of NSW, SA Tasmania and WA repeat a litany of known facts about the chasm in federal/state cost-sharing. They generally ignore spare beds in the private hospital system, and offer few new insights on how to create new home care services, community care or complex care of the mentally-ill.

The private health sector is not yet a reform agent. The Reinsurance Pool offers no incentives to overcome the unwillingness of the health insurance funds to coordinate hospital and out-of-hospital care or to improve access to home and community care of chronic illness. Discussions about possible reforms in 2006 include risk-rated capitation payments covering out-of-hospital benefits, but there has been no public debate on what those benefits should cover. Sadly, that reform has

[45] See for example: R Cunningham." Action through collaboration: a conversation with David Brailer". *Health Affairs* 2005; 24 (5) (September-October): 1150-1157.

again been postponed until at least 2007, forestalling any efficiency gains in the funds,

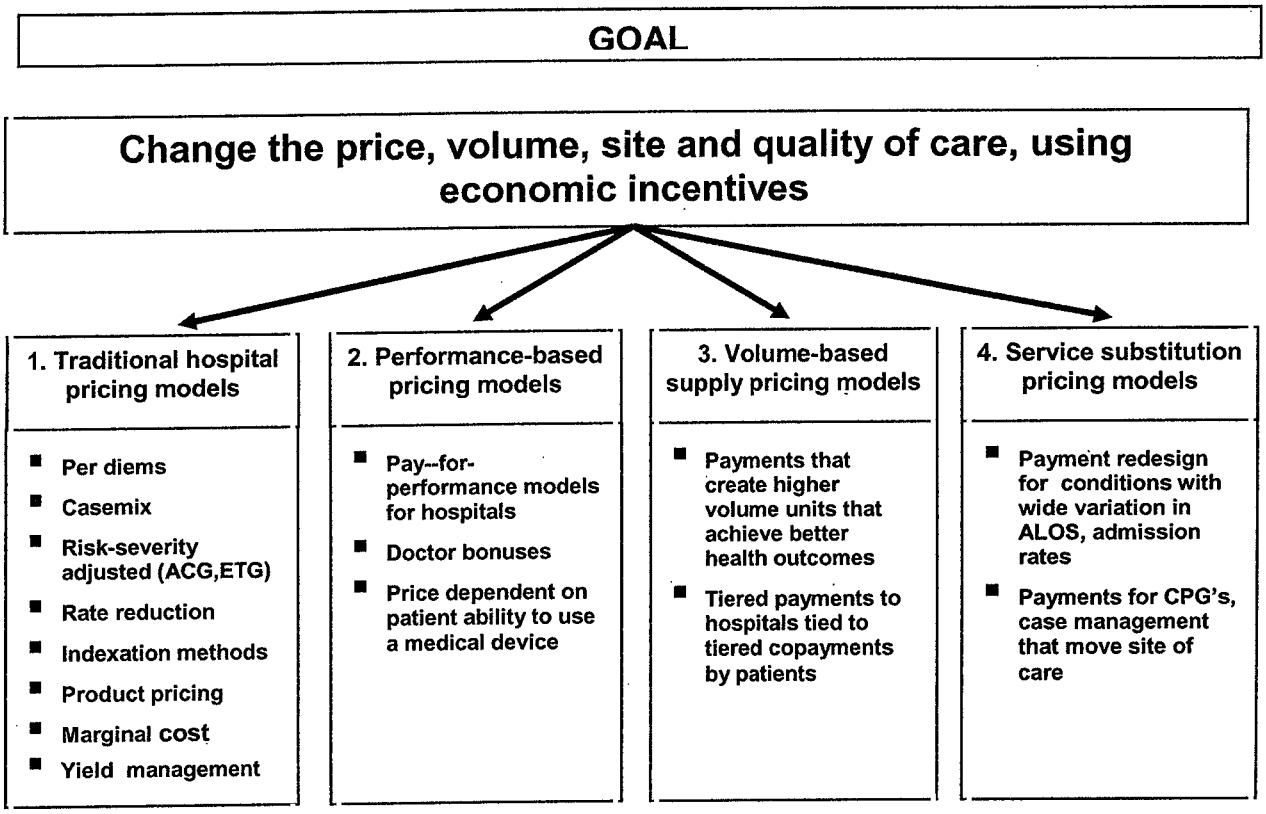
Replace payment systems that reward unsafe hospital care of unmeasured quality. In the 2005/06 Budget, the federal government announced funding of $1.5 million for a new Hospital Safety Initiatives Program. This contribution of 7.5 cents per person should be compared with the *per capita* equivalents of

- the funding made available since FY 2001 from the US Congress to the Agency for Healthcare Research and Quality (AHRQ), totaling US$240 million to FY 2004, with an additional US$ 84 million proposed for FY 2005;[46]
- the funding and objectives of the overall US National Patient Safety Initiative;[47]
- the new US8 million announced on 8 June 2005 by the US Agency for Healthcare Research and Quality of US$8 million for 15 projects to increase patient safety within two years;[48] and
- the five core strategies of the CMS Quality Improvement Roadmap.[49]

Unlike the Australian Council for Quality and Safety in Health Care (ACSQHC), AHRQ is already funding interventions that are known to improve patient safety,[50] rather than dwell incessantly on the medical culture that needs to be changed. Unlike the ACQSHC and COAG talkfests about quality and safety in hospitals that ignore Donald Berwick's warning that "*some is not a number, soon is not a time*", the benchmark for reform in patient safety is now the attempt by US hospital leaders to reduce the number of deaths in US hospitals by 100,000 by 9am on 14 June 2006.[51]

One obvious solution is to pay all hospitals more for higher measured performance. Governments and private health insurers are now paying more to high quality hospitals to improve the quality of medical and hospital care, using payment strategies that also attempt to change the price, volume and site of care, as depicted below:

[46] AHRQ.'" State of AHRQ-Part II: Improvements in patient safety: the future is now". Paper presented to AHQA Annual Meeting and Technical Conference, San Francisco, 12 March 2004.
[47] See for example: DO Farley, SC Morton, CL Damberg et al.," Assessment of the National Patient Safety Initiative: Context and baseline Report 1". Santa Monica, RAND Corporation, 2005
[48] AHRQ. *AHRQ awards more than $8 million to further implementation of evidence-based patient safety findings.* Press Release, 8 June 2005- see: http://www.ahrq.gov/news/press/pr2005/pipspr.htm)
[49] Centers for Medicare and Medicaid Services. Quality improvement roadmap. Washington, DC, CMS, July 2005, 19 pages-see: http://www.cms.hhs.gov/quality/quality%20roadmap.pdf
[50] See for example: CM Clancy. *"Patient safety activities at the Department of Health and Human Services.* Testimony before the Subcommittee on Health, Committee on Energy and Commerce, US House of Representatives, 9 June 2005, 7 pages- see: http://www.ahrq.gov/news/test60905.htm)
[51] DM Berwick. "*Some is not a number, soon is not a time*". Paper presented at AHQA Annual Meeting and Technical Conference, San Francisco, 23 February 2005. Six specific interventions are proposed: rapid response teams (drawing on Australia's outstanding results achieved by some pioneers), reliable care for AMI, reliable use of ventilator associated pneumonia bundles, reliable use of central venous line bundles, surgical site infection prophylaxis, and prevention of adverse drug events with reconciliation.



Listed in the newer provider payment currencies (not just the pay-for-performance pricing models) are strategies that pay more for higher quality care, including care based on E-B guidelines that doctors and PHI companies develop together, and which are now shared with patients so they can recognise "quality" and buy access to care that exudes quality.[52] The criteria used to calculate the additional payment for higher quality include:

- measures of *efficiency*, such as whether lengths of stay are in line with world best practice or within the 90th percentile band of efficient stays by similar hospitals;
- measures of *patient safety*, such as whether hospitals had in place protocols that require prophylactic use of antibiotics before certain types of surgery that are known to be influenced by antibiotic use;[53]

[52] PF Gross." New provider payment currencies in healthcare: what they mean to payers, providers and patients, and a business case for their use in Australian hospitals". Presentation to eight health insurance funds in 2003-2004.

[53] I note here the comments to the Committee Hearings on 16 March 2006 by Dr Del Hodge, President-elect of the Queensland AMA, on my purported advocacy of such measures. She quoted from a third hand article, she seemed to take the view that clinicians would not support this measure advocated by an academic health economist, and she inferred that clinicians would think differently from health economists. On this particular issue of P4P and even on the prophylactic use of antibiotics in surgery, she would be wrong to assume that clinicians are not supporting this measure, or that governments are not promoting it as good quality care, or that doctors do not like the whole P4P approach. She might benefit from a careful reading of the opinions expressed on the P4P model by the US AMA and the relevant medical boards in the USA, given that hospital-based P4P is running in parallel with doctor-based P4P in many large health systems- see for example: K Milgate and SB Cheng." Pay-for-performance: the MEDPAC perspective". *Health Affairs* 2006; 25 (2): 413-419; Institute of Medicine." Performance measurement: accelerating improvement. Washington DC, IOM, December 2005; and Center for Studying Health System Change." Can money buy performance? Physicians response to pay for performance". HSC, 9 January 2006.

- measures of *effectiveness* of hospital care, such as whether appropriate patients admitted with an acute myocardial infarction were given beta blockers within a certain time after admission, and made available at discharge;
- measures of the *patient satisfaction* with the care given during hospitalisation; and
- measures of *coordination of the care* of patients with chronic conditions that require close attention back in the community after discharge, and which require the patient to take appropriate drugs after discharge.

Those hospitals that achieved threshold levels on each criterion might receive a 2-4% increase in their case-mix payment (DRG in Australia) for all patients affected by the criteria. They have some features that should be considered by the Committee as overdue in Australian hospital contracts:

- The measures do not require huge bureaucracies, not huge bands of travelling auditors checking medical records. The word of the hospital that the necessary protocols are in place is sufficient for three of these above criteria.
- They require intense and frank dialogue between all parties to the performance contract to ensure they are fair, and measure thinks that can be improved.
- They educate consumers to be more astute payers for their hospital care.
- In other nations, even the USA, the medical profession has embraced them and is receiving payments based on demonstrably higher quality care. The American Academy of Family Physicians (AAFP) has concluded that such systems have the potential to improve quality, and it wants to see prospective data collection and tools in the hands of US family doctors, something that GP's In Australia surely endorse.[54]

Sadly, of all government departments in Canberra only the Department of Veterans Affairs (DVA) has any clear, practical strategy to lift quality and patient safety in hospitals. It has done so by leadership that says: we cannot go on paying the same dollar for good and poor hospital care, which is exactly what the current casemix payment system does.

DVA has recognized what the private health insurers and AHMAC have not grasped as the major task ahead for any Federal Government promising to sustain high quality public and private hospitals.

That task was identified by the Administrator of the US Centers for Medicare and Medicaid Services, Dr Mark McClellan, on 25 March this year. Referring to the US Medicare program for the aged, he could have been talking about our Medicare, saying:

``We can't solve Medicare's sustainability problems by leaving Medicare's benefits out of date (which) distorts the way health care should be delivered, away from modern preventive treatments, (and) raises the costs of health care and sticks beneficiaries with these unnecessary costs".

[54] B Darves." Pay-for-performance has quality-improvement potential, AAFP says". *Medscape Medical News* 3 October 2005 (downloaded 13 October 2005 from: http://www.medscape.com/viewarticle/513917_print)

``We must solve our sustainability problems with a focus on increasing quality and avoiding unnecessary costs-that is, a focus on performance."

Performance incentives, embedded within a pay-for-performance system, are already underway in UK, US and Germany.

Such innovations are impeded in Australia by the Medicare cost-sharing arrangements for public hospital care and by National Health Act restrictions on health fund payments to hospitals. Only the federal government can amend legislation so we pay more for measurably better quality care in all hospitals and related specialist practice. It's not a hard ask.

Approve new funding for a national health information IT structure with deadlines and incentives to the private sector for rollout: The world leader in health system reform is the Kaiser Permanente Group, which has spent US$3.2 billion over ten years to its national IT infrastructure that will support high quality care for its 8.3 million members in eight regions of the United States. Other parallel reforms in the IT systems of US hospitals suggest that electronic patient records that can reduce waste and improve quality care might over five years require average capital investments of US $10-20 million per hospital and affiliated medical clinics.

By comparison with the Kaiser investment for about half the population of Australia, Australia's budgets for hospital IT and automation of GP practices are picayune by comparison, funded by too many false starts at the state government level since the 1980's, poor project management, and any investment is still sub-optimal in 2006 because of the inter-operability problems that require national leadership.

To advance the quality care agenda and bring Australian hospital care into the era of performance improvement and informed patients, the federal government must provide incentives for active involvement of the private health sector, perhaps using a vehicle similar to the recently announced US Commission on A High Performance Health System to be funded by the Commonwealth Fund.[55]

- It is a non-government body.
- Its explicit goal is to create a US health system that achieves better access, improved quality and greater efficiency.
- Its major focus will be on the most vulnerable defined by low income, race, health or age.
- Its four major tasks will be to propose opportunities to change financing and delivery, identify public AND private policies/practices that would cause such improvements, consider the gains from higher health insurance coverage, and show how to reinvest any savings from efficiency gains.

We have many of the same problems, and COAG works at glacial speed. An independent Commission, usually eschewed by governments, may be timely in Australia if it completed a fast-track review of some of specific hospital funding options (with associated IT budgets) within six months of the Standing Committee's report. The task can be completed in such a time by competent experts from the

[55] The Commonwealth Fund." *New Commission on a high performance health system*". Media Release, 3 June 2005

public, for-profit private and not-for profit sectors. We must find workable alternatives to COAG that embrace these other interests and which do not rely on public service deadlines and experience.

The Standing Committee should recommend this approach to fast-track solutions impeded by the glacially-slow COAG process.

3.3 Inefficiencies in private health insurance: restructure the 30 percent PHI rebate to attack risk factors and increase the national savings ratio by allowing related medical savings accounts

Politics of the rebate

There are many reasons to sustain but change the use of our 30% rebate. One powerful political reason is that politically, it is easier to sell to the public than a tax hike to fund a single payer system from higher income tax levies for Medicare.

Our Medicare tax of 1.5 per cent of income (plus the extra 1 per cent surcharge for high income persons with inadequate private insurance) raises about $5.5 billion per year. The levy would need to be 10-12 percent just to finance Medicare's promises of access to "free" public hospitals, subsidized medical care and PBS drugs. I cannot see that happening quickly without a citizen revolt or major reform of the whole tax system.

Offering similar promises of universality as our Medicare system, many nations in Europe finance their social health insurance by a 10 to 15 percent payroll tax and when the resulting tax revenue is inadequate even at these levels, they are allowing supplementary private health insurance to reduce growing co-payments and uncovered costs.

However, despite its undeniable advantages to those with PHI, no Parliament or government can be oblivious to the limits of a 30% rebate that

- does not require funds to have websites showing specialist charges paid by the funds;
- has not reduced the average annual 8% growth rate of PHI premiums;
- drives up the average price of PHI by regulating the minimum deductible that qualifies for the rebate, and so the young are forced to buy more cover than they need;
- sustains inadequate treatment of the chronically ill and leaves the elderly in acute hospitals;
- gives no incentives to reduce major risk factors that will be the major drivers of healthcare spending in 5-10 years; and
- costs $2.8 billion per year in tax expenditures, which will surely increase because of the above five factors and the safety nets.

So if we retain the 30% rebate, we should use it to transform today's imponderable PHI product range into innovative insurance products across the life cycle that (1) link health insurance to medical savings accounts and (2) increase personal savings and

personal risk management activities from the earliest age, starting with obesity prevention and weight loss management.

Transforming today's "me-too" health insurance products:

Today, the health funds are hamstrung by excessive government regulation of all PHI products, costly contract negotiations with the hospitals, disincentives to reform when all of us pay roughly the same premium, and a government-imposed straitjacket that stops insurers from helping us reduce our risk factors or use healthcare efficiently.

We now have an obesity epidemic that will drive up future healthcare expenditures faster than the recent Productivity Commission estimates, yet we refuse to introduce the economic incentives that other nations have introduced to prevent obesity and increase weight loss.[56]

We select from PHI products that look the same, we pay our PHI premium minus the 30% rebate, we claim from the insurer, the insurer pays the claim, the insurer's actuary records all our claims and advises next year's premium, Canberra gets a set of data on all claims, and nothing else changes. The insurer is just a book-keeper subsidised by a 30% rebate, not a pro-active insurer of gaps in healthcare outside the hospital walls, not a trusted source of advice on who offers high quality, safe hospital and specialist care, and not an innovative designer of insurance that is appropriate to all stages of the life cycle.

Little wonder that the young consider PHI unnecessary when their cover is for comprehensive care they are unlikely to need,[57] or when no-claim bonuses are not allowed by government regulation.[58]

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[56] PF Gross. "International evidence supporting the fast-tracking of integrated health, social, tax and regulatory policies to control rising obesity and related chronic conditions in Australia". Sydney, Institute of Health Economics and Technology Assessment, forthcoming, 2006.

[57] The Health Minister's attack on fund exclusions in his 6 June speech is misplaced. If someone opts for a cheaper policy that is lower priced because of exclusions of surgical costs that are statistically unlikely, it is not the same as buying a car with only two doors. If, as he argues earlier in his June speech, consumers know more about their condition than the insurer, he can hardly argue that consumers are incapable of assessing risk, particularly if the health insurer (1) provides information on the actuarial risks of incurring healthcare expenditures at different ages (not done much in Australia), or (2) itemises clearly those costs that are not covered by the lower priced policy (usually in the fine print). The consumer can chose car and household insurance having regard to risk so why does a government need to intervene if the risks are made more explicit, and if the sole effect of the government's intervention is to drive up the average cost of a premium by forcing the consumer to pay for comprehensive care without choice? As I note further on, this problem can be addressed by allowing consumers to buy lower cost coverage tied to a separate policy that covers catastrophic events, with both funded from a tax-protected savings account. I do not ignore the related issue of ensuring portability of benefits when the exclusions are embedded in turgid fund brochures or websites. It is in the interest of health funds to minimise the exclusions or explain them in lay language.

[58] In his speech on 6 June, the Minister of Health hinted that government might be prepared to review proposals to include loyalty bonuses. However on 6 July, HBF in Western Australia had a recent proposal refused -see: http://www.abc.net.au/news/newsitems/200507/s1408152.htm . The Administrative Appeals Tribunal upheld a decision by the Federal Health Minister's office forcing HBF to cancel the scheme because it discriminates against younger members. Some funds have seen that overseas innovators are also embedding rewards for reduction of risk factors by weight-loss, physical activity and other self-care interventions. Australia is light-years behind on such demand-side management strategies- see for example: Scott R Weingarten, James M Henning, Enkhe Badamgarav, Kevin Knight, Vic Hasselblad, Anacleto Gano, Jr, and Joshua J Ofman " Interventions used in disease management programmes for patients with chronic illness—which ones work? Meta-analysis of published reports". *BMJ*, October 2002; 325: 925.

The tax rebate impact on consumer behaviour:

The 30% rebate is equivalent to a 30% cut in the coinsurance rate. Two known effects of a reduced coinsurance rate are that people buy more expensive insurance than they need, and they may also demand or accept referral to more expensive care than they would in the absence of the 30% subsidy. These two effects (labelled "moral hazard" by economists) render the unconditional 30% rebate less efficient than other forms of tax expenditure on subsidies by government.

At the same time, Australians are facing out-of-pocket costs (e.g., the medical gap, PBS drugs, and prostheses in private hospitals) that are increasing faster in Australia than in almost all industrialised nations. On 1 July 2005, tax deductions for cosmetic surgery disappeared.

There may now be a case on efficiency grounds to convert the 30% rebate on premiums to a rebate on the total payments for premiums and out-of-pocket costs, a conclusion reached by US economists in 1997.[59]

If we start down this tax reform path, we should consider a new tax subsidy that will (1) change consumer behaviour in buying health insurance that would reduce total tax expenditures on the rebate by reducing average premiums, (2) reduce risk factors by economic incentives within the new PHI product, and (3) encourage household savings over the life cycle.

The necessary research using expenditure and tax data has not been undertaken in Australia, but based on US research into the impact of flexible savings accounts on out-of-pocket costs and the after-tax marginal price of healthcare,[60] it is conceivable that a tax-subsidised medical savings account, if they lead to lower PHI premiums, might have a lower real tax expenditure cost than the current 30% rebate.

[59] W Jack and L Sheiner." Welfare-improving health expenditure subsidies". *American Economic Review* 1997; 87 (1): 206-221.

[60] W Jack, A Levinson, S Rahardja." Employee cost-sharing and the welfare effects of flexible spending accounts". Washington DC, American Enterprise Institute seminar, 29 June 2005.

4. THE POTENTIAL EFFECTS ON EFFICIENCY AND EFFECTIVENESS OF MEDICAL SAVINGS ACCOUNTS LINKED TO LOWER COST PHI PRODUCTS

Overview

Here I reflect briefly on one proposal that might promote debate on one facet of the Committee's Term of Reference "e": *identifying innovations that could make private health insurance more attractive to the uninsured.*

I emphasize up front that is NOT the only option for more appropriate and cheaper health insurance, it is now operational in four nations, but it is worthy of review by the Committee in this inquiry.

4.1 The Medical Savings Account option

In 2005, the Deputy Governor of the Reserve Bank warned the government that if we all live five years longer (one result of advances in medicine), we will need to save more during our working lives or earn 0.5-0.75% more interest each year on our savings over our working lives.

From whence can we achieve such a boost while improving the efficiency of health insurance?

One alternative that could justify the 30% rebate as an incentive to increase the national savings ratio would involve an approved Medical Savings Account (MSA) that can pay for:

- a mandatory high deductible, minimum coverage health insurance plan that allows new incentives (including no-claim bonuses) to reduce risk factors and trivial claims;
- at the insuree's informed choice, an optional catastrophic plan that covers high-cost care at a lower premium than today's insurance; and
- the insuree's choice to meet copayments imposed at the point of service from the MSA.

The individual or household with a personal MSA (not governments or regional health authorities, as in the single payer concept of the HRC noted in **PART 1**) would receive each year a risk-rated income–based subsidy from the government, applicable only to health insurance coverage.

- Using much the same calculation proposed by advocates of the HRC, the subsidy would be the cashed-out value of all government subsidies for Medicare, PBS and private health insurance, indexed for inflation.
- Low income groups would have the same subsidy, but there would be a need to consider safety nets.
- Any MSA balance at the end of the year would be rolled over and would be tax-exempt. Any MSA balance at death would pass to the estate of the deceased.

- As in some US MSA's, healthy behaviour would entitle the insure to a higher interest rate on the MSA balance if they maintained weightloss or stopped smoking for 2 years in a row, or they would receive lower PHI premiums in year 3.
- Individuals could opt for care at public or private hospitals, and all hospitals would be paid by today's casemix method but weighted higher for hospitals submitting data on their safety, efficiency and clinical quality.
- The market for transparent quality and safety, supported by health insurers and state governments advertising agreed performance data, would allow consumers to see what they are buying.
- The MSA would pay 100% for all preventive care, offer discounted weight reduction products and pay bonus interest rates on the MSA balances, all embedded in US and South African MSA models. This is an economic incentive that will appeal to the young, as the take-up rates of the new New Zealand accounts suggest.

4.2 Experience with the MSA in widely differing forms

Different versions of MSA's in Singapore since 1984, South Africa since the early 1990's, China since 2001 and USA since the early 1990's have been shown to

- increase national savings behaviour;
- allow households to choose health insurance products that are appropriate to their composition and stage of life;
- pull the young into more affordable health insurance;
- reduce inappropriate use of healthcare and increase self-care;
- increase the take-up of preventive services; and
- offer rewards for lifestyle changes that reduce the need for expensive care downstream. [61]

The current unconditional 30% rebate is accepted widely, but it has none of these impacts. A government with a Senate majority has an unfettered opportunity to make health insurance more affordable and efficient. However, the Minister of Health showed little insight about these impacts when proposals for MSA's were raised in a recent report by Medicines Australia.[62] He said:

"[T]he problem with (MSA's) would be that it's impossible to predict how much you need to put away each week because you don't know what treatment you will need over 20,30,40 years".

Quite true, but it's the same problem of uncertainty that I face in planning my future retirement income needs, or my grandchildren's higher education fees.

It's a similar problem that the young face in deciding how much health insurance they should buy each year when they have very little choice of products that meet their stage of the life cycle. With today's 30% rebate, they either buy more than they need

[61] ACCC has indicated it will not block MBF's joint venture with FitnessFirst-see its decision at: http://www.accc.gov.au/content/index.phtml/itemId/580641

[62] A Stafford." Wealthy patients may pay more". *AFR* 4 August 2005, 3

or they drop health insurance altogether. MSA's give them cheaper insurance, the option of catastrophic insurance, and as the new NZ developments in July 2005 show, other benefits can be attached, including incentives for them to stay healthy.

The New Zealand model was designed to make health insurance more attractive to the young uninsured. Noting the different regulatory provisions that allow it in New Zealand but impede it in Australia, the Committee might at least contemplate how such MSA's can be embedded within the Australian health system as a funding and a savings system.[63]

The Committee will also no doubt hear the following rebuttals of the MSA concept (and I juxtapose my response based on my last fourteen years of watching their creation and evolution in four other nations):

- They will attract only healthy people and the chronically-ill would quickly use up their medical accounts (WRONG: new US data from a McKinsey survey suggest that most of the MSA holders have positive account balances in their first two years, MSA holders were three times more likely than those in traditional health plans to take steps towards self-care and preventive activities that reduce their risk to higher cost care, and MSA holders were more likely to adhere strictly to recommended treatment plans than the traditional plan members. Aetna reported that MSA's with chronic conditions continued to seek necessary care and there were increases in preventive care).
- They will not attract the aged, poor or uninsured (WRONG: Assurant Health reported that 57% of new MSA holders were over age 40, 29% had family incomes of less than $50,000, and 40% did not have prior health insurance. It is true however that they are easier to sell in a group market, and they may need to offer special incentives to attract individuals).
- They will cause individuals to avoid needed care, leading to higher costs later (WRONG: Aetna's HealthFund Accounts reported that there were lower use rates of high cost hospitals and specialists as MSA holders shopped around, and the use of preventive services rose because most MSA's have no copayments on essential preventive care).
- They will not change consumer behaviour or engage them in price and quality comparisons of hospitals and specialist care (WRONG: the McKinsey survey of 2,500 US employees found that the MSA's increase consumer engagement in healthcare decisions and health management, and improved care for chronic conditions. They were 50% more likely than traditional plan members to ask about costs and three times more likely to choose a less extensive and expensive treatment. The study found that non user-friendly patient decision-support tools were the biggest stumbling block-exactly the same problem in Australia).

My recommendation is that the Committee consider the ways by which the MSA concept could be evaluated in Australia by simple modification of health insurance legislation. They could be trialled by offering, within the Health Insurance Act, a waiver for a five-year trial to evaluate some of their impacts on say 30-50,000 MSA holders enrolled by qualified financial institutions. Health insurers are not the only

[63] A forthcoming Research Note from the Parliamentary Library will canvass some of the options.

source of expertise in this area. At the end of the five years, a decision could be taken to expand them by modified tax rebates- or curtail them.

4.3 Other linked reforms:

Any debate on an MSA can also inform the citizenry on the related matters of pension reform, superannuation, and long-term care in retirement. Indeed, it is a relatively simple step from an MSA covering care up to retirement to a Retirement Savings Account that can be used to pay for LTC insurance to top up today's funding of nursing homes and home health care.

Recent proposals for Hong Kong[64] and the Singapore MSA evolution since 1984 present two feasible approaches for Australia.

The Committee should asses these schemes or proposals.

[64] PF Gross. "Trends in the financing of healthcare and related welfare reforms in Greater China: relevance to future health policy in the Hong Kong SAR". Chapter in: J. Bacon-Shine and G Leung (eds). *The future of Hong Kong's Health Care System*. Hong Kong, University of Hong Kong, forthcoming 2005

5. RESTRUCTURING MEDICARE, PRIVATE HEALTH INSURANCE AND WORKERS COMPENSATION INSURANCE TO CREATE BETTER TARGETED INTERVENTIONS AGAINST CHRONIC DISEASE AND OBESITY

Overview

In this section I expand some of my arguments in **PARTS 3 and 4** to address the second last concern of the Standing Committee, viz., *sustaining a strong private sector linked to a Medicare system* in which the economic incentives that currently drive patients towards expensive hospital care as a last resort are replaced by incentives to reduce risk factors and seek more appropriate care outside the hospital walls.

I first identify the goals of a health system that provides incentives for prevention and appropriate care (**Section 5.1**). I then outline a modified Medicare system, linked to private health insurance, which uses economic incentives to providers and patients to use health care appropriately and efficiently (**Section 5.2**).

In advance of proposing specific types of economic incentive in Medicare, I foreshadow some particular criticisms (with my short response in parentheses):

- Economic incentives do not sustain long-term change in health behavior (WRONG: there is new evidence that US employers, watching the bottom line, are now paying financial incentives to workers with the expectation that the weightloss achieved will lead to improved productivity over the long-term).
- Any changes would not be permanent or verifiable in a practical way (WRONG: height and weight are two easily verified measured needed to define the risk of obesity, and the two measures are being used in at least thirty prevention strategies in other nations).
- Health insurance reforms cannot easily persuade the young group to change their behaviour at reasonable cost (WRONG: at least twenty health funds in South Africa, USA and New Zealand are using new forms of health insurance design, including economic incentives and even the Virgin group has introduced Virgin Miles rewards for sustained physical fitness).
- The distribution of services might not be equal under health insurance but access to such insurance is, and economic rewards alter the latter situation (WRONG: my proposal is to reward consumers for taking personal responsibility, not deny them access to health insurance because they are overweight).
- The proposal assumes that lifestyle is a choice that affects people's health and one that they should be induced to change, but this may not be so if poorer people have worse health and riskier lifestyles than the rich and if the rich clearly gain more than the poor (WRONG: it is more unfair to the poor and chronically ill to ignore their amenable risk factors, and if 80% of the population can still exert some personal responsibility, why should the 80% be allowed to succumb to risk factors that they can change? A number of US

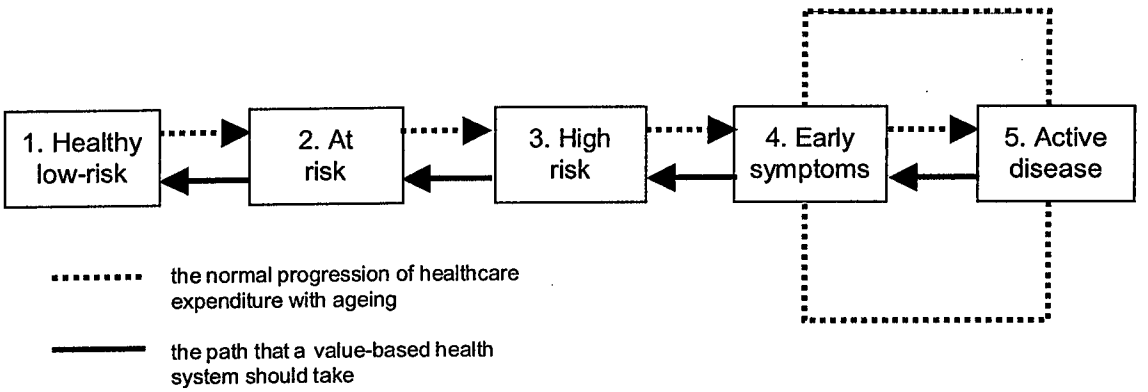
states are now offering low income families incentives believing that being poor does not mean absolution from personal responsibility to reduce risk factors).

- Economic incentives under Medicare are infeasible as it is a universal system of coverage (WRONG: incentives are being embedded in many systems, universality does not mean paying for every conceivable demand by patients, and since when is a universal system, with a huge unused database that could be used to estimate the burden of the high-risk groups, absolved from the responsibility to help all of us gain better health?).

5.1 Gaps in the care continuum that new health funding reforms must fill

Consider the traditional depiction of the care continuum,[65] stretching from the presumptively well on the left end to very seriously sick patients on the right end of the horizontal line in **FIGURE 1**, below, with the average health care expenditure per person rising slowly from category 1 to category 4, and then accelerating upwards.

FIGURE 1: The care continuum dollars vs. value



Some aspects of this diagram are germane to the evolution of health policies that address the problems of chronic illness, and obesity as a specific risk factor.

For most individuals, the growth in use of healthcare and related expenditure starts somewhere on the left side of the graph. Healthcare expenditures do not rise rapidly until the individual has either early symptoms of a major disorder (when diagnostic costs and drug costs may begin to surge) or the individual has an active disease or a high cost surgical intervention with follow-up rehabilitation services. Much of the high expenditure is in the dotted box.

It is quite common to find that somewhere in the area defined by boxes 4 (early symptoms) and 5 (active disease), a small number of individuals consume a large proportion of total healthcare expenditures. The 70:30 and 80:20 rules are quite common. 70% (80%) of the total healthcare expenditures are generated by 30%

[65] This depiction is the model used by HealthPartners, a very large health maintenance organisation in Minnesota. It has been adapted by the U.S. National Committee on Quality assurance (NCQA)

(20%) of the population.[66] At the other end of the spectrum, a large proportion of individuals generate little or no healthcare expenditures. The 50:3 rule is common for these individuals. 50% of individuals generate 3% of total healthcare expenditures.

If the sole goal of health financing in Australia was to contain healthcare expenditures, any interventions that were effective in the high expenditure subgroup might have some cost-reducing effects. The major problem for funders of healthcare (viz., federal and state governments, the private health insurance companies and the Department of Veterans Affairs) is that to achieve reductions in costs, either the higher spenders must be identified in advance of stages 4 and 5, or the care they receive in stage 5 should not consume the heavy resources that are now invested (e.g., the dying could have more access to home hospice care rather than in acute hospitals, particularly within the intensive care units of those hospitals).

Traditional care management in Australia makes minimal efforts to educate and inform the consumer about how to avoid stages 4 and 5 of the continuum of care. At the heart of the problem is the GP consultation process that is based on a fee-for-service system. Despite recent attempts to pay GP's for providing essential information to patients so that they become informed about risk factors, the health promotion literature offers very little solace about the willingness or ability of GP's, within the limits of an average 7 1/2 minute average consultation, to provide information (I) and education (E) in an effective communication (C) process that changes unhealthy lifestyle and risk-taking behaviours.

If "value" in healthcare purchasing is to have any meaning in the GP and specialist consultations, the goal of the consultation should be to provide effective IEC that reduces known risk factors, lowering the future incidence of chronic conditions. "Value purchasing" then means any payment of a consultation that:

- renders the patient a more informed consumer of all care;
- provides economic incentives for behavioral change;
- changes his/her risk profile; and
- reduces the incidence of common chronic conditions.

The types of intervention that are commonplace in U.S., U.K. and German manifestations of disease management are summarised in **TABLE 1** below.

[66] Sadly, Australian data are lacking the important concentration of resource use in healthcare. US data have been widely reported. Data for 1997 show 1% (5%, 10%, 50%) of the US population generated 27% (55%, 65%, 97%), respectively, of total national healthcare expenditures.

TABLE 1: Demand-side interventions across the care continuum and limitations of the current payments by Medicare, DVA and Private Health Insurance organisations

Target group	Intervention	Limitations in Australia
1. Healthy	Health-risk assessment (HRA)	Limited by the Medicare Benefits Schedule. PHI funds are limited by Privacy Act considerations and the absence of Medicare data linked to PHI claims data.
2. At-risk	Using data from the above HRA, use risk modelling to guide prospective outreach and pre-emptive interventions by targeting resources in accordance with the level of risk (e.g., if the HRA shows someone with a BMI over 30, more resources will be needed, on average, than for an individual with a normal BMI)	Inability to link all relevant medical, PBS and hospital claims data. Absence of economic incentives to change risk factors that have been shown to respond to such incentives and behavioural support not easily accessible for lifestyle change under Medicare or PHI payments systems
3. Acute users of discretionary care	Nurse advice lines	GP practices are now employing nurses. PHI funds do not offer information, education and communication (IEC) to reduce the discretionary use of hospitals or ancillary benefits.

The net effect of all such "value purchasing" is to place the average citizen on a path that moves him/her along the dark line from right to left on the continuum of care in **FIGURE 1**.

To ensure sustainable cost-effective health care that will reduce our indefensibly high use rates of acute hospitals with the growth of chronic conditions and obesity, any new Australian reform should embed

- increased payments but also reduce red tape for coordinated care by GP's;
- targeted government subsidies to reduce risk factors such as obesity and the consequently higher use of hospitals;
- health fund rebates for self-care and risk factor reduction by fund members;
- economic incentives to fund members to change lifestyle;
- tax incentives for home care of the aged and chronically ill; and
- new funding for a new national health corps of home health workers (including youth and the growing number of older unemployed) who will support rapidly disappearing nurses in home health care and provide a new workforce of home helpers.

I now develop some of these concepts by proposing specific restructuring of Medicare and PHI. For brevity, the related matter of reforms to workers compensation insurance is relegated to a section at the end.

5.2 Restructuring Medicare payments for more efficient and targeted management of chronic conditions and obesity

Australia does not have a policy for chronic disease or for obesity that is associated with chronic conditions. While successive federal governments have declared that many chronic disorders are National Health Priorities, the current funding of all levels of intervention is chaotic, the care patterns are expensive and risk factor reduction to avert these disorders is barely visible- and is in fact minimised by the methods of paying for care.

The latest manifestation of a quick-fix mentality in the chronic disease arena was the decision by COAG, at its meeting in February 2006, to allow Medicare to pay for an annual wellness check for 45 year-olds with at least one identifiable risk for a chronic disease. The age cut-off is arbitrary, will miss all those younger persons at risk to depression, and does nothing about requiring evidence-based guidelines for such wellness checks. For example there is no provision for a Medicare item for a follow-up visit to a GP, or for reinforcement of lifestyle advice and education, or for use of practice nurses.

As noted earlier, the costs of incoherent national policies for chronic illness are hidden but undoubtedly high.

- Roughly 60 per cent of total healthcare expenditures are incurred on behalf of the 10 per cent of the population with serious chronic conditions.
- About 30 per cent of insured lives have a chronic condition, up to 80 per cent of the payments for these patients are associated with lifestyle conditions, and another 10 per cent of payments are for the care of disorders with known risk factors that might be reduced with existing knowledge.
- The burden of chronic illness rises with age. Those aged over 65, 12 per cent of the Australian population, used about 46 per cent of all days of hospital care in 1997. In 1995, 3 million persons of all ages reported having a long-term condition. Chronic disorders, while prevalent in older persons and a major cause of their disproportionately high hospitalisation, do not spare younger persons.
- Much chronic disorder is still undiagnosed and untreated. A recent study in Western Australia revealed the hidden burden of moderate to severe mental disorder, affecting about 8 per cent of the WA population. People with such mental disorders had far higher death rates from heart disease and cancer than those without the disorders, perhaps because they are less likely to seek or receive care for these other chronic conditions, or perhaps their risk factors are not detected early. Coordination by GP's of their access to needed services would reduce the burden on patients, their carers and society.
- Medicare pays for hospitals and doctors using untargeted subsidies that, excluding the MBS fee paid to GP's for coordinated care, do nothing to promote self-care or coordinated care of chronic illnesses. We have the highest total hospital admission rates in the western world – and perhaps 15-20% of those admissions can be avoided by smarter design of Medicare and health insurance.

I use obesity as a case study. Some facets of the current Medicare funding arrangements impede any major attack on obesity *per se* in Australia.

- Obesity is still not designated a chronic condition in Australia.[67] As such, Medicare does not pay for any non-GP service that provides advice to the obese and overweight.
- There has been an absence of forethought hampering efforts to promote self-help in obesity management. Without much prior discussion, new GP payments were introduced in the 2004 election campaign. Furthermore, there have been no proposals to create economic incentives for healthier lifestyles and none seem likely in health insurance until 2007. The whole question of the role of self-help and the role of such incentives has not been a priority in Australia. In 2005, the Health Minister took a proposal to Cabinet to pay Medicare benefits subsidising 85% of the roughly $200 cost of a 12 week supervised commercial weight loss program such as Weight Watchers and Jenny Craig.[68] The proposal was rejected by Cabinet.[69] This rejection was predictable, given the open-ended nature of such a self-help subsidy to for products that did not then look demonstrably cost-effective. My new costings of obesity in Australia (available on request) suggest that the rejection was premature, and that some subsidies can be justified for weightloss in the obese and the overweight.
- Unlike the US situation where GP's can be paid for email consultations and some limited telemedicine consultations, Australia has steadfastly refused to allow such rebates. A new unpublished US study[70] claims that weight loss pep talks over the phone may be an alternative to clinic-based services, and it is then worthwhile asking whether non-medicos could provide such weight loss counselling over the phone, acting as a health coach.[71] This study comes at about the same time as innovative US commercial health insurers such as Highmark Blue Cross Blue Shield announce an expansion of preventive screening coverage to adults aged 19-65+ and children 2-18.[72] The paradox is obvious: a US commercial health insurer imbued with a profit motive nonetheless recognizes that prevention saves money and so it pays health

[67] There is concern, some of it overstated, that we are creating diseases out of poor lifestyle choices, leading to advocacy of medical solutions. The cost of obesity require close attention to prevention and weightloss management initiatives, some medical solutions are effective and even cost-effective, and obesity IS a chronic condition that is linked to at least ten chronic diseases.

[68] J Koutsoukis." Lose fat, get money back proposed". *The Age* 12 September 2005 (downloaded 27 October 2005 from: http://www.theage.com.au/news/national/lose-fat-get-money-back-proposed/2005/09/11/). This article suggested that the proposal was backed by the Health Minister, the Finance Minister and the Minister for Ageing. The Health Department was said to be skeptical. Treasury models had costed the proposal at $50 million per year, offset by $23 million in savings from reduced use of health care.

[69] E Light." Push for obesity treatment to be Medicare funded". *Medical Observer* 30 September 2005, 9.

[70] The data on the 26-week comparative study of the 1,200 calorie diet by phone and in the clinic, followed by 14 weeks of maintenance in both groups, were presented at the 2005 Conference of the North American Association for the Study of Obesity in Vancouver, 19 October 2005- see: Reuters."Weight loss pep talks by phone can work". *Yahoo News* 31 October 2005; L Kan." Weight loss by telephone can work, KU obesity researcher". *Kansas City Infozine* 20 October 2005; and Yahoo Finance. " Health Management Resources study shows surprising 25 lb. weight loss with diet delivered entirely over the phone". Boston, HMC, 26 October 2005.

[71] One Australian version of the GP Health Coach discussed in Chapters 6 and 7 has been proposed as a way of lowering risk factors to heart disease-see: K Woods and H Carter." Teaming with lifestyle coach can reduce coronary risks". *Medical Observer* 10 June 2005, 15. The Melbourne Division of General Practice has been running its COACH program by phone at bi-monthly intervals

[72] Highmark." Highmark Blue Cross Blue Shield to cover selected services to prevent and treat obesity; new preventive health coverage effective January 2006". *PR Newswire* 31 October 2005 (downloaded 2 November 2005 from http://www.prnewswire.com/cgi-bin/stories.pl?ACCT=AAHP_INS.story)

insurance benefits, while the Australian government with responsibilities to improve health status has not yet clarified what it wants a tax-funded Medicare to subsidise to reduce obesity and overweight.

There is a chance that under current methods of Medicare funding of medical services, the general practitioner will gradually disappear as fewer medical graduates chose the GP specialty as a generalist doctor.

- Although current thinking anticipates more nurse practitioner in the supply of primary care, [73] the supply of nurses is far from adequate in Australia to fill all urban and rural GP voids.
- The generalist physician has already disappeared as medical technology created sub-specialties of physician who are experts in specific body functions (heart, brain, tumours, diabetes, hormones and pain management).
- The GP payment system is still the problem when it does not harness technology to help the GP survive as a health coach- and the web is one such route. If GP's are not paid for web consultations, GP's then have to substitute scarce time for which they receive no reimbursement.
- Beyond the GP *per se*, today's Medicare and private health insurance are open–ended in their promises, and we are still debating why we are paying for hospital care of a diabetic foot but not for podiatry, and why we pay for heart pumps for end-stage heart disease and bariatric surgery for the very obese but not for a weight loss program and interventions that reduce other risk factors noted in an earlier table.

My proposal is simple: to restructure Medicare to target obesity as a chronic condition (much like the National Health Priority Areas) but apply some of the integrated approaches now in use in Germany and the USA.

Goals and components

My proposal is that political leaders at the federal and state/territory level, working with the private health sector outside the restrictions of COAG, create a new Medicare funding stream (the National Chronic Care and Obesity Management Program) that pools MBS, PBS, public hospital subsidies, and HACC payments for particular classes of chronic disorder, including obesity as a chronic condition.[74]

My proposal has the two core goals and three components shown in **TABLE 2** below:

[73] The Minister for Health, Tony Abbott, raised this hope at the AFR Health Congress in Sydney on 1 March 2006.
[74] As noted in **PART 1**, I do not endorse the notion of a Health Reform Commission, but I do accept the need to evaluate pooled funding. My proposal could be implemented with the current inter-governmental arrangements and private health insurance without adding a fourth level of government.

TABLE 2: A new Medicare chronic illness focus for Australia: goals and core components

GOALS	1. Reduce the health risks of at-risk target populations with obesity and related chronic conditions 2. Pay for a full range of interventions that have been shown to reduce disability and handicap, including new economic incentives to GP's and patients to reduce the average BMI in Australia to specific levels by 2010 3. Create new types of private health insurance with incentives for healthy behaviour, including weight loss
COMPONENTS	1. Evidence-based decision-support for doctors and patients to implement obesity prevention and weight loss management programs 2. New business model: pay for population-based outcomes in such interventions 3. New administrative roles for Department of Health and Aged Care (a) setting goals for the reduction of the chronic illness burden and obesity (b) negotiating contracts with public and private providers (c) managing and analysing HIC and health fund data in ways that measure BMI as a risk stratifier, and improve the outcomes of care by integrated strategies similar to the Kaiser Permanente WMI program

A new National Weight Management Initiative as a test case for gradual reform of Medicare and PHI benefits

I sketch below the broad shape of this strategy to target obesity prevention and weight loss. Medicare and private health insurance would be retained but not with their present untargeted, open-ended payment systems. My comments below focus mainly on the Weight Management Initiative and associated changes in Medicare.

Consistent with the Kaiser Permanente four-stage strategy, a new Australian Weight Management Strategy should start with the appointment of a new National Council on Obesity and Chronic Disease (see below) to report within six months on (1) the social and economic burden of obesity and related chronic illnesses, (2) the new services needed to prevent and manage obesity as a chronic illness, and (3) a priority plan and indicative budgets to reduce the burden. It would also advise on other related matters identified under *Issues 3-5* below.

What specific types of chronic care management and related financing are lacking in Australia? Many published randomised trials of coordinated care of the chronically ill achieve better health outcomes when consumers are educated, doctors are prompted by practice guidelines, and when consumers face economic incentives to self-manage their own care and risk factors. Two sets of payment reforms are desirable.

Restructuring federal-state revenue sharing arrangements

We need revenue sharing arrangements in the future funding of new prevention strategies and for more efficient hospital and related care for obesity and related major chronic disorders in Australia. In 2002, Germany's Parliament began the restructuring of social health insurance to include disease management of four

diseases in its revenue-sharing with the *Lander* (states), with selected contracts based on quality indicators.

In its deliberations on 10 February 2006, COAG missed the chance to go down either the German or Kaiser Permanente routes, perhaps waiting for the national Obesity Taskforce to enlighten the nation in its long-delayed report due in April 2006.

I argue here that the immediate priority of the Prime Minister should be to replace the National Taskforce on Obesity by a new National Council on Obesity and Chronic Disease, (NCOCD) headed by a Parliamentary Secretary responsible to the Cabinet for the development of cross-portfolio strategies and the creation of public-private partnerships against obesity and chronic conditions. It would have ear-marked funding and responsibilities that are similar to the German national health foundation under the 2004/05 legislation. It would have a similar funding mechanism that is ear-marked in the Budget, and the same 40:20:20 funding split to the federal/state/PHI project action against obesity and related chronic conditions.

Recognising the weaknesses of the current COAG assembly of governments lacking private sector inputs, my proposal would not be the sole domain of governments. Rather, it would create new public-private partnerships to improve the targeting and outcomes of obesity prevention and weight loss management. My proposal has six components:

(1) The Minister of Health would be empowered to enter into contracts with

- State health regions through the state and territory governments
- Private health insurers[75]
- Pharmaceutical companies[76]
- GP Divisions
- Royal College of Physicians.

(2) The targets would be patients in defined geographical areas with the major chronic conditions related to obesity.

(3) Performance-based funding and perhaps even risk-adjusted capitation[77]would augment and possibly replace some of today's MBS, PBS and health fund payments to hospitals and the medical profession. Some of the performance measures have been listed above.

(4) As indicated below, there would be additional annual upfront payments to GP's, using a mechanism identified below under *GP Incentive Component*:

[75] Private health insurers should not be ignored. About 8.7 million persons are now covered by PHI, and payments by the funds to public hospitals ($3.1 billion) now exceed the payment by the largest of the state governments (NSW- $2.7 billion) - see: AHIA. *Working in partnership: health funds and Medicare. Submission to Senate Select Committee on Medicare*. Canberra, AHIA, June 2003, 13 pages.
[76] The Florida Medicaid contract with Pfizer used a form of risk-sharing not yet seen here-see :DA Draper and MR Gold." Provider risk sharing in Medicaid managed care plans". *Health Affairs* 2003; 22(3): 159-167.
[77] The Netherlands, the US Federal Employees Health Benefits Fund and Dr. Dick Scotton have introduced or proposed valid alternative models in which private insurers (and health regions in the Scotton model) compete for revenue funnelled on a risk-adjusted capitation basis from the federal tax revenue collection hopper. The private health sector, not overly represented in many of the government think-tanks on chronic illness, must be involved.

- GPs (and practice nurses) would agree to take on added responsibilities for patients with two or more chronic conditions or designated risk factors
- The GP would coordinate care and maintain a simple longitudinal patient record including measures of BMI and related risk factors
- Additional quality bonus payments for higher patient satisfaction, health and functional outcomes would be paid, as suggested below

(5) The programs eligible for these new dollars would have to offer:

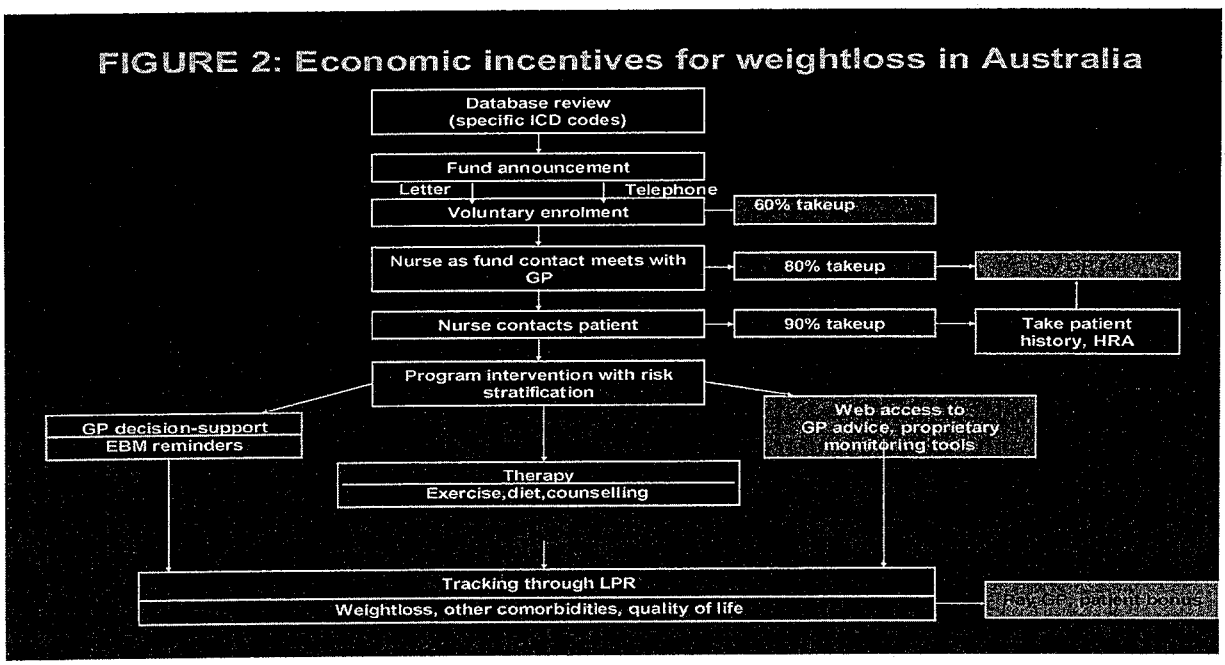
- Voluntary patient enrolment
- Care plans and practice guidelines
- GP coordination of all care
- Evaluation of the impact of the program using clinical trials against non-enrolees, funded by an extra $20 million in research funding over three years
- Specified patient information, education and outreach

(6) The minimum dataset required would include:

- Repeated measures of BMI to enable a profile to be drawn of at-risk groups and to plan targeted interventions
- Monitoring of health and functional status
- Patient satisfaction measures
- Estimates of program costs (both direct and indirect) and benefits

A new GP incentive component allowing health funds to pay doctors above the MBS fee for exceptional chronic care

FIGURE 2 below illustrates some of the economic incentives that are required for a supply and demand side attack on obesity in which (1) the GP is the pivotal point for integrated care of the obese and overweight patient, and (2) private health insurers are persuaded to take a pro-active stance in the weightless of their members.



The proposal would be structured broadly in line with the above diagram.

1. All relevant databases would be pooled to allow both Medicare and the health finds to identify the true prevalence of obesity and overweight, using the Body Mass Index (BMI) as the risk stratifier. An MBS fee would be agreed and BMI would be recorded on Medicare claims for all Australians. The privacy considerations would probably mean that the scheme would be voluntary until the public warmed to the economic incentives below. I estimate a 60% take-up rate after 5 years.
2. All citizens could then register with their health fund their wish to be involved, or indicate to the HIC their intent to take up the subsidy below. At that point, once the HIC was informed by the fund or directly, the GP would be paid an annual health maintenance fee for each enrolled patient (to be negotiated and paid once per year).
3. Each health fund would have health outreach nurses (on contract or employed), who would call the enrollee once the GP fee had been paid. The nurse would contact the enrollee and offer a health risk assessment. The take-up rate of the HRA might be 90% if the enrollee was paid a one-off bonus of $10 say or some other set of incentives.
4. The health fund, either directly or with contracts with approved disease management organisations (as in the German 2004/05 approach), would then offer appropriate advice based on the risk profile (as in the Kaiser WMI strategy). That advice and outreach would be via the Web, telephone and other routes.
5. The individual weightless therapy would be risk-specific, overseen by the GP and underwritten by other incentives that are tied to weightless achievements over a sustained period (as in the Virgin Health Miles approach). The GP would have to maintain a longitudinal patient record on all enrollees and would be paid a practice bonus on a pay-for-performance basis (similar to the US Building Bridges approach or the UK performance payment system for GP's but with more focus on weightless and chronic condition management).

Under this proposal, private health insurers would be

- permitted to offer out-of-hospital medical benefits for health insurance products covering validated interventions in obesity prevention and weight loss;[78]
- allowed to offer bonuses for weight loss and maintenance of weight loss, requiring prior legislative changes concerning the community rating principle.

There remains the question of how to implement the same broad strategy to non-insured patients. My preference would be to see regional health authorities acting in the same role as the health funds, paid the same bonuses for the same levels of commitment and enrolee weightloss. In some large states, the contractor could be a medical school, a specialised agency set up for the role, or a large independent

[78] This possibility was canvassed in actuarial proposals to amend the Reinsurance Pool arrangements in 2005, but they are now delayed until 2007.

school system. This is a performance-based approach in which the major criteria are the levels of outreach, the use of interventions appropriate to risk, the quality of the intervention and the weightloss achieved and sustained.

Alternatively, we could allow employers to be designated as a specialised agency, a matter to which I briefly allude below.

The Committee has to give leadership on needed change, and not be constrained by the vestiges on past schemes that are now unwieldy or irrelevant. The future role and funding of Medicare's promises are unlikely to be resolved by the current federal-state financial agreements.

CONCLUSION

Healthcare reform has been patchwork since the first Medibank scheme in 1975 introduced a profusion of supply-side constraints while eschewing any demand-side constraints such as copayments as blaming the victim or regressive in their financing.

Since then, any attempt to lay out a different canvass has been either ideologically bent (the Macklin inquiry in 1991), tied to the *status quo* (four state government inquiries since 2000), limited to a small part of the health sector (the Hogan review of aged care in 2003/04) or hidden from public view (the Podger review of the fed/state overlaps in 2005 and the COAG Working Party report of late 2005). The resulting mess leaves us all vulnerable to the vagaries of patchwork policy making.

In 2006, neither major political party is seeking to identify - and agree on the common ground of - the healthcare reform agenda. Such tranquillity is unacceptable when a few of the more amenable policy levers require tweaking, not radical replacement of the whole mixed system of financing by a fourth tier of government.

Complacency was flagged as a real danger by the Prime Minister in a speech on 2 October 2005.

"[T]he politics of prosperity are no less challenging than the politics of adversity. The biggest challenge of all is to avoid the pitfalls of complacency. Complacency is the giant killer of Australian politics particularly when it comes to economic management."

He is right- and healthcare reform in an ageing society with obesity and chronic illness rampant is now overdue economic management. Removing inefficiencies in the hospital sector and retooling the 30% rebate to increase national savings behaviour are not big stretches once a critical mass of politicians and opinion leaders realise that we need to reduce waste and reform the tax base in Australia to care for an ageing society.

Complacency in healthcare reform is rife in our collective acceptance of the *status quo*, in platitudes about preferring to be sick in our health system than in the health system of any other nation, and in ignoring the cumulative messages in **PART 1** that we must remove gaps and inefficiencies in care and retool for a fatter, chronically ill and ageing society.

Removing complacency starts with a Parliamentary Committee emphasizing to the government and the public the need for integrated reforms that achieve these outcomes.

The Standing Committee also needs to tell the punters why Australia needs to embrace personal responsibility as a core value, restructure Medicare and develop smarter health insurance to deal with obesity and related chronic conditions, and protect the poorest and sickest in our midst.