Submission from [redacted], Director, Health Program, Grattan Institute

This submission addresses the following aspects of the Commission's Terms of Reference:

Efficiency and effectiveness of government expenditure

- options to manage expenditure growth, including through reviewing existing policy settings, programs and discretionary spending (such as grants);
    - *I argue that current policy settings for Commonwealth government funding of public hospitals are generally appropriate but there is some room for improvement, particularly by states*
    - *Grattan Institute work on prices paid for pharmaceuticals prescribed under the Pharmaceutical Benefits Scheme (PBS) are too high and wasteful. About $1 billion per year could be saved from improved policy settings*
- savings and appropriate price signals – such as the use of co-payments, user-charging or incentive payments – where such signals will help to ensure optimal targeting of programs and expenditure (including to those most in need), while addressing the rising cost of social and other spending;
    - *Many Australians do not obtain necessary health care because of cost. An important recommendation of the National Health and Hospitals Reform Commission was to establish a common safety net (harmonising the PBS and Medicare safety nets). This recommendation wasn't implemented but it should be.*
- options for greater efficiencies in the Australian Government, such as: flattening organisational structures and streamlining lines of responsibility and accountability;
    - *Accountability for many government programs is process-based. Government should move toward more accountability for outputs and outcomes. Accountability arrangements for Medicare Locals provide a case in point. I argue accountability for these organisations should focus on outputs/outcomes such as immunisation rates not voluminous plans.*

Public sector performance and accountability

- identify options for continuous assessment of programs, agencies and performance;
- review and report on the effectiveness of existing performance metrics and options for greater transparency and accountability through improved public reporting;
    - *Government holds vast amounts of data that it has collected for payment and other purposes (e.g. for paying Medicare claims). I argue these data should be made more widely accessible to researchers to analyse service impact and provide for service improvement. Grattan work demonstrates through analysis of routine data where savings can be made*

Options to manage expenditure growth

Public hospital funding

1. Current Grattan Institute work shows there is considerable scope for efficiency improvement in all states and territories in delivery of public hospital services. This will be the subject of a Report to be released in March 2014. I would be happy to brief the Commission on this work in advance of its release if it wishes.
2. Health care is the fastest growing area of government expenditure, across both state and federal governments (see recent Grattan Institute *Budget pressures* Report, http://grattan.edu.au/static/files/assets/ff6f7fe2/187_budget_pressures_report.pdf). Hospital expenditure is the fastest growing area within health.
3. The National Health Reform Agreement, currently being implemented, provides that:
    a. The Commonwealth government's base share of public hospital funding is now described using output measures (measures of hospital activity, hence the description 'activity based funding', ABF). This provides improved transparency of the Commonwealth contribution;
    b. The Commonwealth contributes a fixed share of the costs of increased activity (and costs). Importantly, the Commonwealth is only obliged to contribute to what an independent arbiter (the Independent Hospital Pricing Authority, IHPA), determines are the costs that an 'efficient' hospital would take to provide that additional activity. This is done by IHPA establishing the 'National Efficient Price'; in 2014-15 the Commonwealth will pay 45% of the cost of additional activity at the National Efficient Price.
4. These policy settings are welcomed as they send clear price signals to states and allow comparisons of performance. Current policies will lead to pressures on states to improve their efficiency, and this in turn will drive down the National Efficient Price (as it is currently based on the average hospital performance cross the country), creating a virtuous cycle of improvements in technical efficiency.
5. 2014-15 will be the first year where price signals operate at the national level. The National Efficient Price is currently based on average costs. Over time, the price should be adjusted to reflect better practice (e.g. not paying for adverse events) and potentially productivity growth broadly defined i.e. improvements in outcomes of care. This will lead to improvement in social or allocative efficiency.
6. The National Health Reform Agreement provides for additional payments to states in the form of minimum payment guarantees. These guarantees are not based on payment for additional activity and so mitigate the effect of the efficiency incentives incorporated in the Agreement.
7. IHPA is an important element of the Reform process. Because it is established as an independent authority, it can take decisions in the best interest of the health system, and not become mired in Commonwealth-state disputes which slow decisions (or even paralyse decision making), lead to lowest common denominator standards and inhibit change. IHPA should be continued as an independent authority regardless of what happens with other newly-established health agencies.

Pharmaceutical prices

8. A Grattan Institute released in March 2013, Australia's Bad Drug Deal (http://grattan.edu.au/static/files/assets/5a6efeca/Australias_Bad_Drug_Deal_FINAL.pdf) showed Australians are paying too much for prescription drugs. The cost of this overpayment is now estimated as at least $1 billion a year. This equates to around 10 per cent of the entire Pharmaceutical Benefits Scheme (PBS) budget. In a time of escalating health costs and other strains on the Commonwealth Budget, spending on pharmaceuticals could be reduced relatively easily, if there is the political will to do so.
9. Several good examples show how this could occur. In New Zealand, drug prices have plunged dramatically, freeing up money to spend on new drugs and other kinds of care. New Zealand's secret is simple. The Government has taken the politics out of price-setting and appointed independent experts to make decisions. It has also capped the budget for drugs, which ensures clear priorities and tough negotiations with pharmaceutical companies.
10. For Australia's PBS, by contrast, decisions on drug pricing are opaque and unconstrained by a budget. Key decisions are made by a committee inside the Department of Health and Ageing that includes among its six members two representatives of drug companies. They have little interest in keeping prices low.
11. In New Zealand, politicians decide how much is spent on drugs in total, then independent experts negotiate prices. In Australia, expert judgements come first but can be overridden by political decisions. No one assesses how much we should spend overall. As a result, our wholesale prices for identical drugs are now more than six times New Zealand's. In some cases, they are more than 20 times higher.
12. One drug alone, atorvastatin, has cost the Australian Government and individual patients more than $700 million a year. In its 40 mg form, the PBS paid more than $51 for a box of 30 tablets. New Zealand pays AU $5.80 for a box of 90 tablets. Adopting New Zealand prices for atorvastatin would have saved the PBS more than $1.4 million a day in 2011-12. Patients who paid full co-payments would have saved $22 on each box of tablets.
13. The report proposed three changes to get pharmaceutical prices under control. The first is to establish a truly independent expert board. Like New Zealand's Pharmaceutical Management Agency, it would manage pharmaceutical pricing within a defined budget.
14. The second and vital change is to pay far less for generic drugs, which can be bought for low prices because they are off-patent. In Australia drug companies must cut prices by 16 per cent when a patent expires. Many countries require much bigger cuts. Canada has mandatory cuts of 82 per cent for some drugs. Australia should require a cut of at least 50 per cent, then benchmark prices against the world's best. This might seem unrealistic. But Australia's public hospitals already pay low prices. Like New Zealand, one state's prices are only a sixth of those on the PBS.
15. Down the line, a third reform should encourage people to use cheaper but similar pharmaceuticals, which could save at least $550 million a year more.

16. The main policy currently used to reduce generic drug prices (price disclosure) is not working nearly well enough. After the last two rounds of price cuts, ex-manufacturer prices remain seven times the United Kingdom's and nearly 12 times the best prices in the UK, New Zealand and the Canadian province of Ontario.
17. Grattan Institute has recently analyses the outcomes of the price disclosure, compared to an alternative policy of benchmark pricing in a report *Poor Pricing Progress* which is to be released on 1 December. A copy of that report is attached.
18. The Trans Pacific Partnership (http://www.dfat.gov.au/fta/tpp/) negotiations have the potential to increase costs of the PBS if, for example, 'ever-greening' provisions and non-use of existing evidence serve to delay bringing generic drugs into the Australian market. Government's negotiating position should explicitly take into account these risks.

Safety nets

19. According to an ABS survey (http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4839.0main+features32011-12) around 7% of people who needed to see a GP in the previous 12 months had delayed seeing or had not seen one because of the cost. The Commonwealth Fund's International Health Survey (http://www.commonwealthfund.org/Surveys/2011/Nov/2011-International-Survey.aspx) reported somewhat higher levels, with particularly high levels of delay or non-attendance in remote communities. People also did not fill prescriptions because of cost.
20. Analysis of the Commonwealth Fund survey data done for a recent Grattan Institute report on access to care in rural areas (http://grattan.edu.au/publications/reports/post/access-all-areas-new-solutions-for-gp-shortages-in-rural-australia/) found that about one third of people living in a remote area either skipped visits, treatments, tests or medications because of cost.
21. I was a member of the National Health and Hospitals Reform Commission which reported in June 2009 (http://www.health.gov.au/internet/nhhrc/publishing.nsf/content/nhhrc-report). The Commission recommended that 'the scope and structure of safety net arrangements be reviewed'.
22. The Commission noted that

> 'there are currently multiple safety nets (covering, for example, the MBS (the original and extended Medicare safety nets), the PBS, and a net medical expenses tax rebate). In addition, there is a patchwork of government programs that partially meet the costs of some services (diabetes equipment, continence aids, therapeutic appliances). The purpose of reviewing safety net arrangements is to create a simpler, more family-centred approach that protects people from unaffordably high co-payments for using health services. In saying this, we are essentially acknowledging the need to recognise and tackle the high costs faced by some people for health services which fall outside our current universal service entitlement'.

23. Unfortunately this recommendation does not appear to have been followed up.
24. Out-of-pocket spending on health care is increasing. As indicated above, financial barriers to access to health care remain important in Australia, despite the existence of Medicare and the PBS.
25. The health care safety nets which exist are important ways of protecting consumers from the effect of out-of-pocket costs, but they act imperfectly. If consideration is to be given to expanding out-of-pocket costs in health and related areas, rationalisation of the safety nets should be undertaken as part of that change. One way of improving access, in a fiscally responsible way, would be to address the multiple separate safety nets.

Output/outcome accountability vs process focus

26. Despite decades of proposals for streamlining Commonwealth accountability requirements (e.g. see Joint Committee of Public Accounts (1995) *The administration of specific purpose payments: a focus on outcomes*, Parliament of the Commonwealth of Australia), much Commonwealth funding is bound up in kilometres of red tape, creating make-work for armies of bureaucrats.
27. Accountability requirements are often still expressed in process terms: funded agencies have to submit extensive 'plans' on specified templates. This type of process-accountability inhibits local flexibility and innovation, creates an onerous compliance burden and is often an add-on to local management accountability.
28. Although the point about shifting to output/outcome accountability is a general one, I am the Board member of a Medicare Local and I see the implications of the process focus at first hand.
29. Rather than specifying the outputs or outcomes that are to be achieved (e.g. increased immunisation rates, increased after hours cover) and the populations to be reached (distribution of output/outcome measures across Indigenous populations or population with a culturally or linguistically diverse background), accountability requirements for Medicare Locals are specified in terms of planning documents, and detailed process measures (how many members of the board, what template will be used for the area plan).
30. Local responsiveness would be strengthened, and government objectives achieved simultaneously, if
    a. Government were required to specify its funding objectives in output/outcome terms
    b. Local agencies were held to account for these measures rather than 'compliance' requirements.
31. Streamlined accountability requirements would foster local innovation, and reduce bureaucratic overhead both locally and in government departments.

Public sector performance and accountability

32. Government data holdings, collected as part of routine administration of funding programs, represent a rich but neglected source which potentially could be used to improve public sector efficiency and accountability.
33. Despite the difficulty that external academics have in gaining access to confidentialised data, there is already evidence of the benefits that can accrue to the public from improved access to these data holdings (see http://www.menziesfoundation.org.au/health/health.html, http://www.assa.edu.au/programs/policy/submissions/2013-06-20).
34. It is often not perceived to be in the short term interest of departmental data custodians to facilitate data release as it opens up government programs to increased scrutiny and accountability.
35. However, increased accountability and assessment of government programs is in the public interest. Other countries (e.g. the United States) provide good examples of better access arrangements.
36. At Grattan, we are working on another report which uses specially released national data on the costs of hospital care to identify the significant savings that can be achieved by improved public hospital pricing policies by states and territories. This type of work should be encouraged and facilitated.
37. Provision should be made so that routine data can be made more easily available to researchers to analyse service impact and provide a basis for policy evaluation and improvement as part of an improved public sector performance and accountability regime.

26 November 2013