



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

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Submission to the National Commission of Audit (Health and related expenditure)

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Introduction

Private Healthcare Australia is the industry association representing the 23 leading private health insurance funds, which collectively insure more than 95% of the more than 12.4 million Australians who are privately insured. This submission is provided in the hope that areas of inefficiency and excessive red tape within Australia's health system may be addressed in a way that leads to improved health outcomes and lower insurance premiums.

Based on consideration of the Commonwealth Government's regulation and funding of the health system, Private Healthcare Australia has identified a number of solutions in this document that will:

- improve patient outcomes and quality of life;
- increase the safety and quality of healthcare; and
- reduce Commonwealth expenditure on healthcare.

Finding ways not only to reduce the cost of healthcare but also simultaneously to improve health outcomes is critical to Australia's economic future. A more efficient system that delivers higher quality and more appropriate care will ensure that a greater proportion of Australians remain in the workforce for longer, and fewer are in poor health or requiring corrective procedures as a result of avoidable system inefficiencies.

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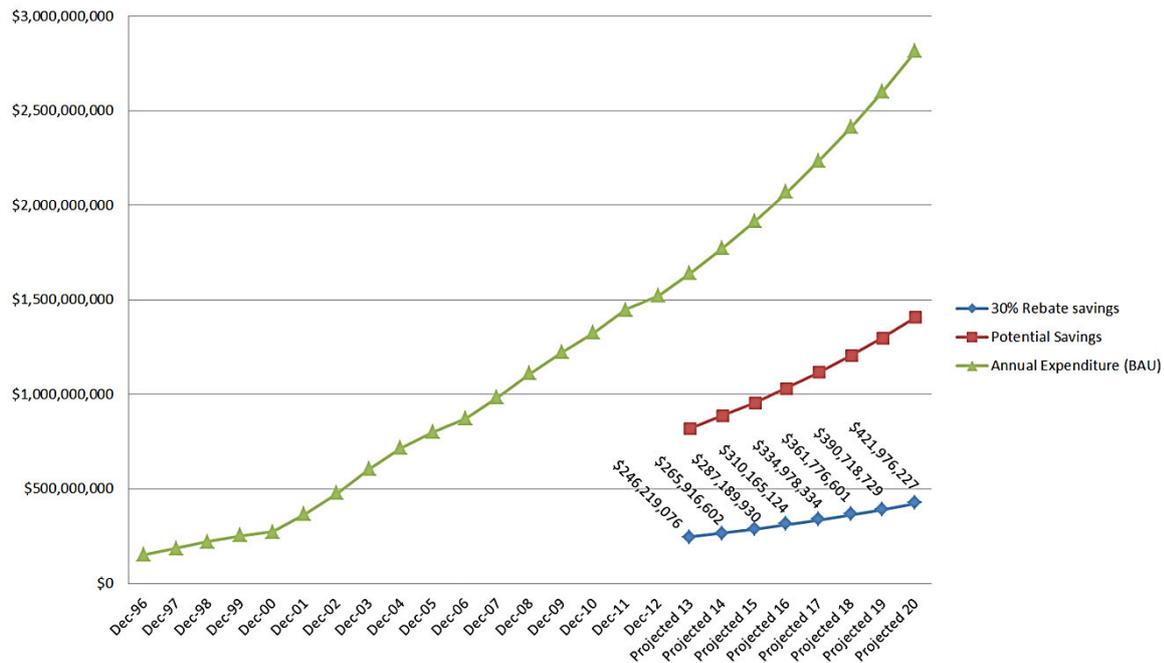
1. Align prostheses benefits to levels in comparable economies

Introducing much-needed reform of prostheses regulation and pricing could save the Federal Government as much as \$1 billion over four years, with lower costs continuing into the future. The potential savings are indicated in the chart below showing the impact on prostheses benefits paid by health funds if the price of prostheses was aligned to the prices paid for the same prostheses in France.

Legislated benefits payable for prostheses in Australia are up to five times higher than the prices paid in comparable economies, such as the United States and United Kingdom. In 2011-12 the total benefits paid by private insurers for prostheses was \$1.5 billion (approximately 14% of all benefits paid).

Reform of prostheses pricing on this basis would save the Federal Government around \$241 million per year instantly from the contributions it makes to the cost of private health insurance premiums through the Australian Government Rebate, with savings reaching around \$335 million per year by 2017.

Potential Savings on Prostheses Expenditure if International Reference Pricing was Implemented (Data post Dec-12 extrapolated from PHIA & LPP data)



The above graph tracks prostheses benefits to date in Australia. The green line shows how prostheses benefits in Australia would increase to 2020 based on the current pattern of increased utilisation only and assuming that benefits do not increase. Continued growth in prostheses expenditure at this rate would lead to significant rises in premiums, impacting not only privately insured Australians but also the Federal Government through the Rebate.

The red line shows the potential savings in Australian prostheses benefits if these were aligned with the benefits paid in France for the same prostheses. These estimates are based on conservative estimates for identical ICDs, pacemakers and coronary stents.

The blue line estimates potential savings in Federal Government expenditure on the Australian Government Rebate, assuming the Government pays 30% of the cost of each prosthesis.

Lower costs will allow greater numbers of Australians to improve their quality of life with new prostheses for the same price. Reducing prostheses outlays would also make private health insurance more affordable and attractive for non-insured Australians, easing the burden on the public hospital system.

Improved regulation of quality and performance of prostheses would also deliver further savings with fewer corrective procedures to remove and replace failed prostheses as poor performing joints are phased out.

2. Stop funding underperforming prostheses

It is not in the interests of patients, doctors, health insurers, public or private hospitals or the government health budgets for unsafe prostheses to be used or remain on the Prostheses List. Poor prostheses result in failures and complications that may require further hospital treatment, in the public and private sectors.

Further medical interventions increase risks to patients and complexity for surgeons. Patients should not be subjected to further pain, suffering, additional treatment or cost due to unsafe prostheses.

Between 36-50% of unplanned readmissions to hospital within 28 days of the original surgery involve prostheses that have been previously identified by the National Joint Replacement Registry as having “higher than anticipated revision rates”, resulting in additional costs to private health insurers of more than \$120 million per year.

This represents a significant financial, emotional and health cost for patients, health insurance funds and the public system.

Safety is vital in prostheses regulation because:

- patients bear the primary risks when health technology goes wrong; and
- unlike pharmaceuticals, patients cannot simply stop medical technology that is causing them harm – they require surgery to remove the technology, if it can be removed.

Private health insurers should only pay for prostheses that:

- have a proven record of safety for the proposed use;
- provide a proven clinical benefit at least equal to other medical treatments; and
- provide that benefit in a cost-effective manner.

Private health insurers should not be required to pay for prostheses with a poor track record or those that are more expensive than their clinical equivalents but provide no better clinical outcomes.

Budget savings measures introduced in the 2012-13 Budget to cease payments for the costly use of underperforming joints have the support of the private health insurance industry but have yet to be implemented. These measures were budgeted to save \$5.8 million over four years.

3. Disinvestment in ineffective procedures

Disinvestment in health procedures is the process of limiting the use of ineffective, inefficient or low-performing medical treatments so that resources may be used in other areas of health care. The concept is being embraced by Governments in the United Kingdom and Europe.

An example of a treatment that should be a candidate for disinvestment is knee arthroscopy. In a paper commissioned by the Medical Benefits Fund of Australia, the Adelaide Health Technology Assessment Agency concluded that therapeutic knee arthroscopy generally offered no significant advantage when compared to blinded placebo treatment in terms of pain, mobility, or quality of life. In 2007-08, the combined total for Medicare and private health insurance benefits contributing to these fees was \$31.7 million, with Medicare contributing \$16.8 million and private health insurers \$14.9 million.

There are further examples of ineffective procedures that could each deliver savings to the health budget without compromising health outcomes.

4. Increase Patient Safety by harmonising Hospital data

A PriceWaterhouseCoopers review of National Hospital Cost Data Collection commissioned by the Independent Hospital Pricing Authority identified significant duplication across various national data requirements that, if rationalised, could produce Budget savings.

Data submission requirements for NHDC are substantial and in some cases duplicative. The NHDC requires numerous files to be submitted as part of the Collection process to support both its methodology and the construction of cost weights. Stakeholders have called for a 'single submission – multiple use' concept of one source of data collection and its subsequent processing. The scope of the collection has grown over time and there is now significant duplication of information provided in other collections such as the Admitted Patient Care (APC) NMDS.

Another area of duplication in data collection is the requirement for states and territories to supply essentially the same data on hospital admitted patient care to two different Commonwealth collection processes – to the Australian Department of Health under the Australian Health Care Agreements and to the Australian Institute of Health and Welfare under the National Health Information Agreement. This duplication increases the likelihood of inconsistencies arising from differences in the data provided and data processing details and adds unnecessary administrative costs to the Commonwealth.

This data should be publicly available to empower healthcare consumers to be able to make informed choices about their healthcare providers.

5. Abolish the Premiums and Competition Unit (PACU) within the Private Health Insurance Administration Council (PHIAC)

PHIAC received \$5.6 million in the 2013-14 Budget to be the prudential regulator of private health funds, to administer the annual premium setting process, to administer the risk equalisation fund, and to collect and publish relevant industry statistics. All of PHIAC's funding comes from the industry through a compulsory levy on all funds.

PACU was established by the Labor Government in the 2012-13 Budget as a division within PHIAC to "identify options to increase competition in the private health insurance market and put downward pressure on industry costs and premiums."¹ Industry did not support the establishment of PACU within PHIAC due to concerns about the propriety of granting the prudential regulator with additional policy advisory powers, which are more appropriately based in the Department.

Since its establishment PACU has completed two papers, one summarising the level of competition that exists within the private health insurance sector, and one analysing the impact of portability rules. According to its website, it has plans to issue three further discussion papers on the subjects of barriers to entry; excesses, exclusions and competition; and the impact of risk equalisation.

The industry does not believe PACU is delivering value and calls for PHIAC to cease its activities in this area, which are more appropriately handled by the Department.

¹ 2012-13 Budget Portfolio Statement – Private Health Insurance Administration Council,

6. Duplication by PHIAC of work done by other commonwealth agencies, plus the inappropriate use of hospital treatment episode data

PHIAC was established with the core principle/objective of being an independent financial regulator to the private health insurance sector. The use and analysis of Hospital Case-mix Protocol Data (HCP), or anything similar, by PHIAC is both beyond its remit and clearly overlaps with work already being done by other Commonwealth health agencies including the Department of Health (DoH), the Australian Institute of Health and Welfare (AIHW), and the Private Health Insurance Ombudsman (PHIO). It also duplicates analysis performed by Private Healthcare Australia for its member funds, as it has been providing detailed analysis of this data at no additional cost for its members since 2005.

HCP data embodies what occurred during a patient's hospital episode, and the industry believes the use of this data by PHIAC not only duplicates of existing services, but also represents a major conflict of interest with PHIAC's remit and current terms of reference. PHIAC's activity in this area creates has the risk that commercially sensitive patient-hospital information is disclosed whilst failing to provide any added value to health insurance consumers or the industry. In addition to adding further cost burden to Commonwealth resources, it also places an additional and excessive burden on industry through the need for increased mandatory PHIAC contribution levies.

The industry also believes that there is a major conflict of interest for PHIAC as the health insurance industry financial regulator to be using HCP data to make fund solvency/financial management decisions based on data that is a hospital clinical patient record generated by hospitals, and as such this data is specific to a patient's hospital episode. It is therefore not data produced by health insurers. This by implication means that PHIAC is now in operating in the realm of investigator and regulator to private hospitals, which lies completely outside of its remit.

7. Guideline Usage by Providers

Many organisations such as the National Heart Foundation, the National Breast and Ovarian Cancer Centre publish guidelines on best practice care on a regular basis. However, these guidelines are not utilised widely. For example, the Medical Journal of Australia reported recently that just 4.9% of treatment for Acute Coronary Syndrome is provided in accordance with the latest treatment guidelines. Treatment according to the latest guidelines is likely to produce improved care, with better outcomes, and hence fewer episodes of inappropriate or poor care. This will save money in itself. If there is no appetite to enforce the use of guidelines, then the money spent on drawing up the guidelines (many millions of dollars annually) could be saved simply by ceasing to fund the process.

8. Changes to Privacy Laws

Interrogation of available Australian data shows vastly variable rates of deaths, infections, etc., in hospitals around Australia. However, privacy laws prevent the names of the poorer performing hospitals and providers being published. This means the less optimal care continues unabated, and the people subjected to this care are unable to make an informed choice as to which care they wish to receive. Given the increased costs to the health system arising from poorer care, significant savings could be made by publicly identifying the poorer performing providers, so that Australians can make appropriate decisions as to where they will receive their care, and in so doing they will make choices which will avoid expensive and distressing corrective procedures because of the less than optimal care.

The current Privacy Act also protects perpetrators of inappropriate behaviour and fraudulent activity. Currently if one health fund discovers inappropriate charging, claiming or fraudulent

activity, they are precluded from informing other health funds of the details of this behaviour. Generally, acts of fraud committed against one health fund are also occurring across all health funds and Medicare. Health funds require the ability to share information ensuring that commercial and/or personal information is only shared in appropriate circumstances and in a manner that is consistent with the objective of analysing and investigating and preventing suspected unlawful, inappropriate or wrongful activity.

Information should be shared by appropriate people within health funds in the case of suspected unlawful activity by health care providers, health funds members or health fund staff. Such activity may take the form of fraud, inappropriate service delivery, falsified claims, false membership and other activity including behaviours that are reasonably believed to be unlawful, inappropriate or wrongful and may result in health funds making unwarranted payments.

Privacy laws should be altered to make publication of care standards compulsory and enable the sharing of information between funds to reduce the amount of fraud.