Productivity Commission

Human Services:
Identifying sectors for reform

Bupa Submission

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Executive Summary

Bupa's Australia and New Zealand group of companies (Bupa) welcomes the opportunity to contribute to the Productivity Commission's (Commission) inquiry into the increased application of competition, contestability and informed user choice to human services. We believe a key outcome of this inquiry is the delivery of reforms to create an effective and efficient public-private health and care system, which delivers the best health and social outcomes for all Australians.

Health care and aged care systems are significant components of the human services portfolio. As a significant player in both sectors, Bupa is committed to working in partnership with the government to ensure all Australians can access timely, affordable and high quality human services, which are appropriate to their needs, and are delivered in a cost-effective manner.

As part of the international Bupa Group, Bupa's Australian and New Zealand businesses share a common purpose of *longer, healthier, happier lives*. We are focussed on providing sustainable healthcare services, support and advice to people throughout their lives, and on leading the industry in the promotion of preventative health and care.

Private Health Insurance

Bupa believes in a strong public health and care system, supported by a strong private system. Around 70% of Australia's health care is delivered by the private health sector. Private health insurance is an essential part of a high quality, financially sustainable health system.

As funders, governments and health insurers face similar challenges. Public health funding and the sustainability of the health insurance sector are impacted by significant growth in chronic disease; increasing patient expectations about access to services; the number and range of health services provided; the increasing cost of those services; and an ageing population. Sustainability of Australia's health system is also impacted by duplication, inefficiencies and a lack of enablers.

Strengthening competition in Australia's health system will help create a more sustainable operating environment for Bupa, but more importantly, it will also assist governments to better contain the growth in health care expenditure by stemming the flow of Australians leaving private health insurance in favour of the public system. This is particularly significant given the size of the budget repair challenge that Australian governments must meet well into the future.

Supply cost drivers of health insurers: In order to help ensure a competitive and sustainable private health insurance market for the long term, Bupa believes insurers will need to move from their traditional role of being a 'payer' to take on the responsibility of becoming an 'active purchaser and change agent', driving improvements in quality, cost effective care and appropriate service delivery models.

The legislated benefits payable for prostheses in Australia means we pay some of the highest price in the world for medical prostheses such as hip joints and pace-makers. In its 2015 report, *Costing an arm and a leg*, Private Healthcare Australia noted that "International and domestic price benchmarks suggest that, on average, the Australian private health system is paying nearly twice the efficient benefit level for prostheses." To address the lack of competitive pressure, reforms are required to diffuse the scope for market power by sponsors, deliver greater savings and benefits to customers, drive greater competition between prostheses sponsors and improve pricing competition between insurers.

Competition – hospitals and medical specialists: To enhance competition in the hospital sector, Bupa believes the regulation of benefits paid to second tier hospitals by insurers should be reviewed. We believe increased competition would drive sustainable long-term pricing in the sector as well as innovation, improved patient experience, quality and safety improvements and models of care which are more cost effective for the system as a whole.

It is Bupa's view that hospital oligopolies detract from competition in the private hospital market by wielding a disproportionate amount of power in relation to other health stakeholders. We believe the case for action on this matter is compelling.

Competition - providers: A collaborative effort between the health insurance industry and government to reduce opportunities for fraudulent claims on the Medicare system and excessive utilisation of health services, we believe, is consistent with the objectives of this inquiry. Competition amongst health care providers is improved and limited public funds are better invested in areas of greater need, for example more efficient use of public hospital beds or reducing elective surgery waiting times, when some providers no longer benefit from an undeserved financial advantage. A reduction in fraud and over use in the health system will meet this inquiry's goals of improving the quality, equity, efficiency, accountability and responsiveness in one of Australia's largest and critical human services sectors.

Informed User Choice: A well informed customer base will inevitably lead to a better functioning and more competitive market. The current policy settings patently do not allow consumers to make informed choices with respect to specialist treatment. Competition in this area of Australia's health system will not be fully realised if consumers continue to be denied the necessary and fundamental information that allow them to make timely and informed decisions that are in the best interests of their health care.

Bupa believes product information and communications should be tailored to meet the needs of consumers. The lack of consistency in the way insurance product information is communicated to customers, caused by the inadequacy of the Standard Information Statement, can easily be addressed. This will lead to a significant improvement in the flow of information to customers.

We believe online comparators and brokers operating in the health insurance market fail to assist consumers to make informed choices. Bupa contends it is reasonable to expect comparators and brokers be required to serve the best interests of their customers. By doing so, this will significantly improve a customer's ability to make timely and informed choices about the most appropriate insurance coverage, which inevitably amplifies competition between health insurers.

Competitive neutrality: The government currently contributes around $5 billion dollars net[1] to 13 million Australians who choose to take out health insurance with the support of the health insurance rebate. In return for this investment of public funds, Bupa believes all insurers should make an equal contribution back to the taxpayer. The reality is all insurers are operating their businesses as commercial enterprises, yet they are not contributing equally through the payment of taxation. Improving competitive neutrality will help ensure consumers fully benefit from this investment of public funds.

Aged Care

Reforms to Australia's aged care sector are required to restore competitive neutrality and increase competition between providers. This will lead to greater consumer choice and develop a truly sustainable aged care system.

About Bupa Australia and New Zealand

As part of the international Bupa Group we are focussed on providing sustainable healthcare services, support and advice to people throughout their lives, and on leading the industry in the promotion of preventative health and care. The international Bupa Group cares for more than 29 million people in over 190 countries.

We provide a wide variety of services for over six million customers across Australia and New Zealand. In Australia, we provide health insurance and aged care services, as well as delivering healthcare services. These include general practice (GP) services (through Bupa Medical GP) health coaching (through Bupa Medical TeleHealth), corporate health services (through Bupa Wellness), eye care (through Bupa Optical), dental (through Bupa Dental Corporation) and audiology services (through Bupa Hearing). In addition, Bupa Medical Visa Services provides visa medical examinations to approximately 250,000 people annually across Australia and other visa and migration services to the Department of Immigration and Border Protection. In New Zealand, Bupa has aged care homes, retirement villages, personal medical alarms and a brain rehabilitation business.

[1] the net figure takes into account the proportion of the $6 billion health insurance rebate paid out being recovered by the government through Individual tax returns as the eligibility for the rebate is income tested. This rebate recovery is expected to increase each year while income thresholds for the health insurance rebate continue to be frozen.

Since 2002, Bupa has invested around $6 billion in Australia and New Zealand's health and care sectors. This investment helped acquire and grow Bupa's health insurance business, dental clinics in both countries, and health services including preventative health and chronic disease management.

Bupa is dedicated to making a lasting difference to Australia's health and care system, including through the Bupa Health Foundation (Foundation). As one of Australia's leading corporate foundations dedicated to health, it is committed to improving the health of the Australian community and ensuring the sustainability of affordable healthcare through collaborative partnerships. Over the past 10 years the Foundation has invested over $26 million in more than 100 projects, focused on translating Australian research into real health and care improvements.

Summary of Recommendations

Recommendation 1 – reform the supply side cost-drivers and reduce barriers to enable health insurers to effectively negotiate lower costs for their members, including through immediate changes to prostheses listing and reimbursement.

Recommendation 2 – enable health insurers to effectively negotiate lower costs for their members (and increase competition in the hospital sector) by removing the second tier default benefits.

Recommendation 3 – improve and encourage appropriate competition practices in the sector by the Productivity Commission examining:

- the level of competition in the Australian private health sector, with detailed review of private hospitals and medical specialists; and
- whether medical specialists should be required to provide patients with written confirmation of details of any financial interests that the consultant holds in medical facilities or equipment.

Recommendation 4 – realise substantial savings to the entire health system through the Government working with health stakeholders to consider options to improve fraud detection and claims leakage efforts in Australia's Medicare system by sharing and integrating de-identified health data.

Recommendation 5 - repeal and replace the Standard Information Statement (SIS) requirements with a minimum mandatory set of product information. This should be developed in consultation with the industry and provided by the insurer to customers under a set of agreed circumstances. The format in which the mandatory information is provided to the customer would be determined by the insurer, who could choose to provide additional information above the minimum set.

Recommendation 6 – empower health care consumers to make timely and informed decisions about their health care needs and the choices available to them. To provide user choice and increase competition in the health system, Bupa would welcome the opportunity to work with stakeholders to:

- identify what information would be most relevant to patients regarding costs of treatment, out-of-pocket expenses, expected outcomes and treatment options; and

- design solutions that will deliver greater transparency of costs and effectiveness through access to relevant information at the right time in the patient's health journey.

Recommendation 7 – introduce additional regulation of online comparators and brokers to provide extra protection for consumers by providing requirements for disclosure to the public of:

- commissions that would be received in relation to particular products including up-front and trail commissions:
- how product recommendations were made, including the number of products/insurers that were considered in reaching the recommendation;
- the percentage of products in the market that comparators/brokers cover and the percentage of products from each insurer they represent;
- detailed reasons for selection of one product/insurer over another product/insurer including the benefits offered by the product being recommended; and
- key product conditions that apply to the recommended product such as exclusions, excesses, co-payments and waiting periods.

Recommendation 8 – improve competition by requiring all registered private health insurers to pay company tax on profits earned from their registered health benefits fund(s) regardless of registration status.

Recommendation 9 – defer the 2016 Budget changes to the Aged Care Funding Instrument and establish an Aged Care Sector Taskforce, comprising representatives of aged care sector stakeholders and officials, to develop alternative, better targeted funding arrangements that ensure there are no unintended consequences to the quality of care for aged care residents with complex care needs.

Recommendation 10 – support the Aged Care Sector Committee's Aged Care Roadmap's short, medium and long term recommendations to create a consumer driven, market based, sustainable aged care sector.

Private Health Insurance

It is critical that both the public and private health care system remain viable, effective and efficient options for Australians in order to allow user choice. Around 70% of Australia's health care is delivered by the private health sector, through for example pharmacists, allied health professionals, GPs, private hospitals and private specialists[2].

Private health insurance is an essential part of a high quality, financially sustainable health system. Specifically 82.5% of mental health treatment; 80% of knee procedures; 72% of complex middle ear infections; and 65% of cancer therapy (chemotherapy)[3] is paid for by private health insurance. Through its inclusive and equitable 'community rating' framework, private health insurance:

- underpins a strong private hospital system;
- eases the pressure on public hospitals;
- reduces government and taxpayer funding for public facilities; and
- offers patients choices, including when they are treated and who treats them.

Importantly, private health insurance also allows customers to avoid long public hospital waiting times. Around 10% of public hospital patients waited over 253 days to be admitted for surgery in 2014-15, while 1.8% of patients waited more than 365 days[4].

Governments and the health insurance sector face similar challenges. Public health funding and health insurance sustainability are impacted by significant growth in chronic disease; increasing patient expectations about access to services; the number and range of health services provided; the increasing cost of those services; and an ageing population.

Therefore it is not surprising that the most significant challenge facing health insurance is one of affordability. This is similar to the health funding challenge faced by governments given the growing health expenditure in the public system. This is highlighted by the fact that Medicare Benefits Schedule (**MBS**) spending per person has grown in real terms by more than 60% over the past 20 years, significantly outstripping real growth in total government spending[5].

It is important to understand the key cost drivers of private health insurance premiums. The most significant are utilisation, the ageing population and medical inflation. Around half of the annual premium increase is attributable to utilisation increase occurred by our ageing population and new technologies and medical advances. These are the same cost pressures facing the public system. Generally, the balance is attributable to increases in contract payments to health service providers. In 2015, Bupa faced and managed the following cost increases:

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[2] Mary Foley, July 2009, A Mixed Public-Private System for 2020. A paper commissioned by the Australian Health and Hospitals Reform Commission.
[3] Private Healthcare Australia (PHA) media release, PHI Value and Choice for Members, 23 November 2015.
[4] AIHW 2015. Elective surgery waiting times 2014–15: Australian hospital statistics. Health services series no. 64. Cat. no. HSE 166. Canberra: AIHW.
[5] Parliamentary Budget Office. 2015. "Medicare Benefits Schedule. Spending trends and projections. Report no 04/2015." Page vi. Available at http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Budget_Office/research_reports/Medicare_Benefits_Schedule

- 9% growth in knee replacement hospital benefits paid and 19% increase in medical benefits while the actual number of knee replacement episodes only increased by 6%;
- 13% growth in overnight rehabilitation hospital benefits and 10% growth in the number of episodes; and
- 13% increase in benefits paid to ophthalmologists, 9% increase in benefits paid to orthopaedic surgeons and 7.7% increase paid for dental services.

These cost increases are above the average premium increase by Bupa of around 6% in 2014 and 2015. This explains why the average increase for health funds runs well above the rate of general inflation. It is critical that actions be taken to help address the rate of growth of these costs.

Bupa contends the current rate of increase in premiums is not sustainable. Operating under a regulatory framework that prevents Bupa from being able to negotiate with providers the best possible prices for our customers impedes competition and fails to serve the best interests of Australian consumers.

Health insurers are subject to considerable regulation regarding the benefits that policies must include. For example, 30% of all Bupa's current hospital benefits are regulated benefits. This means the benefits that must be paid are set by the government in regulation and are guaranteed to be provided regardless of quality or appropriateness of the medical treatment.

Without being able to exercise a greater level of control over our own supply chain, the affordability of insurance products will continue to decline. This will continue to reduce consumer choice, and place unnecessary cost pressures on insurers for no justifiable policy rationale. The inevitable result of this will be greater pressure on the public health system.

With 33 private health insurers registered under the Australian Prudential Regulation Authority's (APRA)[6] *Private Health Insurance (Prudential Supervision) Act 2015*, we believe contestability is well served in this market. However Bupa believes the current policy settings are not as effective as they could be in generating greater competition in Australia's health and care system, and informed user choice can be strengthened by implementing enhanced information disclosure obligations.

In this context, Bupa identifies the following policy settings and makes recommendations that will deliver reform to improve competition in Australia's health system and ensure consumers can make better health care choices.

5.1 Supply Cost Drivers of Health Insurers

In order to help ensure a competitive and sustainable private health insurance market for the long term, Bupa believes insurers will need to move from their traditional role of being a 'payer' to take on the responsibility of becoming an 'active purchaser and change agent', driving improvements in quality, cost effective care and appropriate service delivery models.

[6] http://www.apra.gov.au/PHI/Pages/Register-of-Private-Health-Insurers.aspx

Prostheses Pricing Reform

The legislated benefits payable for prostheses in Australia means we pay the highest price in the world for medical prostheses such as hip joints and pace-makers.[7] For example, while the international reference price for a specialist orthopaedic plate is $92, the same device from the same manufacturer costs $1,060 in Australia.[8]

This has significant implications for competition, as health insurers are required to pay the stated benefit on the Prostheses List, which is provided as part of an episode of hospital treatment, or hospital substitute treatment, where a Medicare benefit is payable. As a result, prostheses benefits paid by the Australian private health insurance sector have rapidly escalated. In 2015, Bupa paid out around $550 million in prostheses benefits, which is an 8.5% increase on 2014.

In many cases there is also a significant difference in the price charged in public and private hospitals. For example, a standard branded ceramic hip is purchased by the Prince of Wales Public Hospital in Sydney for $4,900 while a private patient in the hospital next door pays $11,000.[9] Therefore the cost of prostheses could be significantly reduced by up to $800 million each year with simple competition related pricing reform.[10]

In addition, the selection of prostheses stocked by the private hospital is made almost entirely on the basis of the individual clinician's choice not on clinical efficacy or cost-effectiveness.. This has the potential to drive up costs unnecessarily as the opportunity for savings gained through the introduction of generic or alternative lower cost prostheses is lost. It also reduces competition and contestability in the decision-making process.

There has been a broad trend of prostheses sponsors' consolidation, which has the potential to result in fewer players holding greater market power. Bupa believes that changes enacted in 2010, as a result of the 2008 Health Technology Assessment Review, have caused the competitive advantage of existing prostheses sponsors to be enhanced and act as barriers to entry for new sponsors. This has resulted in reduced savings and benefits being delivered to consumers.

To address the lack of competitive pressure, Bupa supports the submission lodged by Private Healthcare Australia (PHA) [11] to the 2015 Private Health Insurance Review with respect to achieving prostheses pricing reform. PHA proposes a reference pricing model as the most appropriate method to closely align prostheses benefits with market prices. Figure 1 outlines how a reference pricing model could be implemented (see Figure 1)."[12]

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[7] PHA Budget 2016 Media Statement, 4 May 2016

[8] PHA International Reference Pricing Data 2015

[9] Australian Orthopaedic Association

[10] PHA 'Costing an Arm and a Leg' – Making healthcare more affordable and accessible for Australians – October 2015

[11] http://www.privatehealthcareaustralia.org.au/wp-content/uploads/PHA-Submission-PHI-Consultations-4-Dec-2015.pdf

[12] Ibid

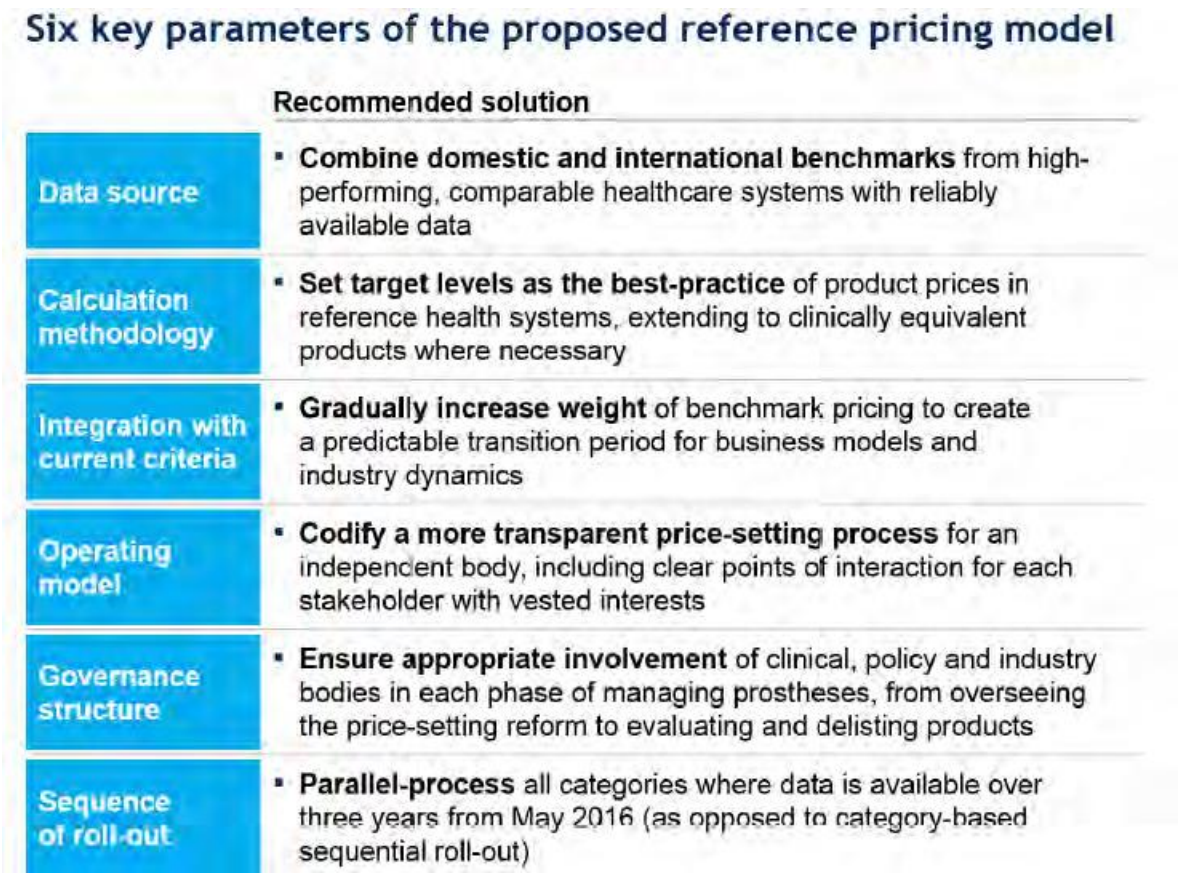

Figure1: Six key parameters of the proposed reference pricing model

Recommendation 1 - reform the supply side cost-drivers and reduce barriers to enable health insurers to effectively negotiate lower costs for their members, including through immediate changes to prostheses listing and reimbursement.

5.2 Competition - hospitals and medical specialists

Second tier private hospital benefits

To enhance competition in the private hospital sector, Bupa believes the set regulation of benefits paid to second tier hospitals by insurers should be reviewed. Increasing competition in this way would drive effective and efficient models of care, service delivery innovation, greater choice and sustainable affordability for Australians.

The level at which the floor price for second tier private hospitals is currently set removes a significant incentive that would otherwise exist for these hospitals to contract with insurers. Current regulation means that any hospital designated as being second tier ais able to receive automatically 85% of the average of an insurer's contracted hospital rates without having to agree to any of the terms that contracted hospitals are required to meet. This not only increases costs for insurers, but it also impacts on the level of competition that could otherwise exist between private hospitals and potentially places considerably more power in the hands of the larger hospital groups than they would otherwise have. Additionally it removes an incentive for hospitals to enter into strategic and

other contractual arrangements with insurers which could deliver innovative models of care and reduce wastage.

A removal of the set second tier benefits would increase the competitive tension between hospitals and allow for contestability by reducing the potential power of larger hospital groups and removing the incentive to choose to not contract, or to seek to contract at unreasonable rates, with insurers.

Recommendation 2 - enable health insurers to effectively negotiate lower costs for their members (and increase competition in the hospital sector) by removing the second tier default benefits.

Hospital oligopolies

It is Bupa's view that hospital oligopolies detract from competition in the private hospital market by wielding a disproportionate amount of power in relation to other health stakeholders. The only way the public and private health system, will be able to continue operating in the future is to adequately manage costs in the present.

Bupa's largest cost, by far, is the benefits we pay on behalf of our members to private hospitals and negotiating fair and reasonable prices and pursuing quality with all providers is part of the process of ensuring the sustainability of Bupa's business. Yet many hospital groups operate multiple hospitals, many groups providing the only hospital care within a reasonable distance of home for many of our members. It is for this reason that some hospital groups are able to demonstrate monopoly behaviour when negotiating contracts with health insurers.

Bupa continues to increase the costs paid to many hospital groups above inflation which, ultimately, is not sustainable for our members. Wielding this level of power ultimately impacts on competition and pricing as, of course, higher hospital costs are eventually passed onto health insurance members through higher premiums.

The UK Competition and Markets Authority recently reported on the issues surrounding competition in UK private health market in their final report as part of the *Private healthcare market investigation* (the Investigation).[13] It is Bupa's belief, there is merit in the Commission considering the issues raised in the UK Competition and Markets Authority case within the Australian context Specifically, Bupa asks the Commission to consider the Investigation's findings in relation to the effect some hospital groups and consultants can have on competition eg, high barriers to entry and expansion for private hospitals, as well as weak competitive constraints on private hospitals in some local markets,[14] could be replicated in the Australian market. In addition, the Investigation found that the structure and features of these hospital networks lead to higher prices with the lack of sufficient publicly available performance information on both healthcare facilities and on consultants was a contributing factor which "prevented patients from exercising effective choice in selecting the consultants by whom to be diagnosed and treated. This reduce[d] competition between consultants on the basis of quality and price." [15]

[13] https://www.gov.uk/cma-cases/private-healthcare-market-investigation
[14] https://assets.digital.cabinet-office.gov.uk/media/533af065e5274a5660000023/Private_healthcare_main_report.pdf pg 1
[15] Ibid, p 2

Medical specialists

In relation to consultants, it is Bupa's understanding that some hospitals pay direct incentives to consultants and operate profit sharing arrangements with them. Indeed there are numerous day surgery facilities, which are owned by the consultants that operate within them. This gives the consultant a financial interest in performing procedures at this hospital. This could have implications for competition not to mention the potential inflationary impact on the health system.

The UK Investigation notes that "offering incentives to consultants had become commonplace since it was necessary to do so in order to attract key consultants and that competition for consultants was intense."[16] Bupa questions if this arrangement is also as commonplace in Australia and, if so, if this is operating in the best interests of consumers.

In addition, it was also put to the Investigation that "...irrespective of the incentive schemes that hospital operators may adopt to encourage consultants to use their facilities, the private medical sector's fee-for-service model may in itself create a tension between the consultant's duty to act in the patient's best clinical interest and the consultant's own, financial interest."[17]

Considering their findings, key instructions that may be of similar relevance in Australia include:

- hospitals will no longer be able to pay direct incentives to consultants, and profit sharing agreements between hospitals and consultants will be restricted;
- information on the performance of private hospitals and individual consultants should be collected and published, and private hospital operators should also require consultants to publish information on their fees; and[18]
- "That any scheme operated by a private hospital operator, whether contractual or not, which provided an inducement to, or created an obligation on, a clinician to treat or refer patients for tests at its facilities, should be prohibited outright."

Given Bupa UK was heavily involved in the investigation process, we would be happy to provide the Commission with any further information or assistance in regards to the UK investigation.

Recommendation 3 - improve and encourage appropriate competition practices in the sector by the Productivity Commission examining:

1. the level of competition in the Australian private health sector with detailed review on private hospitals and medical specialists; and
2. whether medical specialists should be required to provide patients with written confirmation of details of any financial interests that the consultant holds in medical facilities or equipment.

[16] Ibid p 258
[17] Ibid p 277
[18] Ibid p 388

5.3 Competition - Providers

Reducing Medicare excessive utilisation based fraud

Generally, the Australian health the system operates under an honour system where the funders – government, insurers and the public – pay the claims submitted on face value. While the majority of providers operate in a responsible and honest manner, unfortunately there are some who do not.

The impact of fraud on health care cost inflation by 'creative' billing practices, also known as revenue maximisation, cannot be underestimated especially its effect on encouraging competition. Even small improvements addressing these behaviours will deliver significant savings and should be pursued.

For example, a one per cent reduction in waste or unnecessary services expenditure could equate to a saving of as much as $1.45 billion across the entire health system, given total recurrent health spending was %145.5 billion in 2013/14. These savings could be reinvested into more services to more Australians, lower prices for consumers, or used to offset the rate of growth in health expenditure so that other Government programs are not adversely affected.

Unwarranted utilisation and clinical practice variation adds further costs to the system. Also known as claims leakage, these needless claims may be caused by a range of factors including inadequate information system controls, unregistered providers billing for services, members of the public "doctor shopping" for drugs and identity theft.

While there have been moves by governments to put constraints on this behaviour, in addition to the MBS rules, such as the current reviews of the MBS and the efficacy of particular services, we believe more can be done in this area. Initiatives such as the development of clinical registries and clinical pathways designed to establish appropriate care benchmarks, have not been utilised as well as they could be to achieve meaning cost savings. The recent establishment of the U.S. initiated Choosing Wisely program in Australia is another move in the right direction to eliminate the use of unnecessary and sometimes harmful tests, treatments and procedures, but it has yet to make an impact.

It is also appropriate to note that the 2009 National Health and Hospitals Reform Commission made a number of recommendations in the areas of waste, preventable hospital admissions, minimising the cost of adverse events, and better use of performance data. Similar views about the needs to avoid ineffective treatments have been advocated by the Grattan Institute[19]. Bupa has long recognised this opportunity and is the industry leader focusing on ensuring the outlays paid on behalf of our customers are appropriate and comply with the product and fund rules, IT system clinical and business rules, contracts with providers and accepted clinical practice.

Bupa has a clear belief that we have a responsibility to hold doctors, hospitals and allied health providers accountable for their billings. We have invested heavily in our people and systems to identify fraud and incorrect billings across the system, and recover funds when these payments are

[19] https://grattan.edu.au/report/questionable-care-avoiding-ineffective-treatment/

made. Bupa saved in calendar year 2015, $39 million dollars on behalf of our customers, and this calendar year, as at 30 June had saved $24.8 million with a projected saving for the year of $41 million. Over the period, calendar year 1999 to 2015, the cumulative savings are $290.4 million.

Every year, Bupa undertakes retrospective and predictive analytics of membership, product, clinical, and provider and claims data, using advanced statistical and data mining techniques to uncover fraud and claims leakage. Bupa also undertakes onsite and desk top audits of providers, including chart to bill audits, clinical coding audits, as well as audits to ensure compliance with Government requirements, such as acute care certificates. We believe that many of the matters we identify have the potential to also impact public funders, and therefore the taxpayer.

A collaborative effort between industry and Government to reduce opportunities for fraudulent claims on the Medicare system and excessive utilisation of health services, we believe, is consistent with the objectives of the Commission's current inquiry into human services. Currently, Government and private health insurers work independently of each other. It is possible for both parties to share clinical data service patterns, at a generic level, so that each can see if they are experiencing the same problems. We believe this can be done without compromising personal privacy.

We believe health insurers have a better understanding of a customer's enhanced episode of care, sometimes referred to as a single view of the customer, by linking data related to hospital, episodic and ancillary care to determine whether the components of that care were necessary. We deliver this type of data analysis could be useful to Medicare to determine patterns of claims leakage.

A reduction in fraud and claims leakage in the health system will meet this inquiry's goals of improving the quality, equity, efficiency, accountability and responsiveness in one of Australia's largest and critical human services sectors.

Recommendation 4 - realise substantial savings to the entire health system through the Government working with health stakeholders to consider options to improve fraud detection and claims leakage efforts in Australia's Medicare system, by sharing de-identified generic data.

5.4 Informed User Choice

Well informed consumers are key to the effective and efficient functioning of a competitive market. There are several opportunities for improvement in this area in private health insurance.

Standard Information Statement (SIS) Reform

The SIS is the standardised form of product information that is intended to provide 'basic information for the purposes of comparison only'[20]. Under current law, insurers must provide customers with a copy of the SIS at least once a year. Complying with current SIS obligations is a significant undertaking, with Bupa spending around $1 million annually on this task.

[20] Please refer to Part 3 and Schedules 1, 2, 3 and 4 of the Private Health Insurance (Complying Product) Rules 2010 (No. 2), which set out the form of, and the permitted content to be contained in, a SIS about a product subgroup of a product.

The restrictive, 'one size fits all' SIS template means that insurers cannot always easily describe their products accurately, particularly as product innovation sees new types of products released. Additionally, the SIS does not enable consumers to comprehensively compare products and determine which is best for them because it does not allow for the intricacies between products to be represented.

A further shortcoming of the prescriptive nature in which information must be provided on the SIS can mean the product description is incomplete or the product is inaccurately represented. For example, the way benefits must be listed in the SIS means Bupa is unable to provide the details on benefits payable for using providers who are part of Bupa's Members First provider network. Bupa works hard to negotiate and maintain a strong Members First provider network because this provides customers with certainty regarding costs. The network enables Bupa to actively keep downward pressure on provider charges. The inability to reflect the benefits that are payable for using network providers not only means that Bupa is not able to actively promote the benefits of its network on the SIS, enhancing competition, but also may not provide customers with details about the true potential benefit they may gain if they took out the Bupa product. This may mean that some consumers are making decisions about a product without knowing all the key information about the value that product could deliver them.

To help consumers understand all of the key features of their product, many insurers supply additional information to make up for the shortcomings of the SIS and its inability to convey certain pieces of information that are not included in the rigid template. This means that customers receive multiple pieces of information about their health insurance product in different formats, many overlapping while containing varying levels of detail, covering different features in different ways.

For example, currently a consumer may receive both a product summary brochure and a SIS at, or around, the same time. The product brochure is designed to provide the consumer with straight forward, in-depth information about their product so it is written in a way that guides the consumer through key elements and questions with respect to their product. The SIS however, is intended to provide a basic comparative summary of health insurance products and is heavily constrained by its strict template format. The result can be that a consumer is left confused because the information contained within the SIS may not appear to be aligned with the product document and vice versa. While the information represented in each of these pieces of information is accurate, it is easy to see how multiple, seemingly inconsistent pieces of communication, would cause confusion for consumers.

Lastly, the benefit of sending customers a SIS once a year, consistent with legal requirement, is negligible as the SIS includes information that is incomplete or inaccurate for many customers and often contradicts the other information provided at the same time by the insurer, such as a product sheet, product brochure or premium letter. For example, the premium payable amount is often inconsistently communicated, as the SIS does not take into account the level of government rebate payable and any Lifetime Health Cover Loading payable. It also fails to include details of the coverage offered by the product. For example, on some products loyalty features exist, such as annual limits that increase with each year of membership, yet it is only the first year limit that is displayed on the

SIS. In addition, and as outlined above, the restrictive nature of the content on the SIS does not enable all the features of a product to be included which can lead to confusion between what the customer thought they bought, as represented by the insurer, and the information contained on the SIS.

Bupa believes product information and communications should be tailored to meet the needs of consumers, not a template. The above lack of consistency in the way product information is communicated to customers, caused by the inadequacy of the SIS and the requirement that it be sent, can easily be addressed. We believe addressing this issue as recommended below will lead to administration savings for the industry and significant information improvements for consumers.

This is a clear example of where the current policy settings continue to cause consumer confusion and inhibit informed user choice. It is expected acting on our recommendations below will also result in increased competitive tension between health insurers as they seek to ensure their members are better informed and presented with clearer information around their product options.

Recommendation 5 - repeal and replace the Standard Information Statement (SIS) requirements with a minimum mandatory set of product information. This should be developed in consultation with the industry and provided by the insurer to customers under a set of agreed circumstances. The format in which the mandatory information is provided to the customer would be determined by the insurer, who could choose to provide additional information above the minimum set.

Empowering consumers with information and enabling true informed financial consent

Bupa is committed to ensuring consumers are given the right information, at the right time, so that they have the opportunity to make a truly considered and informed financial decision about their treatment options. Health insurers have been very successful in increasing transparency and reducing knowledge gaps for their customers by establishing contracting arrangements and gap schemes, thereby providing a better overall out-of-pocket in-patient experience. Bupa has also begun to address this asymmetry of information by publishing the average medical costs of the top 127 medical procedures we fund. However there are limitations to what they have been able to do without additional reforms in the whole sector.

Patients and their families do not receive sufficient information to make choices about the type of treatment that is most appropriate for them, either in terms of options available, service providers of the options, efficacy and cost-effectiveness of each choice as well as cost of options. When adequate information on the effectiveness, possible risks and benefits and costs of treatment options are presented to patients, they often opt for less invasive, lower cost treatments. The Australian Commission on Safety and Quality in Health Care noted that, "at the level of the individual, people with lower health literacy had an increased expenditure of between $143 and $7,798 per person per year compared to people with adequate health literacy."[21]

[21] The Australian Commission on Safety and Quality in Health Care. 2013. "Consumers, the health system and health literacy: Taking action to improve safety and quality." *Consultation Paper.* Available at http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/Consumers-the-health-system-and-health-literacy-Taking-action-to-improve-safety-and-quality3.pdf

Bupa believes that along with insurers, consumers hold the key as change agents to driving better health and cost outcomes in health care. We believe more should be done in this space as provision of information regarding quality, safety and pricing structures is common practice across other sectors of the economy to allow transparency and, consequently, as a basis for competitive tension. Bupa asserts that an important step to realising increased competition amongst health service providers is to ensure transparency of costs together with effectiveness.

There is very little or no information available to guide patients on their choice of health care provider, be it a hospital or specialist. There is no easy way for people to compare specialists' charges or quality of outcomes. This type of information is available in other countries. We believe that people need to be provided with appropriate consistent information to allow for informed decision-making. By doing this, we believe patients will make user choices that result in the delivery of better health outcomes as well as result in reduction in ineffective or wasteful treatments.

As stated by Woolf and colleagues, "the health care system cannot truly support informed decision making without correcting the underlying obstacles that impede patient access to needed information. Patient demand for guidance will only increase as clinical options multiply and the world of information continues its rapid growth."[22] Further, "controlled trials have shown that…decision-making aids improve patient knowledge regarding options, enhance realistic expectations about various alternatives, reduce patient frustration with the decision-making process, and stimulate people to take an active role in decision making."[23]

The way in which specialist referral and pricing currently operates inhibits consistency, cohesion and transparency and does not operate in the best interests of consumers. Greater transparency in this area would improve competition among specialists and would aid in keeping medical fee inflation at a manageable level. Bupa believes that it is entirely reasonable for the Government to require that specialists' charges are completely transparent, particularly given the significant amount of taxpayer funding that is provided through Medicare contributions. It is for these reasons we believe increasing transparency in pricing for specialists should be a key reform priority.

Currently, informed financial consent occurs too late in the health journey for a patient to be able to utilise it for anything other than, at best, budgeting purposes. Informed financial consent, when given, currently occurs when the patient has already met with the specialist, decided the course of treatment with that specialist, paid for an initial consultation and, in some cases, decided a date for their procedure. Consumers have little information available to them to know whether the charges of the specialist are aligned with charges of other specialists. Therefore patients currently experience large out-of-pocket costs and have little visibility of alternative options or access to discernible criteria to evaluate alternative options, even if they were aware of them.

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[22] Woolf, S., Chan, E., et al. 2005. "Promoting informed choice: transforming health care to dispense knowledge for decision making." *Annals of internal medicine.* Volume 143(4). Available at http://annals.org/article.aspx?articleid=718692

[23] California HealthCare Foundation. 2006. "Consumers in Health Care: Creating Decision-Support Tools that Work. Available at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CreatingDecisionSupportTools.pdf

Despite a strong desire to assist our customers, insurers are limited in their ability to provide consumers with all the information required to make an informed financial decision for a number of reasons. Firstly, we may not know that a customer has seen a medical specialist, or been admitted to hospital, until the customer is booked into surgery, or after we receive a claim for the episode.

Secondly, even in cases where insurers are aware that a customer is being admitted to hospital, the insurer often does not know specifically what treatment is planned and therefore what MBS items would apply to that treatment episode. Health insurers only know that they will be covering 25% of the MBS items charged. Without knowing what item numbers will be used, and how much the medical specialist will charge for the episode of care, we are unable to give customers accurate information about the costs of their treatment, or the gap they might need to pay.

Thirdly, hospitals often have well established processes to ensure informed financial consent is obtained from patients in relation to the hospital charges. The treating medical specialist may also have processes to obtain informed financial consent, however these processes often only relate to their component of the patient's episode of care and do not always extend to all elements, including additional doctors involved in their treatment.

Bupa does not believe the onus should be on customers to ascertain the full costs associated with their treatment episode. We believe all parts of, and participants in, the health system could and should do more to increase transparency in healthcare for consumers. By publishing the average medical costs of the top 127 medical procedures Bupa funds, we are enabling a consumer to check the rate charged, and the gap experienced, with the specialist they have been referred to, compared with the average. Providing information of this nature will enable the consumer to find an alternative specialist with a lower charge rate if they wish.

The need for reforms in this areas is compelling. That a consumer may commit to specialist treatment without being aware of the full cost of treatment is certainly not indicative of a competitive environment or an informed client base. In many cases, when a person seeks specialist care, they are often at their most vulnerable in terms of health, stress levels and financial capacity. Medical conditions that warrant special referral or treatment often lead to people reducing their working hours, or ceasing paid work entirely. Given this context, it is measured and reasonable to expect a consumer will be aware of their treatment options and the costs of these options, and able to seek additional referrals and select specialist treatment that meets their health needs and budget.

We believe this area of health system reform is completely within the remit of this inquiry. The current policy settings patently do not allow consumers to make informed user choices with respect to specialist treatment. Competition in this area of Australia's health system will not be fully realised if consumers continue to be denied the necessary and fundamental information that allows them to make timely and informed decisions that are in the best interests of their health care.

Recommendation 6 – empower health care consumers to make timely and informed decisions about their health care needs and the choices available to them. To provide user choice and increase competition in the health system, Bupa would welcome the opportunity to work with stakeholders to:

1. identify what information would be most relevant to patients regarding costs of treatment, out-of-pocket expenses, expected outcomes and treatment options; and
2. design solutions that will deliver greater transparency of costs and effectiveness through access to relevant information at the right time in the patient's health journey.

Regulation of online comparators and brokers

Just over 43% of all people switching insurers, or taking out private health insurance, contact a comparator[24]. Bupa believes that while online comparators can be a useful tool for consumers, it is important to be transparent to the public that the current comparators operating in Australia are not true comparators, but are, in fact, brokers on behalf of their clients ie, insurers. We believe the best interests of the consumer should always come before the remuneration arrangements between comparators, brokers and insurers.

Bupa estimates that the current cost to the industry of these brokers is around $250 million per annum, which is largely made up of commissions paid by insurers to the broker for 'advice' provided to consumers. Bupa argues there is very little value provided by this service, particularly to consumers, in return for such a large amount of money leaving the industry. In fact, we believe they are contributing to the level of confusion and dissatisfaction with health insurance.

The concern with this approach is two-fold. Firstly, the focus of every health insurance sales interaction should be around the current, and where possible future health needs and expectations of customers. Currently, many so called 'comparator' websites focus primarily on price and only provide access and information to a very limited number of products that are available to consumers. Therefore they do not provide consumers with an adequate opportunity to fully consider different policies against the health needs that consumers may or may not wish to be insured for.

A price driven approach can encourage consumers to take out or swap from their current product to a lower cost product. This inevitably means less health need coverage for customers. Bupa does not believe comparators are doing enough to ensure that the products they match people to will meet the consumer's needs; or that the consumer has a strong understanding of the differences between what is covered under their current product and the product being recommended.

The effect of this impact should not be ignored as the IPSOS 2015 survey shows that the influence of the comparator recommendation is strong, with 92% of buyers who contacted an intermediary taking out a product with a fund recommended by the comparator, regardless of whether they purchased the product with this comparator or not[25].

[24] IPSOS Survey 2015, Report 15 (Sections 15.5-15.7)
[25] IPSOS Survey 2015, Report 15 (Sections 15.5-15.7)

That is why we are concerned that the increasing use of online brokers and comparators by consumers, particularly to reach their purchase decision, may be contributing significantly to the level of confusion and concern experienced by consumers, particularly around not being covered for services they may require in the future.

While the number of complaints that the Private Health Insurance Ombudsman currently receives in relation to online comparators is low, Bupa believes this is simply due to the fact that many customers will not become aware that they were recommended a product which did not meet their needs until they seek to make a claim, which may be some years down the track. At that point, it is likely the consumer has forgotten that an intermediary recommended the product and is simply focused on the insurer with which they hold the product. Bupa believes there is a need to introduce regulation of online comparators and brokers to ensure that consumers using them are protected and are fully informed when they make their purchase based on information provided by these sites.

Encouraging compliance with Australia's competition and consumer protection laws by the comparator website industry is required. Bupa notes the ACCC published a report in November 2014, *The comparator website industry in Australia,* in which the ACCC identified a number of areas where conduct by comparator website operators can potentially mislead or deceive consumers. We also note that lack of transparency was a key issue of concern in terms of material on the website and behind-the-scenes conduct, including back office and commercial relationships. Bupa fully supports and commends the ACCC for issuing the *Comparator Websites: A guide for comparator website operators and suppliers,* however we feel there is still a compelling need to increase regulation of comparators.

Bupa believes there is merit in considering the introduction of additional consumer protection, in a similar form to what currently applies to financial advisers under Chapter 7 of the Corporations Act 2007 (Cth). This requires registration and regulation of parties acting in a broker type capacity who make recommendations on products for retail customers in relation to health insurance.

We believe current arrangements with respect to online comparators and brokers operating in this market fail to assist consumers to make informed choices in relation to health need. Bupa contends that is reasonable to expect comparators and brokers, who are contending to be helping consumers make a significant decision, be required to ensure they serve the best interests of the consumer not their client. This will significantly improve a consumer's ability to make timely and informed choices about their most appropriate insurance coverage, which inevitably amplifies competition between health insurers.

Bupa considers the reforms required to achieve these outcomes, set out below, are completely congruent with the purpose of the Commission's inquiry to improve the function of the health system through competition and enhanced informed user choice.

Recommendation 7 - introduce additional regulation of online comparators and brokers to provide extra protection for consumers by providing requirements for disclosure to the public of:

1. commissions that would be received in relation to particular products including up-front and trail commissions;
2. how product recommendations were made, including the number of products/insurers that were considered in reaching the recommendation;
3. information that must be given about the percentage of products in the market that comparators/brokers cover and the percentage of products from each insurer they represent;
4. detailed reasons for selection of one product/insurer over another product/insurer including the benefits offered by the product being recommended; and
5. clear signposting of key product conditions that apply to the recommended product such as exclusions, excesses, co-payments and waiting periods.

5.5 Competitive Neutrality

Equal contribution by all health insurers

The government currently contributes around $5 billion dollars net[26] to 13 million Australians who choose to take out health insurance with the support of the health insurance rebate. This contribution is made to support more than half of Australia's population to privately insure rather than rely on the public system. This investment of public funds ultimately benefits the taxpayer by slowing the growth in costs to the public health system by having the health care costs of such a significant number of Australians covered by insurers. The contribution made by government also benefits the health insurance sector by ensuring participation rates remain buoyant.

Bupa believes that in return for this public investment, all insurers should make an equal contribution back to the taxpayer. Currently, the sector is a mix of insurers who are registered as for-profit and those who are registered as not-for-profit. The reality is that all insurers are operating their businesses as commercial enterprises, yet they are not contributing equally through the payment of tax. Bupa believes all registered private health insurers who benefit from the payment of the government health insurance rebate to customers should be required to pay tax regardless of their registration status. This will deliver a level playing field and increase competition in the sector.

Recommendation 8 - improve competition by requiring all registered private health insurers to pay company tax on profits earned from their registered health benefits fund(s) regardless of registration status.

[26] the net figure takes into account the proportion of the $6 billion health insurance rebate paid out being recovered by the government through Individual tax returns as the eligibility for the rebate is income tested. This rebate recovery is expected to increase each year while income thresholds for the health insurance rebate continue to be frozen.

Aged Care

Bupa is a leading provider of aged care in Australia, employing more than 8,500 people to provide dedicated care to around 7,000 residents in over 70 aged care homes across the country, 70 per cent of whom are living with dementia. We are passionate about providing the best quality care for our residents, and have put in place an innovative model of care that successfully manages complex health conditions in our residential care homes. The Bupa Model of Care not only delivers better quality care, it is also the preference of aged care residents and relieves the burden on hospital emergency departments, as confirmed by the Productivity Commission's 2011 report, *Caring for Older Australians*[27].

Our industry-leading model of care provides our residents with an improved level of multi-disciplinary care and improved access to medical services through the employment of general practitioners in our homes. Our people focus on delivering preventative healthcare and immediate medical treatment where necessary, and this approach has significantly reduced residents' rates of multi-pharmacy, falls and infections. By delivering more complex care in our care homes, we have reduced the need to transfer residents to acute facilities, leading to unplanned hospital transfers dropping by as much as half. Initial indications are that this approach is saving the acute sector around $500,000 per home annually in unplanned hospital transfers. [28]

This model of care, while requiring significant investment to establish and deliver, is proven to be successful in managing complex health conditions in residential care homes, rather than transferring residents to hospitals for acute care. Without innovative models of care such as Bupa's, care will continue to be delivered in costly in-hospital settings, adding unnecessary strain on a system already at capacity and putting upward pressure on public hospital funding in the longer term.

Notwithstanding the significant material benefits to the health system and aged care residents, maintaining innovative models of care remains challenging under the current regulatory framework. We set out the case below for reforms that will restore competitive neutrality and increase competition between aged care providers, provide greater consumer choice and develop a sustainable aged care system.

6.1 Creating a sustainable future aged care system

Australia's health and care system is facing increasing financial pressure from an ageing population. The population aged over 85 years is expected to more than double from 455,400 in 2014 to 954,600 by 2034.[29] This will inevitably lead to higher costs for consumers, healthcare providers and governments.

The challenge for Government, aged care providers and consumers is to strike a balance between curbing expenditure growth while improving the quality of care available to all Australians.

We know the complex care needs of older Australians are best managed in home settings, and not in hospitals. This model of care, however, can only be delivered over the long term with sustainable funding.

[27] Productivity Commission 2011, *Caring for Older Australians*, Report No. 53, Final Inquiry Report, Canberra.
[28] Interim findings, University of Tasmania's Wicking Institute evaluation of Bupa Model of Care.
[29] AIHW 2015. Australia's welfare 2015. Australia's welfare no. 12. Cat. no. AUS 189. Canberra: AIHW. p 233

We understand the Government's concern about higher than expected growth in aged care funding, and agree that the Aged Care Funding Instrument (**ACFI**) needs to be redesigned to achieve a sustainable funding model.

We are concerned, however, that the changes to the ACFI announced in the 2016 Budget will have a far greater negative impact on funding than has been modelled, thus threatening the viability of operators delivering high quality care for residents with complex care needs. We are concerned this will have adverse impacts on the long term sustainability of the sector and will place greater pressure on an already stretched system which faces ever increasing demands of an ageing population.

Our analysis of these changes indicates a dramatic shift in the number of residents who currently score a High for the Complex Health Care (**CHC**) domain within the ACFI, which will see them scoring a Medium or even a Low classification under the new rules. We expect this will see a drop from 69% of our residents who are currently scoring a High CHC to less than 10% in a relatively short period of time.

Our concerns align with those expressed by other private and not-for-profit operators and organisations including the Aged Care Guild, Australian Medical Association, Catholic Health Australia, Alzheimer's Australia, Palliative Care Australia and Aged and Community Services Australia, as well as a range of state base nursing unions. That is, these material downside changes to the funding of CHC in aged care clinical service delivery are at odds with both the 2011 Productivity Commission report regarding funding for aged care service delivery and the entire sector's advice to government under the Aged Care Roadmap for ACFI sustainability. We believe, in its current form, these changes materially impact the sustainability of the system for elderly Australians to receive appropriate clinical care in residential facilities. It also limits the scope of all providers to attract clinicians to deliver care in this setting despite prior Productivity Commission advice to this effect to prevent spiralling costs and trauma in acute care settings.

The ACFI changes are subject to ongoing direct discussions with Government, however we believe the challenge of delivering sustainable funding in the aged care sector should be a key area of inquiry in the Commission's review of Australia's human services.

We propose the ACFI changes be deferred for 12 months to allow time for the sector to work through the changes with the Government and ensure there are no unintended consequences. This could be achieved through the establishment of an Aged Care Sector Taskforce, comprising representatives of aged care sector stakeholders and officials, which could be charged with developing alternative, better targeted funding arrangements.

Recommendation 9 - defer the 2016 Budget changes to the Aged Care Funding Instrument and establish an Aged Care Sector Taskforce, comprising representatives of aged care sector stakeholders and officials, to develop alternative, better targeted funding arrangements that ensure there are no unintended consequences to the quality of care for aged care residents with complex care needs.

6.2 The Aged Care Sector Committee and the Aged Care Roadmap

The challenge of creating a consumer driven, market based sustainable aged care system has recently been thoroughly considered by the expert-based Aged Care Sector Committee (Committee). By way of background, the Committee is chaired by an Independent Chair, and its membership

comprises representatives from across the aged care sector, including, peak bodies, large for-profit and not-for-profit providers, consumers, workforce, the National Aged Care Alliance, the Department of Health and Bupa. The Committee provides advice to the Government on aged care policy development and implementation and helps to guide the future reform of the aged care system.

In April 2015, the Aged Care Sector Committee was tasked by the then former Assistant Minister for Social Services to develop a roadmap to advise on future directions for aged care.
The Committee released the Aged Care Roadmap which presents its views on the short, medium and long-term actions required to transform the current aged care system into a sustainable, consumer-driven and market-based system.

The Aged Care Roadmap was developed by the Committee and features a series of recommendations to develop a sustainable, consumer-led aged care market, where consumers have increased choice and control of what care and support they receive. The Committee has sought to align the Roadmap with the reforms to the sector that commenced with the Productivity Commission's 2011 recommendations, and has recommended action be taken in nine key domains:

1. How do consumers prepare for and engage with their aged care?
2. How are eligibility and care needs assessed?
3. How are consumers with different needs supported?
4. How do we make dementia core business throughout the system?
5. What care is available?
6. Who provides care?
7. Who pays?
8. How will the formal and informal workforce be supported?
9. How will quality be achieved?

In developing the Roadmap, the Committee was informed by key policy documents, including the Aged Care Sector Statement of Principles and the National Aged Care Alliance's June 2015 Blueprint, *Enhancing the quality of life of older people through better support and care*.

We believe the Commission's inquiry into human services is well served by the thorough, collaborative and expert nature the Aged Care Roadmap, and its recommendations to achieve a sustainable, consumer-led aged care market where consumers have increased choice and control of what care and support they received.

Recommendation 11 – support the Aged Care Sector Committee's Aged Care Roadmap's short, medium and long term recommendations to create a consumer driven, market based, sustainable aged care sector.

Appendix 1 - Swedish Quality Registries

Clinical registries have existed in Sweden since the beginning of the 1970's. Over the past 40 years Sweden has developed over 100 "Quality Registries" for everything from heart surgery to cataracts. These clinical registries were established to improve the quality of health care in Sweden. They gather critical information used by clinicians, researchers, policy makers and the public and are considered a crucial element of the success of the Swedish health care system.

The Swedish Quality Registries are considered the international benchmark. The development, refinement and implementation of Swedish Quality Registries over the past 40 years has revealed:

- without proper scientific assessment of the benefits and risks of clinical interventions, clinical practice may be misguided and limited resources may be squandered;
- generic drugs may be under-utilised at the expense of more costly but equally safe and effective brand name drugs;
- data generated during routine clinical practice can be utilised to learn more about the long term benefits and risks of clinical intervention in the general population:
    - for example, Sweden now has the lowest failure rates in the world for hip replacements because the registry has helped identify the implants that work the best. Unlike other countries, in Sweden, only six types of implants make up almost all hip replacements whereas 20 years ago over 50 implants were used.
- effective registries must contain relevant data, be time efficient with respect to data enter, retrieve and analyse, must be appropriately secure and protected;
- registries must have solid support among clinicians;
    - A 2010 survey of health registry contacts at hospitals revealed that 89% of respondent agreed that the registry helped their organization identify areas to improve; 99% of doctors and nurses who responded also agreed the registry helped improve the quality of care.
- many registries encompass close to 100% of target populations, indicating many hospital departments and primary care centres find it meaningful to participate.