Submission to the National Health and Hospitals Reform Commission (nhhrc).

A New Health Savings Based System for Australia.

A new health savings based system is proposed based on the best aspects of the current system but with built-in incentives for containing costs. Universal cover is retained and access to the hospital system is improved. The division of health responsibilities between Federal and State governments is greatly simplified and the proposed system could be readily implemented.

The Australian health system, often described as among the best in the world, faces enormous challenges in the future, According to the latest available data from the Australian Institute for Health and Welfare (AIHW) in 2003-04 Australia spent 9.7% of gross domestic product (GDP) on health. While this was lower than that of the United States (15.7%) it was higher than the average for the European Community (8.6%) and considerably higher than that of Singapore (3.7%) which has a health savings based system. Furthermore health costs in Australia are rising at a significantly faster rate than general inflation. If this trend continues the Australian health system in its current format will become unaffordable.
It is clear that change is necessary, but the challenge is to reform the Australian system in a way that contains costs while retaining features such as high standard of care, universal coverage, balance between public and private activities and retention of the doctor-patient relationship. This submission proposes a scheme that addresses this challenge.

The proposal

The proposed scheme is summarised in the table below.

Table 1: Components of the proposed health scheme

- A *Commonwealth Health Bank* guaranteed by the Federal Government.

- A *health account* held in that bank by every citizen currently entitled to medicare.

- An *annual base health amount* (indexed for age) which is the sum of money paid annually into each citizen's heath account by the Federal Government. This amount would be supplemented by an equal employer/employee contribution of 2% of income.

- A *health dividend* which is the annual bonus paid to each citizen with a positive health account.

- An independent *Health Advisory Council* which would determine which medical services and pharmaceuticals were eligible under the scheme and

set scheduled fees.

The annual base health amount would be calculated by dividing the amount of money the federal Government was prepared to spend on health by the number of eligible citizens. For example, in 2003-04, total health expenditure was an average of $3931 per person, with the Government contributing 68% of this or 6.6% of GDP (Table 2).

Table 2: Australian Health Expenditure in 2003-04

	$Billion
Government	53.4 (68%)
Private	25.2 (32%)
Total	78.6 = 9.7% of GDP.

Government expenditure per person = *$2673*
Average health expenditure per person = *$3931*

If, for example the new scheme was introduced in 2008-09 and the Government spent the same proportion of GDP on heath, allowing for an average health inflation rate of 4% per annum since 2003-4, the annual base health amount would be $3263 indexed for age so that older citizens be allocated more and younger citizens allocated less. If this amount were supplemented by an equal employer/employee contribution of 2% of income the proportion of government to private health spending would be much the same as it is now. Expenditure in subsequent years would be determined by the financial status of the Commonwealth Health Bank, with adjustment for the health dividend. If, as expected, the new scheme saves money the proportion of GDP the Government would need to spend on health would gradually fall.

How would the scheme work?

Citizens would be entitled to withdraw an amount equivalent to the scheduled fee for an approved health service irrespective of whether their health account was in positive or negative balance. Health service providers could charge more than the scheduled fee, but the excess would need to be made up by patients or by their private health insurance. For those whose health account was in positive balance and above a predetermined level (eg, $5000), 15% more than the scheduled fee could be withdrawn for a particular health service. Citizens would not be able to use their health accounts for non-approved health services such as cosmetic surgery, insurance screenings, or alternative medicine. Citizens' health accounts could be used to pay for approved health expenses of immediate family members.

At the end of each financial year, people with health accounts in positive balance and above a predetermined level (eg,$5000) would be entitled to a bonus of 5% of the balance (health dividend), to be spent in any way they wished. A negative balance below a certain threshold would incur a taxation penalty for those with a taxable income above a certain threshold (eg, $50,000 pa), and then increase on a sliding scale. The additional taxation would be paid directly into the citizen's health account.

On the death of a citizen, the Commonwealth Health Bank would receive 20% of a positive balance for general funds to be used for administrative purposes. The remainder could be willed to another person's health account — in the absence of a will, to that of the nearest living relative. In the event of a negative health balance at the time of death, the difference would have to be met from the deceased's estate. However if this necessitated selling joint property the spouse or partner of the deceased could apply to take over the deceased's health account.

Hospital funding

Public hospitals would be funded by an case-mix system. Each particular illness would be classified into a diagnosis-related group (DRG), which would in turn attract an amount of money (DRG scheduled fee) determined by the Health Advisory Council and based on the true average costs of treating that illness. The DRG scheduled fee would include a component to cover the cost of providing resident and senior medical cover (medical component) and a component to cover teaching and clinical research activities (training component). Patients electing to be public patients would be charged the DRG scheduled fee for the particular illness, which would be withdrawn from the patient's health account irrespective of its being in positive or negative balance. Patients electing to be private patients in public hospitals with choice of doctor could be charged up to 15% more than the DRG scheduled fee. The additional 15% could be withdrawn from the health account if it was in positive balance. The method of paying the medical staff would be entirely a matter between the hospital and the staff concerned.

Patients could also elect to be treated in private hospitals. The private hospital could claim up to 15% more than the DRG scheduled fee, minus the medical component from the patient's health account (again, the additional 15% could be claimed only if the health account was in positive

balance). Likewise, the treating doctor could claim from the health account up to 15% above the medical component for that DRG schedule. Both the doctor and the private hospital could charge more than 15% above the schedule fee, but this excess would have to be met from the patient's pocket or by private health insurance.

Alternately, private hospitals, with the agreement of medical staff, could charge the DRG scheduled fee (including the medical component) plus a percentage, with the hospital then paying the paying the doctor a mutually agreed amount. This would have the advantage of a single bill being fully rebatable from the health account, providing it was not more than 15% above the scheduled fee.

Pharmaceuticals

Cost of approved pharmaceuticals would be deducted from the patient's health account at a fee determined by the Health Advisory Council. Costs of non-approved pharmaceuticals would have to be met from the patient's own pocket.

Roles of the Federal and State governments

In this system Federal State relationships would be greatly simplified. Cost shifting would no longer be possible and the Federal State "blame game" would be ended. The Federal Government would be the guarantor of the Commonwealth Health Bank and as such responsible for the majority of heath spending. At any time the financial state of the bank would be determined by the sum of all health accounts. If this was negative the Government would need to increase the annual base amount (the additional amount being raised by taxation). If it was positive it would be possible to decrease the annual base amount. Government spending on health could be from general taxation revenue, from a special "Medicare"-type levy, or from a combination of both.

The Federal Government would be responsible for funding the Health Advisory Council, which would assume many of the roles of the current Health Insurance Commission. The Federal Government would continue to fund bodies such as the National Health and Medical Research Council, and to provide moneys for special health initiatives such as Aboriginal health.

The role of State governments would be reduced. They would continue to be responsible for maintaining standards in public hospitals, for State Medical Boards and for handling consumer complaints. As the scheme simplifies the current complex Federal/State health arrangements, administration expenses should be significantly reduced.

Private health insurance

People could take out private health insurance to cover expenses above the scheduled fee, to cover non-approved services, and to cover catastrophic illness that would otherwise deplete the health account. Private health insurance premiums could be deducted from the health account, providing it was in positive balance.

Discussion

Advantages of the proposed system

The proposal addresses some weaknesses of the current health system, particularly in relation to the consumption of medical services, while enhancing the positive aspects. Universal health coverage, the cornerstone of Medicare, is maintained. People remain entitled to treatment in a public hospital regardless of the balance of their health accounts. However, unlike the current system, this proposal offers incentives for maintaining a positive or minimising a negative account. As such the scheme will significantly reduce health expenditure as compared to the current system.

There are currently no meaningful incentives for either patients or doctors to contain ever rising health costs. Indeed, it is obviously financially advantageous for doctors to provide as many services as possible, and this tendency is reinforced by medicolegal considerations. Likewise, for many patients, the perception of a "free" or almost free service is an irresistible temptation. Changing the environment so that patients have a direct financial interest in health transactions will undoubtedly reduce costs. Overservicing, overprescribing and "doctor shopping" will be markedly reduced, and the role of general practitioners will be enhanced as consumers seek value and quality for their health expenditure.

Another advantage is that this scheme rewards good health and therefore encourages preventative medicine, which will more than compensate for a reduction in investigations and services. The role of the doctor will assume greater importance in explaining necessary investigations and treatments, and this will enhance the doctor-patient relationship.

Hospitals will benefit under this scheme if the DRG scheduled fee adequately reflects the true average costs of treating that illness. A case-mix system rewards hospitals for the work they do, but also encourages efficiency and minimises expenditure on a particular illness. The training and educational role of public hospitals will be recognised by including a "training" component in the DRG scheduled fee.

In this system public and private hospitals will compete for patients who will (presumably) choose the hospital where they think they will get best value for money. Waiting lists will undoubtedly be reduced. Many non-insured patients are likely to choose private hospitals for elective procedures, particularly if their health account is in positive balance and if the private hospital charges are only 15% above the scheduled fee. True competition between hospitals will further help reduce health costs.

Yet another advantage of this system is that patients will receive a single bill after a public hospital admission and, at most, two bills (one for the hospital services, including pathology and imaging costs, and one for professional services) from a private hospital. In instances where more than one doctor was involved in the care of the patient, it would be the responsibility of the principal treating doctor to raise the account and to allocate it among the treating doctors.

Fairness and potential disadvantages

The system will be predominantly funded by taxation and in essence will be as fair as is the taxation system. Those who pay no tax will still have a access to a "free" health system. Nevertheless, there will still be strong financial incentives for them not to use health services unnecessarily.

It could be argued that patients with chronic illnesses, like those requiring renal dialysis or organ transplantations, will be disadvantaged. They will undoubtedly run up large negative balances. If they have sufficient income they will be required to pay marginally higher taxes. If they are below the income threshold they will not be financially disadvantaged during their lifetime (with the exception that health dividend bonuses will not be available to them), but their estates will be diminished.

In essence, their relatives who might be expected to inherit the estate will be contributing indirectly to their health costs. For some patients the negative health balance will exceed the value of their estate, in which case the excess will be met by the general tax-paying population. Nevertheless, in this system, the number of people subsidised by the taxpayer and the amounts involved will be considerably less than they are now. Importantly, in this system, no-one's health need be compromised by their financial status.

Government versus private health expenditure

Introduction of this scheme would change the relationship between government and private sector health expenditure without necessarily altering the balance between the two entities. Assuming that the incentives described above are effective, there will be less overall expenditure on health, but in contrast to the current system most private hospital expenses will be funded from the Commonwealth Health Bank. Again in contrast to the current system most private sector health expenditure will come from the employer/employee contribution of 2% of income to the annual base health amount. Private health insurance will play a lesser role. In this system the current 30% government subsidy of private health insurance will no longer be necessary. Taking all these factors into account it is likely that the current balance of approximately 68% government to 32% private sector health expenditure will be maintained.

Comparison with other health systems

The proposed system most closely resembles the Singapore health system, but there are important differences. The Singapore system is a compulsory savings scheme (Medisave) in which employees and employers contribute equally (6%-8% of income depending on age). Funds from Medisave can be used to meet medical expenses, but citizens are unable to run up negative account balances and must pay additional expenses themselves or through voluntary health insurance (Medishield). Coverage is not universal – approximately 75% of Singapore's population have Medisave accounts, although as in the proposed system, citizens' accounts can be

used to pay expenses of immediate family members. The poor and needy, who may have no Medisave account and no health insurance, can apply to the government-appointed hospital Medifund committee for assistance in paying medical expenses.

The proposal described in this article offers a greater safety net to the disadvantaged than the Singapore scheme. There are also important differences in the methods of hospital funding. Nevertheless, both schemes reward good health and ensure that people have a direct financial stake in their own health. It is noteworthy that Singapore, a wealthy country with a high standard of health equal to that of any Western country, spends only 3.7% of GDP on health. This is the most compelling evidence that health savings accounts save money without compromising health care. Introducing a health savings component to the Australian health system as proposed in this scheme is undoubtedly the fairest and most practical way of reducing the future proportion of GDP spent on health.

Ease of implementation

Health funding arrangements would be markedly simplified with the Commonwealth Health Bank funding all aspects of health except nursing homes, administration and research and special health services, which could be funded by either Federal or State governments. Structures such as the Health Insurance Commission, the Pharmaceutical Benefits Scheme, the Medicare Schedule Review Task Force and the NHMRC could be easily adapted to the new system.

Compliance with the nhhrc Principles for Australia's Health System

The health system proposed in this submission is comprehensive, increases access to hospitals, strengthens prevention and wellness and satisfies the nhhrc principles of equity, shared responsibility, value for money, responsible spending on health and providing for future generations.

Richard Harper, May 2008