Submission to the Productivity Commission Study – Performance of Public and Private Hospital Systems. (R. Harper, 24/07/09)

Dear Productivity Commission,

I am an interventional and consultant cardiologist. As part of my practice I perform percutaneous coronary interventions (PCI) which mainly consists of coronary angioplasty and stenting.

I was foundation Director of Cardiology at Monash Medical Centre for 18 years and my current position is Emeritus director of Cardiology at that institution. I also have a consultant position with the Department of Human services (DHS), Victoria. My title is Clinical Co-Lead, Cardiology Clinical Network, DHS, Victoria. Finally I also have an honorary appointment as Professor of Medicine in the Department of Medicine, Monash University. I wish to emphasise however that this an individual submission and is not made on behalf of any of the above three organisations.

Monash Medical Centre has the busiest public cardiology unit in Victoria and perhaps in Australia. There is a co-located Private Hospital (Jessie MacPherson Private Hospital) which shares many of the cardiac facilities of the public hospital including the Cardiac Catheterisation Laboratory. I have had wide experience of cardiology practise both in public and in co-located and independent private hospitals. For many years I have had a keen interest in the relative cost efficiencies of the public and private system particularly in regard to cardiac procedures which are a large part of the health budget. In 2000 I published, in the Medical Journal of Australia, a study comparing the relative costs of angioplasty and stenting in the public and private system. A copy of the article is enclosed with this submission. I believe it is one of the few studies, indeed perhaps the only study, to address this problem in the Australian context in a scientific manner.

Our study showed that PCI was considerably more cost efficient in the public as opposed to the private system. Although the study is now almost 9 years old I suspect a similar study today would show much the same result although perhaps to a lesser degree. One thing I did learn was that it was much easier to estimate the true costs of treating a particular illness (in this case coronary angioplasty and stenting) in the public system than in the private system. In general the cost weighted DRG (cwDRG) system of funding the treatment of illnesses in the public system is a reasonably accurate measure of the true costs of treating that particular illness. This was reflected in our study. Furthermore the cwDRG encompasses all costs including the salaries of the medical personnel involved in providing the treatment. A major advantage of the cwDRG system is that it necessitates hospitals to be cost efficient otherwise they make a loss. True costs in the private hospital system are harder to estimate: they include bed day costs, theatre costs, prosthesis charges, pathology and diagnostic imaging costs and usually multiple medical fees often charged well above the medicare rebate level. In our study the total of all these charges far exceeded the cwDRG for coronary angioplasty and stenting which in essence is what the State government paid the public hospital for providing this service. There are now incentives for private hospitals to reduce bed day costs and length of stay but not the other costs. In the past ,at least, private hospitals made tidy profits by charging Health Insurance companies considerably more for prostheses (such as stents) than their purchase price. I am not sure whether this is still the case now. I suspect it is but on a lesser scale. Unlike the public system where professional medical fees are included in

the cwDRG, in the private system there is no limitation to how many doctors can be involved in the treatment of a private in-patient and all may charge fees well in excess of the rebate.

A further factor which is not always considered is the frequency of procedures in the private and public hospital systems. Many non life saving elective procedures are performed far more frequently per head of population in the private as compared to the public system. For example, in contrast to acute coronary syndromes (ACS) where PCI may be life saving, randomised studies in patients with stable coronary artery disease (CAD) have shown no benefit of PCI as compared to medical therapy in terms of reduction in mortality or reduction in the incidence of heart attack. In stable CAD PCI does have a role in reducing symptoms in those in whom symptoms cannot be adequately controlled with medical therapy but such patients are a minority. In the private system in particular, where the rewards to the cardiologist and the private hospital may be considerable, many patients with minimal or no symptoms or patients who have not had a trial of adequate medical therapy undergo unnecessary PCI usually in the false belief that the procedure is prolonging their life or reducing their risk of heart attack. I have little doubt that examination of recent data regarding PCI in Australia would show that the rate of PCI for insured and non insured patients for ACS would be similar but the rate of PCI for insured patients with stable CAD would be much higher than for non-insured patients. In part this may represent under-servicing in the public system but from my knowledge of both systems the main reason for the discrepancy is over-servicing in the private system. The same may apply to other treatments for other diseases but I have no direct knowledge of this.

Unfortunately the problems that I describe above are inherent in our health system which by its very structure encourages over-servicing. The problems will not be easily corrected without significant changes to our current health system. Ideally (in my opinion) the charge for treatment of an illness in hospital , whether private or public, should be that of a previously determined cwDRG for treating that particular illness. Importantly the cwDRG would need to structured to cover all reasonable costs involved in treating that illness. For private patients the cwDRG would be divided into a hospital and medical component. If more than one doctor was involved in the treatment it would be up to the principal treating doctor to allocate the medical component on an equitable basis. In turn the cwDRG could be deducted from the patient's health savings account. A public hospital would always only charge the cwDRG but if a private hospital or private doctor wished to charge above the cwDRG the excess would need to be met from Private Health Insurance or from their own pocket. Such a system would, for the first time, introduce meaningful competition between private and public hospitals for both insured and non-insured patients with patients likely to choose the hospital where they wished to be treated on the basis of quality and cost. As I am sure the productivity commission will appreciate true competition between hospitals is probably the most productive way of constraining ever rising hospital costs.

Implementation of such a system would require changing our health system to a government supported universal health savings system. As the Singapore system so amply demonstrates health savings systems are the most cost efficient way of delivering health care without compromising quality. (Singapore spends ~ 4% of GDP on health as compared to 9.7 % of GDP in Australia without any measurable health disadvantage). Health savings accounts gives consumers greater control over their health spending, reduces over-servicing and encourages healthier lifestyles and preventative medicine. I believe it would be possible to modify our current Medicare

system to a universal health savings system without compromising the basic principles of Medicare while at the same time still providing the same safety net features of Medicare. I enclose with this submission a copy of a detailed submission that I previously made to the nhhrc (submission 278) which explains how this health system could be implemented in Australia.

I fully realise that the productivity commission does not have a brief, at least at this stage, to recommend major changes to the health system but rather the brief is to examine the cost differences and differences in quality of care between public and private hospitals. Nevertheless I believe my experience and knowledge of the two hospital systems, particularly in relation to costs of cardiac procedures, would be of benefit to the commission and I would welcome the opportunity to directly address the commission on this matter.

Yours sincerely

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