9th November 2004

C/o Productivity Commission
P O Box 80
Belconnen
Canberra ACT 2616

I understand that, as part of it's enquiry into National Competition Policy, the Productivity Commission has pointed to the need to improve the performance of Australia's health care system. I ask that this letter with its associated attachments be regarded as a formal submission to this enquiry.

I am a Cardiologist with over 30 years of experience in the public and private health system. My current appointment is Director of Cardiology at Monash Medical Centre which is a large public hospital in metropolitan Melbourne with an associated private hospital (Jessie McPherson Private Hospital). I also hold an Honorary appointment as a Professor of Medicine at Monash University. Although my principal concern is Cardiology, I have long had an interest in Health Economics. In 1998, I published an article (Reference 1, Attachment 1) describing a new health system which I believe would be much more cost efficient than the current system, yet still retain its best features.

The system described is a health savings based system with universal coverage and safety net features. Unlike the current system, standard market forces would govern the interaction between consumer and provider and competition between public and private hospitals would be promoted. Good health would be rewarded, thus encouraging preventative medicine.

All the above features would act to constrain costs. Although predominantly government funded, with private health insurance covering catastrophic illness and "extras", the system could be easily modified to include employer/employee contributions.

The article in 1998 resulted in invitations to speak at several health economic type forums. One such power point type presentation from 1999 is included (attachment 2) in this submission. I apologise for the fact that I have not had the time to update the figures but the message is the same and as pertinent today as it was then. The presentations always aroused considerable audience interest, but as you are no doubt aware there are many vested interests in health and instituting major change is a Herculean task. In 1999 I did not have the time and resources to push the scheme. Since then however health costs have continued to rise at a much greater rate than the CPI and with each passing year the need for meaningful structural change becomes greater. With a government majority in both Houses of Parliament, there is now a realistic opportunity for health reform and I am keen that this scheme be reappraised. I would welcome the chance to present this scheme in person to the Productivity Commission.

Finally with this submission, I also include a paper (Reference 2, Attachment 3) describing the marked difference in costs to the health system of providing the same service in a public and a private hospital. With true competition in the health system, these differences would be reduced or eliminated.

Yours sincerely,

PROFESSOR RICHARD W. HARPER
Director of Cardiology
Rh/lds/cost efficiencies in the Health system

References:

1. Harper RW. Towards an improved and more cost effective health system for Australia. MJA 1998; 168:286 – 91.

2. Harper RW, Sampson KD, See PL, Kealey JL, Meredith IT. Costs charges and revenues of elective coronary angioplasty and stenting: the public versus the private system. MJA 2000; 173: 296 – 300.

New Health System for Australia

Richard W. Harper

Rising health costs are a problem faced by all countries. The three main reasons are listed below:

Why Are Health Costs Rising?

- Ageing population
- High cost of new technology
- Increasing consumer expectations

How Is Health Funded?

- Government (taxation based)
- Private sector (private health insurance)

Australian Health Expenditure 1997-98

$ Million

- Government 32,647 (69.1%)
- Private 14,620 (30.9%)
- Total 47,267 = 8.4% of GDP

* Government expenditure per person = $1752

Average health expenditure per person = $2536

Should the Government Spend Less and the Private Sector More?

- Govt proportion of health spending has continually risen over the last 3 decades
- Recently the government introduced a 30% subsidy of private health insurance (PHI) premiums in the hope of attracting more people to take out PHI
- Will this initiative reduce or increase govt spending on health?

International Comparisons

Country	Expenditure (% GDP)	Predominant Funding	Life Expectancy	
			M	F
USA	14.2%	Pr sector	72.2	79.2
UK	6.8%	Go	73.7	79.2
AUS	8.4%	Co	75.4	81.1
Singapore	3.1%	Private sector (private sector) saving	74.6	79.2

Why Does Singapore Spend So Little on Health?

- Younger population
- Less expectations
- Medical Savings System encourages thrift*

** This feature is almost certainly the main reason why Singapore's health expenditure is so much less than other countries of comparable wealth*

Health Transactions in Australia

- Not subject to normal `commercial' forces
- System encourages consumption (exception - public hospitals)
- The consumer exerts little control over his or her health expenditure

What Is the Main Feature of a Health Savings Scheme?

Patient (consumer) assumes the financial responsibility for his/her health expenditure

The Australian Health System encourages consumption

Example

- I have a headache
- I go to the GP
- I am not satisfied with his opinion
- I ask to be referred to a specialist
- He refers me to a neurologist
- I have a CT scan and an EEG
- I am reviewed by the neurologist but am not satisfied with his opinion - I return to the GP and ask for a second opinion
- I am seen by another neurologist
- I have private health insurance so I am admitted to a private hospital for further investigations
- I have an MRI scan, a cerebral angiogram, other pathology tests and see other specialists
- Finally I am happy that all is ok

The Singapore Health System does not encourage consumption. Greater responsibility is placed on the consumer

Example

- I have a headache
- I go the chemist and get an aspirin
- If my headache does not go away I may go the GP but if it is my money that is being spent I am less likely to ask for multiple referrals and less likely to agree to multiple tests

Within the current Australian system it is very difficult to constrain medical services and to detect or prove overservicing. As a consequence it is not surprising that costs are continually rising at a rate greater than the CPI as shown below ...

Components of Health System

Rise pa

- Out of Hospital Medicare benefits 4-8%
- Private Health Insurance premiums 8-14%
- Private hospital costs 8%
- Pharmaceuticals (PBS) 5-8%

The remainder of this presentation will be in 2 parts

In Part 1

- **Evidence will be provided for two propositions. Namely Health care is most effective when:**
  - **a. Consumer has a financial stake in the health transaction and**
  - **b. The provider has a financial interest in containing costs**

Part 2

- **A health system that encompasses the above principles while still maintaining health standards and providing universal care is described**

The best evidence for the first proposition "that health care is most cost effective when the consumer has a financial stake in the health transaction" comes from the Singapore Health System which will now be described in more detail ...

Components of the Singapore Health System

Medisave:	Compulsory savings scheme
Medishield:	Voluntary catastrophic insurance scheme
Medifund:	Government endowed fund for the poor

Medisave

- 6-8% of income depending on age*
- Equal contribution from employer/employee
- Funds can only be used for approved health services
- Can be used for immediate family members
- Interest is earned on savings
- Negative balances not allowed**

* Higher income earners will have a greater capacity to accumulate money in their health savings accounts

** If there is no money in the account the consumer has to pay for the health service from their own pocket

Medishield/Medishield Plus

- Voluntary low cost `catastrophic' insurance for major or prolonged illness (supplements Medisave)
- Can be supplemented by Medishield Plus to allow extras (private room etc)
- High participation rate (88%)
- Premiums can be deducted from Medisave account

Medifund

- Government endowed fund initially of $300 million. More money has subsequently been added
- Interest distributed to public sector hospitals
- Patients unable to pay their bills can apply for help from the Hospital Medifund Committee

Disadvantages of Singapore Health System

- Only 75% of population have Medisave accounts
- Poor and needy are dependent on `charity'

The Singapore health system is a `hard nosed' system and would be regarded as unfair by most Australians. It is unlikely to be politically acceptable to the Australian public unless significantly modified

Second Proposition

- Health costs are less when the provider has financial interest in containing costs

Evidence for this proposition can be readily obtained by examining costs (and charges) of treating patients with the same illness in private and public hospitals

Funding of Victorian Hospital Admissions

Public Hospitals

- Casemix payment = payment per Diagnostic Related Grouping (DRG)

Private Hospitals

- Charges are raised for all aspects of treatment of an illness ie bed day charges, charges for pathology tests and imaging tests, charges for medical care which often involves multiple doctors
- Patient receives multiple bills

The example chosen is that of elective:

Coronary Angioplasty and Stenting

- High technology, high cost procedure performed in both public and private hospitals
- Approximately 20,000 procedures per annum in Australia

Costs Involved in Coronary Angioplasty and Stenting

- Cost of consumables - balloons, catheters, etc
- Cost of stents (prosthetic costs)
- Cost of labour - salaries for medical, nursing and technical staff
- Cost of depreciation of equipment
- Cost of associated pathology tests
- Cost of stay in hospital (1-3 days)

At Monash Medical Centre we have the unique situation where the cardiac catheterisation laboratory services both the public and a co-located private hospital (Jessie McPherson Private Hospital).
We have meticulously identified all costs involved in performing elective coronary angioplasty and stenting in both private and public patients including both pre and post care. The results are shown in the following pages.

Costs and Charges of Coronary Stenting Public vs Private

- Prospective study of 199 consecutive patients undergoing coronary stenting at MMC (public) and Jessie McPherson Private Hospital over a 12 month period
- Detailed costing of all aspects of hospital admission and procedures
- Costs, charges and revenue (from casemix) compared

Costs of Coronary Stenting

Average Costs $	Public (n=137)	Private (JMPH) (n=62)
Prosthesis (stent cost)	1741	1965
Consumables	1370	1246
Pharmaceuticals	334	556
Salaries*	212	178
Overheads	262	262
Bed day costs	1556 (ALOS 1.7)	1925 (ALOS 2.1)
Preadmission clinic	35	12
Total Average Cost	5510	6151
Revenue	6355	14050
Funding Surplus	$845	$7849

Salaries in the public group include doctors salaries as no separate medical fees are raised in contrast to private patients

Coronary Stenting - Private Hospital Charges

Private Patients - PTCA with Stent

Average Charges $	Jessie McPherson Private Hospital	`Industry Standard' Private Hospital
Theatre	4893	4893
Prosthetics	4813	4813
Medical	1808	2260
Bed Charge	1890	3309
Pharmaceuticals	563	986
Tests	83	83
Total Charges	14050	16344

We have reliable data to indicate that charges in Jessie McPherson Private Hospital are less than the average private hospital. If anything the estimated charges for the `Industry Standard' private hospital are probably on the low side

How much does it cost the government for a private coronary angioplasty and stent?

Government Costs of Private Coronary Stenting

	Private Patients - PTCA with Stent	
Costs $	Jessie McPherson Private Hospital	`Industry Standard' Private Hospital
Total Costs	14050	16344
Health Insurance Costs	11948	13919
Direct Government Costs	2002	2425
Add 30% subsidy of private insurance	3584	4176
Total Government Costs	5586	6601

NB Casemix payment in public hospitals = $6355

This data shows it actually costs the Federal Government more for a coronary stenting procedure to be performed in an 'Industry Standard Private Hospital' than in a public hospital

54% of patients undergoing coronary revascularisation (either coronary angioplasty or coronary surgery) in Victoria in 1996 were private patients *(Richardson et al, Centre for Health Program Evaluation)*

- Level of PHI in Victoria 32.4%
- Private admissions to hospital 27%

ie a patient with private health insurance (PHI) is twice as likely to undergo a coronary angioplasty as a public patient - this data supports the contention that the Australian Health System favours consumption except in the public hospital system. Encouraging consumers to take out PHI will increase the number of angioplasties performed and thus the costs to the government

Can We Design an `Ideal health System' that

- Combines the cost efficiencies of medical savings accounts and casemix payments for hospital admissions
- Rewards good health
- Maintains universal high quality care
- Preserves the doctor/patient relationship
- Allows ready access to hospital care when needed

This health systems described in detail in an article in the Medical Journal of Australia as referenced below

For Debate

Towards an improved and more cost effective health system for Australia

Richard W. Harper

A new health 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. *(MJA 1998; 168:286-291)*

Proposed System

- Taxation based universal medical savings system with `safety net' features
- Hospital care (both public and private) predominantly funded by a casemix system

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 entitled to Medicare
- An annual base health amount (indexed for age) which is the sum of money paid annually into each citizen's health account by the Federal Government

Components of the Proposed Health Scheme (cost)

- 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 including casemix fees for hospital admissions

How Much Would the Annual Base Health Amount Need to Be?

- Current health expenditure is $2536 per person per annum (1998)
- Assume cost efficiencies of new system
- Initial amount required approx $1760*
- Subsequent annual amounts would depend on the financial status of the Commonwealth Health Bank

* Harper, MJA 1998; 168:286-291

How Would the System Work?

- Charges for approved medical services (eg visits to GP, specialists, medical tests, hospital admissions) could be deducted from health savings account to the level of the schedule fee even if the account balance was negative

How Would the System Work? (cont)

- Providers of health services could set their own level of fees as is the case now
- Up to 15% more than the scheduled fee could be deducted if the account balance was positive
- Additional charges from doctors, private hospitals, etc would have to be met from patients own resources or PHI as would charges for nonapproved medical services

If the Account Balance Was Positive

- A 5% annual health dividend payable

This money could be spent as the consumer wishes and not necessarily on health. It could however be added to the health savings account. It is an important incentive for the consumer to maintain good health.

If the Account Balance was Negative

- Higher marginal tax rate above a certain income threshold until the negative balance was corrected

Note: this would obviously not apply to the unemployed, pensioners and those on low incomes

What Happens When the Patient Dies?

- Positive health account could be willed to the health account of another individual (eg family member)
- Negative health account would have to be met by the deceased's estate however the spouse or partner could apply to take over the deceased's health account. This provision would avoid the necessity to sell joint assets if one partner dies.

Hospital Admissions

- Public Hospitals would charge the Casemix fee (as determined by the health advisory council)
- Private Hospitals could charge above the Casemix Fee but only the Casemix Fee plus 15% could be deducted from the health account

Casemix Fee

- Consists of a hospital and medical component
- Principal treating doctor would charge medical component. He would have to pay other doctors involved in the management from that fee
- Multiple billing for hospital admissions avoided

Competition Between Hospitals

In this system patients without PHI but with positive health accounts may choose to go to a private hospital for an elective procedure such as hip replacement particularly if there is a long waiting list at the public hospital and if the private hospital charged only 15% above the scheduled casemix fees.

As a result there would be much more competition between public and private hospitals and between private hospitals for patients than there is now.

Private Hospital Insurance

- Cover catastrophic illness which would otherwise deplete health account (as in the Singapore system)
- Cover extras and non-approved medical services
- Premiums could be deducted from health account (if positive) and would be much reduced

Incentives to Maintain a Positive Health Balance

- Higher health dividend
- Avoid increased taxation
- More flexibility for private hospital care
- Asset to be passed onto relatives

These incentives will encourage consumers to practice preventative health measures and will also reduce unnecessary visits to the doctor and the level of overservicing

The Disadvantaged?

- Still entitled to the same level of health care as now*
- Access to a health dividend if account balance is positive

** ie still entitled to visit their own doctor and to be admitted to public hospitals when necessary irrespective of the status of their health account*

Other Advantages

- All government funding would be via Commonwealth Health Bank, ie Federal/State wrangles, cost shifting etc no longer relevant
- Good health rewarded
- Greater access to private hospital system for general population (shorter waiting lists)
- No multiple billings for hospital admissions
- Private health insurance cheaper