Submission to the

Australian Government's Competition Policy Review

June 2014

Introduction

The Australian Healthcare & Hospitals Association (AHHA) welcomes the opportunity to provide a submission as part of the National Competition Policy Review.

The AHHA is Australia's national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Medicare Locals and primary healthcare providers, universities, and individual health professionals and academics. We are uniquely placed to be an independent, national voice for universal high quality healthcare to benefit the whole community.

The Terms of Reference for the Competition Policy Review include the following principle:

> *'Government should not be a substitute for the private sector where markets are, or can, function effectively or where contestability can be realised'.*

To this end, the Review's policy goals are innovation, cost efficiency and consumer responsiveness. These are shared goals in health policy, but are complemented by health-specific goals:

- Providing equitable access to care
- Achieving and maintaining quality and safety of care, and
- Ensuring care is affordable.

The AHHA's vision is for health policy which delivers equitable access to excellent and efficient universal healthcare, as characterised by:

1. Evidence based practice;
2. Equity of access to safe and high quality healthcare regardless of location or personal characteristics;
3. Socially, economically and environmentally sustainable policy;
4. Efficiently and adequately resourced services; and
5. Efficient and effective coordination across all levels of government and the private health sector.

It is AHHA's submission that each of the key indicators of a healthy healthcare system should be considered in assessing changes to competition policy within the health sector. In this submission, the AHHA highlights key issues that would impact the health sector from this standpoint.

The AHHA makes the following recommendations:

- Expansion of competition in the health sector (both for service providers and insurers) must have equity of access and affordability as primary performance measures alongside fiscal sustainability.
- Strategies to increase competition must be formulated within the context of the maintenance or enhancement of service quality, safety and value for money.
- The implications of greater competition must be considered for areas of current or potential market failure.

- Strategies must be developed that consider the whole patient journey rather than focusing on simple episodic components of care, or individual system components.
- Increasing the availability of health service and provider outcome data should be a priority to improve consumer choice and facilitate better understanding about the efficiency and effectiveness of the health system.

We welcome the opportunity to discuss these issues in greater detail at any public hearing.

Would there be a net public benefit in encouraging greater competition and choice in sectors with substantial government participation (including education, health and disability care and support)?

For many sectors, it is argued that competition drives efficiency and innovation. While competition already exists in certain areas of the Australian healthcare system – for example, among general practitioners working in private practice, and between public and private hospitals for workforce and elective surgery – the notion of expanding competition is contentious. One of the main concerns is that there are many areas of demonstrated market failure in health care, which makes it difficult to apply competition principles.

AHHA's view is that policymakers must accept and acknowledge the differences between the health sector and other sectors in seeking to design and implement effective competition policies. While this does not preclude greater use of competition in health care, serious consideration needs to be given to the implications for service delivery and patient care, in terms of efficiency, quality and equitable access to care.

Evaluating the impact of any reforms on access to care is not straightforward. Access depends on a range of factors, including people's need for services; whether or not they recognise or can act on that need; the actual demand for services, regardless of the level of need; and the supply of services.

People need to be able to:

- **perceive their need for service**
  - this depends on their health literacy, health beliefs, trust, and expectations
- **seek the service they need**
  - this depends on their personal and social values, culture and gender, and autonomy
- **reach the service**
  - this depends on their living environment, available transport, and their mobility and social support
- **pay for the service**
  - this depends on income, assets, social capital and health insurance
- **engage effectively with the service**
  - this depends on having sufficient confidence and information, a common language and cultural values, and where relevant, caregiver support.

Accessible health care also requires services to be:

- **approachable**
  - this requires transparency, outreach and provision of information
- **acceptable**
  - this is influenced by professional values and norms, and the culture and gender of the service provider
- **available**
  - this is influenced by supply and geographic location, availability of accommodation, opening hours and appointment mechanisms

- **affordable**
  - this is influenced by direct, indirect and opportunity costs
- **appropriate**
  - this is influenced by technical and interpersonal quality, coordination, and continuity of service provision.

Governments in Australia have always had a strong role in financing and delivering health services. While the role of the private sector has grown over time, Commonwealth, State and Territory governments have continued to fund and deliver many health and hospital services. One reason for this is the limited capacity and/or willingness of the private sector to fully respond to consumer needs and wants, across the full spectrum of health requirements, across all geographic locations, and at pricing which meets goals related to equity of access and affordability.

Because governments have traditionally played such a substantial role in health care, they have had a major influence on the types of services provided, the quantum of funding provided for them, and service delivery arrangements, including determining whether services are provided by government agencies, private business, or not-for-profit organisations.

However, as the role of the private sector has expanded over time, health care financing and delivery arrangements in Australia have become suboptimal, in part because this shift from public to private sector financing and delivery has not been well thought through. In many areas of health care, services are now funded and delivered by both the public and private sectors: for example, hospital services, primary health care and dental services. This is not problematic in itself, but it can become so if it means some people, for example, those with private health insurance, have preferential access to basic health care services.

One way of rationalising and clarifying the roles of the public and private sectors in health is to have public and private insurers compete on equal footing for members, and public and private providers compete for patients. However a 2012 report on access, quality and affordability in healthcare from the John Hopkins University found that too much competition without coordination and cooperation will fail, and that free competition is ineffective in healthcare, leading to market failure and fragmentation, evidenced through spiralling insurance premiums, restricted access to care and negative quality impacts, particularly where activity, not quality, is rewarded.[1]

Governments need to find ways of slowing the growth in health care expenditure without adversely affecting health outcomes, particularly in a society with an ageing population and a growing burden of chronic disease, – but increased competition is not a panacea. While there is a role for competition in health care, it must be considered alongside other options. Using appropriately targeted regulation and acting on evidence based policy in many areas of the system would also drive significant savings and contribute to public benefit. For example, considerable cost savings could be achieved in areas such as medical services simply by making sure fees reflect the underlying cost of service delivery, or are more closely aligned with patient outcomes.

[1] Gopffarth D, 'Access, quality and affordability in healthcare in Germany and the United States', *AICGS Policy Report 51*, John Hopkins University: http://www.aicgs.org/site/wp-content/uploads/2012/06/PR51-Health-Care-Goepffarth.pdf

In seeking to control health expenditure, governments need to be able to influence health care providers, many of whom operate in the private sector beyond the direct control of governments.[2] This can be difficult, but governments do have some tools for influencing fees and prices in the private sector. Because the Medical Benefits Scheme (MBS) and the Pharmaceuticals Benefit Scheme (PBS) are publicly funded, governments are able to exert influence on prices by adjusting rebates or subsidies. Additionally the MBS and PBS can be used to incentivise best practice and provide disincentives for undesirable practices.

Governments are also able to influence total expenditure by regulating the supply or distribution of health care providers, for example, through limiting the number of medical schools, the provision of Medicare provider numbers, and the licensing of private hospitals.

Hospitals

While there is some competition between public and private hospitals, caution is required when comparing their services and outputs. The range of services and the client mix of private hospitals are significantly different from that of public hospitals. Emergency departments are less common in private hospitals, and few provide highly specialised treatments, such as transplant and burns services. Additionally, case mix differs significantly across the public and private sectors, with higher proportions of patients with multiple comorbidities and complex conditions being managed in the public sector. The high cost of care and of the maintenance of specialised equipment, and the availability of suitably trained and experienced staff limits the viability of these services outside of large specialised public sector facilities.

The cost of private hospital services (and private health insurance) creates a divide between the consumers of private and public hospital services. There is evidence, for example, that people living in more socioeconomically advantaged areas are more likely to have private health insurance.[3] There is also strong evidence showing that people living in more socioeconomically advantaged areas have better health than those in socioeconomically disadvantaged areas.[4] Because people with private insurance are more likely to use private hospitals than people without it, the client mix of private hospitals is likely to be different from that of public hospitals. On the whole, private hospital patients tend to be healthier, and therefore cheaper to treat than public hospital patients.[5]

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[2] Boxall A, 'What are we doing to ensure the sustainability of the health system?', *Research Paper no. 4 2011-12*, Library of Parliament, Parliament of Australia, 18 November 2011: http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1112/12rp04#_Toc310493613

[3] Australian Bureau of Statistics, 'Private health insurance', *Australian Health Survey: Health Service Usage and Health Related Actions, 2011-12*: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/E334D0A98272E4DCCA257B39000F2DCF?opendocument

[4] World Health Organization, *Social determinants of health*: http://www.who.int/social_determinants/themes/en/

[5] Johar M et. al., *Discrimination in a universal health system: explaining socioeconomic waiting time gaps*: http://www.ecineq.org/ecineq_bari13/FILESxBari13/CR2/p116.pdf

Additionally private hospitals tend to have a higher proportion of elective services and shorter episodes of care compared to the public sector.[6] This is driven in part by the private hospitals' greater focus on cost containment and financial risk management. This in turn impacts on the capacity and willingness of private hospitals to compete with public providers across the full range of services.

Service providers

Competition between health services providers is primarily based on factors such as waiting times, convenience, cost and reputation. There is limited information available to consumers relating to the quality of the services provided, making it difficult for them to make an informed decision on which provider to see. Instead, the choice is often left up to the patient's general practitioner.

The data available on quality of care in Australia is limited in scope (e.g. MRSA infection rates, hand washing data, waiting times) and detail (hospital level data only). In the USA, a web-based tool provided by government allows consumers to compare different physicians' participation in a range of quality improvement programs.[7] Similarly the HospitalCompare site provides data on hospital readmission rates. [8] In some parts of the United States, government agencies, and professional associations publish detailed and timely performance data on a range of quality indicators for common surgical procedures and medical conditions. [9,10]

Any efforts to increase consumer driven competition will require greatly improved availability of quality and clinical outcome data across the public and private sectors. Without it, competition will be driven by the quality of self-promotion, rather than the quality of care.

In rural and regional areas there is a lack of competition in many areas of health care due to the relatively high cost of service provision and limited number of providers. AHHA members estimate that the costs of providing basic medical services in rural and remote areas can be in the order of 500 per cent more than in regional centres. The challenge of overcoming market failure in these areas has been regularly identified, including in the National Health and Hospitals Reform Commission Report.[11] The more recent Review of Medicare Locals also highlighted the need for government supported services in areas of market failure. [12]

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[6] Australian Government, Productivity Commission, *Public and Private Hospitals: Productivity Commission Research Report*, December 2009: http://www.pc.gov.au/_data/assets/pdf_file/0015/93030/hospitals-report.pdf

[7] US Government, Medicare, *Physician Compare*: http://www.medicare.gov/physiciancompare/search.html

[8] US Government, Medicare, *Hospital Compare*: http://www.medicare.gov/hospitalcompare/search.html

[9] State of California, Office of the Patient Advocate, *HMO Quality Rating Summary*: http://reportcard.opa.ca.gov/rc/hmorating.aspx

[10] Washington State Hospital Association, *Quality Indicator Search Page*: http://www.wahospitalquality.org/

[11] Australian Government, National Health and Hospitals Reform Commission, *A healthier future for all Australians: Final report*, June 2009: http://www.health.gov.au/internet/nhhrc/publishing.nsf/content/1AFDEAF1FB76A1D8CA257600000B5BE2/$File/Final_Report_of_the%20nhhrc_June_2009.pdf

[12] Australian Government, Department of Health, *Review of Medicare Locals: Final report*, 4 March 2014: http://www.health.gov.au/internet/main/publishing.nsf/Content/A69978FAABB1225ECA257CD3001810B7/$File/Review-of-Medicare-Locals-may-2014.pdf

Public hospital and health services in rural and remote areas are often the only available service providers and the viability of these services can sometimes be marginal. Competition policy is highly unlikely to assist in achieving any of the goals of health policy in these areas and in AHHA's view, may result in even fewer services and uncertainty of ongoing provision. Further, there is a significant risk that greater competition between public and private hospitals in the more cost-efficient metropolitan areas may dilute the economies of scale achieved by large-scale public sector health services, thus making delivery of services in areas of market failure even more costly.

Introducing competition into discrete, non-clinical areas of service delivery may also have an impact on the viability of the whole enterprise. For example, the kitchen and laundry facilities of a rural hospital may provide services to other industry in the local area and the loss of that service would impact on staff and the community more widely.

Significantly, the viability of health and human services in some communities has been improved through a reduction in competition. The Multi-Purposes Service model in operation across Australia arose to address concerns about the viability of small rural hospitals and aged care facilities which had been operating independently and were effectively competing for funding and staff. By pooling funds, amalgamating facilities and combining staffing and management structures, a robust and flexible business approach was established which was engaged with the community and could adapt to respond to changing needs.

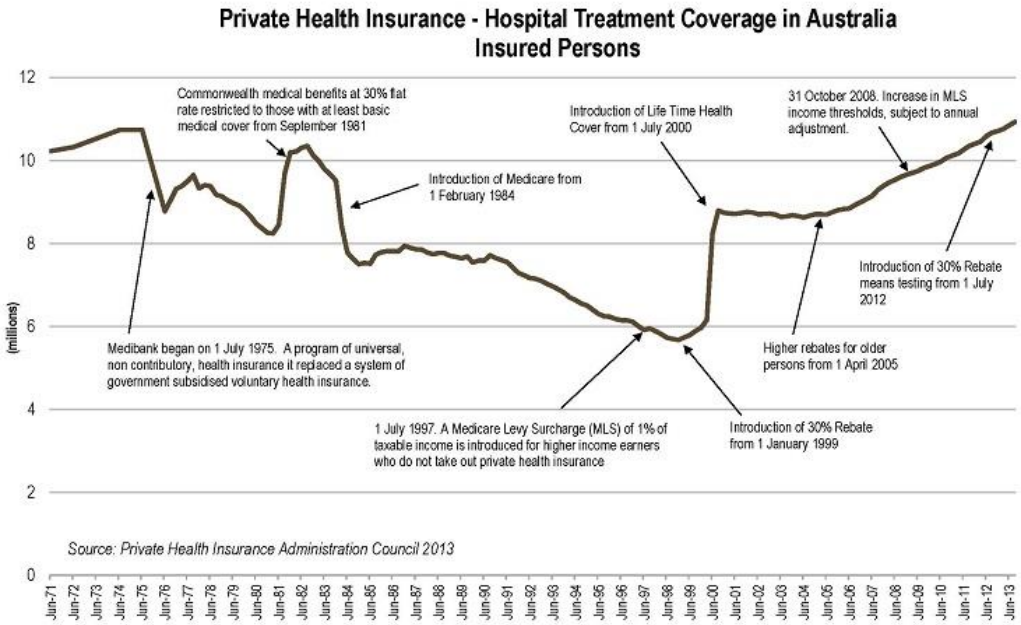
Health insurance

There are two aspects to competition in the private health insurance market; competition between public insurance (Medicare) and private health insurers, and competition among private health insurers.

While Medicare is universal, the rate of private insurance coverage was 47 per cent as at March 2014.[13] Competition exists between Medicare and private insurance largely in the hospital market. Private insurers compete for customers based on their ability to offer shorter waiting times for elective surgery and the possibility of choosing one's own doctor. Private insurers are also able to attract customers because they provide benefits for some ancillary services (for example, physiotherapy and dental services) not covered under Medicare.

There are also several financial incentives in place that encourage people to purchase private insurance, including means-tested premium subsidies, the Medicare Levy Surcharge and the Lifetime Health Cover loading penalty. The introduction of the Lifetime Health Cover loading penalty in 2000 saw an increase in the take up of private health insurance, with further upward growth since 2008 following the increase in Medicare Levy Surcharge income thresholds (see chart below). [14]

[13] Private Health Insurance Administration Council, *Statistical Trends in Membership and Benefits Data Tables*: http://phiac.gov.au/industry/industry-statistics/statistical-trends/
[14] ibid.



The current array of financial and non-financial incentives to purchase private health insurance obscures a longstanding structural problem. Compared with most other OECD countries, health insurance arrangements in Australia have a high degree of duplication – that is, private health insurance and Medicare provide cover for many of the same services, and Medicare is compulsory.[15]

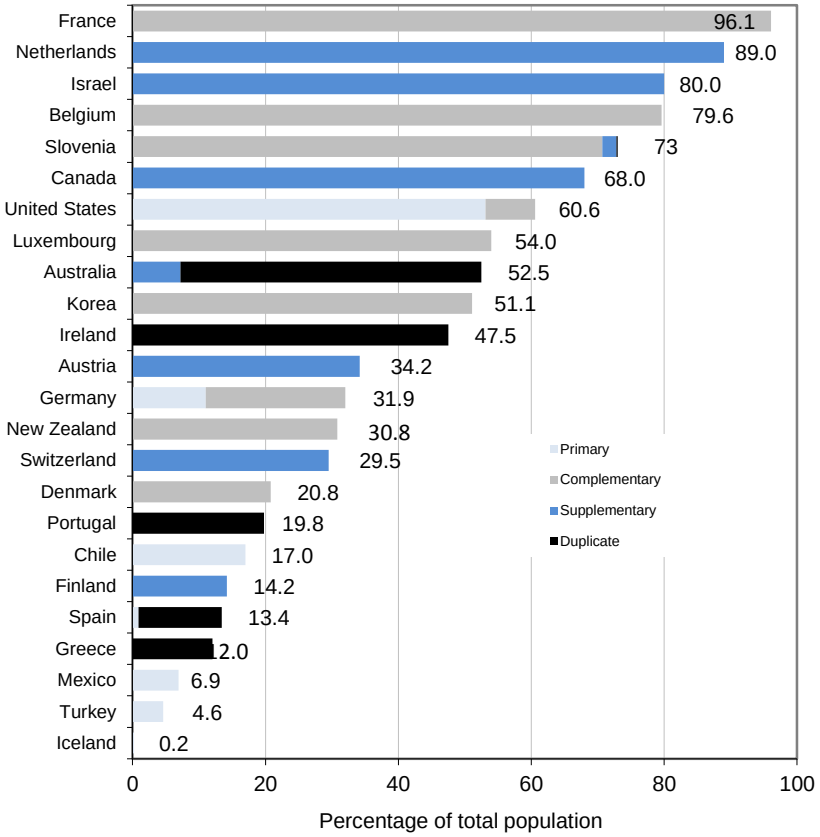
While duplicative insurance has the potential to make the health system more responsive to people's needs (for those who hold it), it has several downsides, according to the OECD including:

- it increases inequity;
- is likely to play a role in diverting resources away from the public sector (especially if medical specialists are able to work in both the public and private sectors, as they can in Australia);
- adds to health expenditure and health service utilisation; and
- makes little contribution to the overall efficiency of the health system.[16]

[15] Organisation for Economic Co-operation and Development, *OECD Health Working Paper No. 50: Health System Institutional Characteristics: A Survey of 29 OECD Countries*, 28 April 2010: http://www.oecd-ilibrary.org/docserver/download/5kmfxfq9qbnr.pdf?expires=1402884291&id=id&accname=guest&checksum=7DE59567C23D14068DE764C895D0F05B

[16] http://www.oecd-ilibrary.org/docserver/download/5kmfxfq9qbnr.pdf?expires=1402884291&id=id&accname=guest&checksum=7DE59567C23D14068DE764C895D0F05B

Private health insurance coverage, by type, 2011 (or nearest year)



Note: Private health insurance can be both complementary and supplementary in Denmark, Korea and New Zealand; and duplicate, complementary and supplementary in Israel.

Source: OECD Health Statistics 2013[17]

The Industry Commission identified the high degree of duplication in the Australian health insurance system as a problem more than a decade ago. The report clearly explained the problem:

> *"Through supporting private health insurance, and by providing financial incentives in response to this pressure, the Government is endeavouring to switch health funding from the public sector to private sources. This process is also aided by the expenditure constraints imposed on the public health system in recent years, reflected in constrained access to public hospitals.*
>
> *At the same time, Government policy supports universal access under Medicare, and private health insurance remains voluntary."*

The report went on to point out:

> *"As a consequence, the dual role currently being served by private health insurance poses some difficulties for its regulation:*
> - *the objective of displacing public funding under Medicare can be seen as providing justification for some form of community rating of private health insurance; but*
> - *the objective of merely topping up Medicare funding (with optional extras), would seem to provide little justification for community rating of private health insurance."*

[17] OECD Health Statistics 2013: http://dx.doi.org/10.1787/health-data-en

The report concluded:

> *"There is, at present, an inherent tension between the policies of support for universal access under Medicare, and support for voluntary, community rated, private health insurance. Resolution of such conflicts would seem to require changes to the overall settings for health care policy in Australia."*[18]

There have been several major changes to health insurance introduced since then (including the introduction and subsequent means-testing of rebates, and the introduction of Life Time Health Cover), but the fundamental challenge of clarifying the role of private health insurance in the context of the compulsory Medicare scheme remains and should be a priority for consideration as part of this inquiry into competition policies.

In addition to the duplicative arrangements between Medicare and private health insurers, there is competition between private health insurers for market share, based on insurance products, premium prices, benefits, and service. However, despite this competition, the Private Health Insurance Administration Council (PHIAC) states that the industry continues to be dominated by a small number of large insurers, with the two largest providers representing 56 per cent of all policies and the top 5 representing 82 per cent of the market.[19]

Government intervention in the private health insurance market is also relatively high, compared with many other countries.[20] The government intervenes by controlling premium increases, providing rebates to some people, regulating capital reserves and financial solvency, setting minimum benefits levels, controlling premium increases and the product range that funds offer. Private health insurance funds in Australia are also prevented from discriminating between people on the basis of their health, their age (other than age at entry for Lifetime Health Cover), gender, race, sexual orientation, state of health, religion, or the size of their family. The community rating principle, as it is known, has been a longstanding but contested feature of the system.[21]

One of the main reasons funds cannot easily break free from this regulatory environment is that they only have a limited capacity to control the factors driving up premiums. According to a 2005 Access Economics report, the private funds are essentially passive payers in the insurance market as they simply pass through to members the costs they incur, for example private hospital accommodation charges and medical fees. Even though there is some evidence that funds are beginning to take a more active role by focusing on prevention and health outcomes, in a free

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[18] Australian Government, Industry Commission, *Private Health Insurance*, 28 February 1997: http://www.pc.gov.au/__data/assets/pdf_file/0010/7021/57privatehealth.pdf

[19] Australian Government, Private Health Insurance Administration Council, *The Operations of Private Health Insurers Annual Report 2012–2013*: http://phiac.gov.au/wp-content/uploads/2013/12/2012-13-accessible-pdf.pdf

[20] F Colombo, N Tapay, *Private Health Insurance in Australia: A case study*, OECD Health Working Papers, No. 8, OECD Publishing, Paris, 2003; A Shamsullah, 'Australia's private health insurance industry: structure, competition, regulation and role in a less than 'ideal world', *Australian Health Review*, vol. 35, pp. 23–31, 2011, http://parlinfo.aph.gov.au/parlInfo/download/library/jrnart/598683/upload_binary/598683.pdf;fileType=application%2Fpdf#search=%22shamsullah%22

[21] http://www.pc.gov.au/__data/assets/pdf_file/0010/7021/57privatehealth.pdf

market, some of the smaller funds with lower capital reserves would struggle to remain financially viable if they were forced to compete.[22]

The AHHA supports the notion of encouraging competition in the private health insurance market, to the extent that it delivers benefits in cost, equity and efficiency for consumers, and the health system as a whole. Clarifying the role of private health insurance in the context of the compulsory Medicare scheme should also be a consideration as part of this inquiry into competition policy.

Contestability

There is an expanding focus on contestability in the public health sector across Australia. Currently, a range of services are put out to tender, ranging across the building and operation of hospitals, provision of 'hotel' services, diagnostic imaging, pathology, ICT and to a lesser extent clinical services.

There are, however, many challenges associated with contestability. For example, the provision of health services is not financially viable in some geographical areas due to high overheads and low or unpredictable demand. To some extent the economies of scale available to a state-wide public sector enterprise can offset or minimise the loss associated with provision of non-viable services in rural or remote locations.

The contracting out of the viable components of a service would reduce the offset and make provision and sustainability of non-viable services even more fragile. The system-wide implications of increased competition must be considered and the viability of all parts of a service maintained.

Public sector health services are heavily focused on maximising efficiency and value for money in order to meet budget. This approach to fiscal restraint contrasts with that of private providers which have profit as a goal. While public health service managers are loathe to describe their planning processes in this way, every decision a health service manager makes is a rationing decision as it is a continual challenge to provide health services to an increasing number of increasingly complex consumers with a finite level of resources.

[22] Access Economics, *Regulation of Private Health Insurance Pricing*, Access Economics, Canberra, 2005; T Boreham, 'Giant private health insurer in wellness push', *The Australian*, 4 June 2011, p. 28, http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressclp%2F819753%22

Recommendations

- Expansion of competition in the health sector (both for service providers and insurers) must have equity of access and affordability as primary performance measures alongside fiscal sustainability.
- Strategies to increase competition must be formulated within the context of the maintenance or enhancement of service quality, safety and value for money.
- The implications of greater competition must be considered for areas of current or potential market failure.
- Strategies must be developed that consider the whole patient journey rather than focusing on simple episodic components of care, or individual system components.
- Increasing the availability of health service and provider outcome data should be a priority to improve consumer choice and facilitate better understanding about the efficiency and effectiveness of the health system.