Australian Health Care Reform Alliance

POLICY POSITION PAPER: EFFICIENCY OPPORTUNITIES IN THE AUSTRALIAN HEALTH CARE SYSTEM

Key points

- **Claims that our public health system is unsustainable are over-stated, but are used to justify expansion of the private system through both taxes and individual contributions.**
- **However, there are many potential efficiency gains in government spending in the public system and by reducing subsidies that support the private system**
- **With appropriate re-investment of these savings/ efficiencies, all Australians could benefit from further improvements in equity and the quality of our public health system.**
- **There is at least $2.5 billion in savings available annually through reductions in spending on pharmaceuticals, hospital care, and health technology assessment.**
- **There is at least a further $11 billion in taxes annually spent on private health insurance rebate and avoidable public hospital care which could be reallocated more efficiently.**
- **Internationally the most efficient health systems have strong primary health care and prevention. The most cost-effective care is at the top of the cliff, not the more expensive disaster management team at the bottom of the cliff.**

WHY IS EFFICIENCY SO IMPORTANT

Health care takes up a large proportion of the resources of most developed countries. Further rising community expectations and costs of health care mean it is important that the money spent in this area, especially public spending, delivers maximum value. Wasting public money can lead to disillusionment with the concept of taxpayer-funded health care, especially amongst those who contribute the most and can afford not to use the public system. Arguments about the sustainability of the health system have tended to be simplistic and over-stated but have looked to increasing consumer out of pocket costs and subsidising private health insurance and private care for a minority, rather than first making better use of existing spending to benefit all.

Waste in health spending may be caused by *technical inefficiencies* e.g. spending twice as much for an operation in one hospital compared to another, or *allocative inefficiencies* e.g. spending large sums on ineffective end-of-life care rather than elsewhere in the system.

This paper focuses on some of the documented inefficiencies within the Australian health system that are amenable to policy interventions. It includes recommendations for action in both the short and longer terms. Overall, these recommendations will increase the efficiency of health spending and lead to better health outcomes for a lower cost than our current system.

PHARMACEUTICALS

Currently, the Australian Government pays the pharmaceutical industry many times the world market price for many prescription drugs. For example, a month's supply of a commonly used breast cancer treatment (Arimidex) costs the Australian taxpayer $90 and the British taxpayer $3. Statins used to lower cholesterol cost ten times as much in Australia as they do in New Zealand. Thus it is clearly not even a matter of market size. Both large and small countries pay much less than Australia. Whilst there are multiple explanations for this, the essential reason is that Federal Governments (current and past) has not been prepared to stand up to the pharmaceutical industry. Estimates suggest that if the Australian Government paid world market prices for prescription drugs it could save $1 billion every year, starting now.

It has been suggested by the Productivity Commission that an independent pricing authority be set up by the Federal Government to decide, independent of politics, the appropriate price for these products. This could be done within months and savings could start almost immediately.

HOSPITALS

A recent analysis of the cost of a variety of procedures in public hospitals across Australia revealed that there was marked variation both between hospitals and between procedures. It was found that the same procedure on the same patient would cost a lot more in one hospital than in another. It was estimated that if all hospitals improved their efficiency to the median cost there would be savings of $1 billion per year. This would require gathering the evidence of procedural costs and publishing the data so that hospitals could then see what areas needed to be addressed to correct their costs. This would require a small investment in data collection but the estimated savings to the hospital budget (public/private/Federal/State Governments) would more than outweigh this investment. Combined with activity-based funding, this would provide an incentive for hospital efficiency. Clearly, this would also require the integration of quality and safety measures to prevent the inappropriate reduction of costs.

Such efficiencies could also be implemented for publically subsidised procedures in private hospitals.

HEALTH TECHNOLOGY ASSESSMENT

Prescription drugs, medical devices, and procedures are assessed and reviewed for public subsidies by a variety of mechanisms. Although there is quite extensive use of evidence in some areas of these decision-making processes, there are other areas in which decisions are based more on political or other reasons than on evidence.

For example research has identified a number of low value Medicare-funded services that are regularly provided in our health system. Looking at the savings found in the United States by reducing the use of only 26 low value services, and translating that to the Australian context, it has been estimated Medicare could save $500 million annually.

This requires political will and resources. Some of the savings could be realised almost immediately (for example in the case of unnecessary vitamin D testing). The current MBS Review (which AHCRA Supports) is addressing this but it needs to be accelerated and translated into major action.

PRIMARY HEALTH CARE

Primary health care includes both access to services and prevention, including primary and secondary prevention and population health.

There is substantial international evidence that a well-functioning primary health care system delivers efficient, equitable and good value care. There has also been bipartisan support for improving Australia's primary health care system because it is a more efficient and effective way of improving health than waiting for serious illness to develop and then paying for expensive and avoidable hospital and specialist care.

ACCESS TO CARE

There is evidence from the high number of avoidable hospital admissions that Australia's primary health care system is not functioning optimally. Data indicates that currently about 8% of hospital admissions are due to conditions which could and should have been managed in the community.

Reducing the number of avoidable hospital admissions could save our health system billions each year. Hospital care costs over $1,000 per day so halving the number of avoidable hospital admissions would save around $2 billion annually from the total spend on public and private hospitals.

This would require an initial investment in the areas that lead to avoidable hospital admissions. One of these is for acute dental care. Currently, many groups in the community have inadequate access to both general and acute dental care. Access to GP services is also likely to be reduced because the Medicare rebate has been frozen. People in nursing homes have poor access to a range of health care services. Improving access in all these areas would reduce the numbers of avoidable hospital admissions and increase the overall quality and efficiency of our health system.

Beyond providing affordable access however, primary health care also needs to be resourced to overcome geographical and cultural barriers to appropriate care and to address the complex needs of those with chronic disease (see AHCRA's Primary Health Care position paper).

PREVENTION

Primary: There are clearly areas of expenditure at both the primary health care level and at the population health level which have benefited from primary prevention e.g. reductions in tobacco use and related morbidity and mortality. There are many other areas where the way forward is less clear even though the burden of disease is obvious e.g. obesity and alcohol related diseases. In these areas proven strategies need to be put in place and funding for new strategies and their analysis needs to be provided. Both a strong primary health care system and a national approach to population-based preventive health measures is required. When this saves lives and reduces morbidity, savings are likely to follow. Data collection and analysis are crucial to this project.

Secondary: A strong primary health care system with the elimination of access barriers is central to improved secondary prevention. Furthermore, population health measures around lifestyle also play a vital role in reducing morbidity and mortality. Such measures are generally good value compared to hospital admission but quantifying the efficiency savings is difficult. As in other areas, data collection and analysis are crucial, but resources need to be provided as a long-term investment in saving money and lives.

WORKFORCE

A major barrier to workforce efficiencies within our current health system is the existence of professional boundaries which are based on historical practices and professional political forces rather than clinical evidence or consumer preferences. Role demarcations restrict which activities health professionals can undertake, often preventing the provision of services from lower-cost providers. Addressing this issue will require ongoing research and consultation with stakeholders including consumers, to break down established professional boundaries where this is indicated by research and supported by the community.

Key targets for workforce reform within the hospital sector include:

1) expanding the use of nursing assistants and clarifying their role
2) introducing new specialist nursing roles for endoscopies and anaesthesia
3) expanding the use of allied health assistants
4) expanding the training and use of community paramedics and
5) expanding the training and use of physician's assistants.

Modelling has indicated that these changes would save Australia's public hospital system $430 million a year.

Within the primary health care sector there is scope for an increased role for practice nurses, nurse practitioners, community paramedics and physicians assistants in order to reduce the pressure on medical practitioners and increase the overall efficiency of the sector.

Within the oral health care system there are major opportunities to address major inequities, expand services and re-orientate them towards prevention through increasing the roles and independence of oral health therapists, dental hygienists and dental assistants.

PRIVATE HEALTH INSURANCE

The private health insurance (PHI) rebate costs the community around $8 billion per year, which includes tax lost on the amount rebated. There is no evidence it reduces the load on the public system and it is an inefficient way to subsidise private health care. The main goal of private health insurance is to facilitate access for those who can afford the private system, resulting in an inequitable and two-tiered system, particularly for elective surgery. Increasingly, a similar pattern of two-tiered access to non-hospital care, including dental care, chronic disease management programs and chemotherapy, is evolving as the PHI industry increases its investment in these areas. Redirecting the $8 billion to public hospitals and to improved primary health care including dental care would improve both equity and efficiency.

PHARMACIES

Currently pharmacies are subject to a number of regulations limiting their ownership to qualified pharmacists and placing location restrictions on the opening of new pharmacies. These rules restrict competition within the pharmacy market by protecting existing pharmacies from competition from non-pharmacist retailers and newly qualified pharmacists.

The Harper Review into competition policy has found that restrictions undermine the efficiency of the health system through reducing competition in the provision of medicines. It stated that existing restrictions *"limit the ability of consumers to choose where to obtain pharmacy products and services, and the ability of providers to meet consumers' preferences."*

Deregulating pharmacy ownership and location rules would increase competition and efficiency within the pharmacy sector, leading to increased access to medicines for consumers and greater overall efficiency. At the same time there may be useful extensions of community pharmacists' roles that would make some elements of testing and care more readily available to consumers. Pharmacists would need to link with consumers' GPs to ensure they are part of each consumer's overall care team.

RECOMMENDATIONS

1. Reduce the number of avoidable admissions to hospital: **Potential savings from avoidable admissions up to $4 billion annually**

- Restore MBS rebate indexation
- Restore Commonwealth dental program funding and instigate major reform in dental care
- Invest in expansion, improvement, integration of primary health care to reduce acute care demand.

2.Achieve **$3 billion annual** efficiency gains in other areas

- Set up an independent pricing authority to assess costs of prescription drugs against world market prices, and pay accordingly. **Savings $1 billion yearly**
- Publish data regarding public and private hospital item costs and outcomes. Hospital Performance Authority to analyse costs and adjust payments for avoidable costs. **Potential savings $1 billion annually.**
- Restore activity based funding for public hospitals to improve allocative efficiency.
- Adequately resource and expand current review of health technology (pharmaceuticals, devices, MBS item costs. **Potential savings minimum $500 million annually**
- Workforce role modification and expansion. Potential savings **$430 million annually**
- Remove retail pharmacy restrictions on ownership and location

3. Freeze the private health insurance rebate with a view to elimination as public hospital, primary health care and dental care funding improves. **I.e. $8 billion re-allocated.**

4. Respond to the tri-partisan Senate Committee Report on Social Determinants of Health and implement their recommendations.

5. Re-invest all savings into the health system

FOR MORE INFORMATION

The Grattan Institute

Premium policy? Getting better value from the PBS

Unlocking skills in hospitals: better jobs, more care

Controlling costly care: a billion-dollar hospital opportunity

Adam Elshaug et al, Over 150 potentially low-value health care practices: an Australian study

The Productivity Commission, Efficiency in Health

Paramedics Australasia – Paramedic role descriptions:
http://www.paramedics.org/content/2009/07/PRD_211212_WEBONLY.pdf

The CIE Report. Responsive patient centred care. The economic value and potential of Nurse Practitioners in Australia

https://acnp.org.au/sites/default/files/docs/final_report_value_of_community_nps_1.pdf

CONTEXT AND CONTACT DETAILS

This paper is one in a series being developed by AHCRA focussing on the future of our health system. Papers in the series include: Universal Health Care, Primary Health Care, Mental Health and Prevention. They are available on the AHCRA website www.healthreform.org.au. Papers are also in development on Aboriginal and Torres Strait Islander Health, Oral Health and Workforce.

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