



Submission to the National Health and Hospitals Reform Commission

30 May 2008

CHOICE is a not-for-profit, non-government, non-party-political organisation established in 1959. CHOICE works to improve the lives of consumers by taking on the issues that matter to them. We arm consumers with the information to make confident choices and campaign for change when markets or regulation fails consumers.



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Executive summary

CHOICE supports the principles put forward by the National Health and Hospitals Reform Commission. We believe the following initiatives are needed to put these principles into effect for the benefit of consumers.

A person and family-centred health system

Primary care is the best first point for obtaining health information, managing one's own health and managing chronic disease. It is also the only contact many people have with the health system in any year. CHOICE believes that to develop a person and family centred system we must reform primary care. CHOICE believes consumers would benefit from multidisciplinary wellness centres providing a full range of primary health and prevention services to a defined population. These centres should make greater use of nurse practitioners, particularly in rural and regional areas, to increase access to primary health.

The current Medicare fee-for-service arrangements work reasonably well for people with simple needs but are not effective for consumers with chronic disease. It is possible to retain fee-for-service arrangements for episodic care and simple consultations but provide incentives to manage chronic disease which includes pay for performance. The arrangements for chronic disease management should also take into account the complexity of the patient's needs. Case managers should be allocated to people with complex needs to work with them to coordinate their care, access services and stabilise their condition.

There also needs to be a greater focus on prevention. This needs to go beyond health promotion campaigns which are of limited long-term effectiveness. Programs must be developed to provide support for people to develop healthy habits in their communities, schools and workplaces. Junk food marketing and other influences act against people's rational desire to be healthy.

A shared electronic personal health record will be an important driver of a person and family centred system. It must give every Australian control over their own medical records and the level of access they provide to their health care providers. National leadership and investment is needed to make this a reality.

To empower consumers to manage their own health, there must also be a focus on increasing health literacy and providing access to reliable health information. This is particularly important for people with chronic diseases. They should be able to have sessions with a health educator or nurse to improve their knowledge about how to manage their condition.

Pharmaceuticals

Recent reform to the Pharmaceutical Benefits Scheme has undermined the reference pricing arrangements. The government should consider ways to reintegrate the PBS formularies over time to restore reference pricing arrangements for medicines which provide the same health benefits.



The reforms will also bring more medicines under the level of the general copayment. This will result in less price transparency for consumers. Measures to increase price competition and transparency for consumers are needed.

Dental health

Abolish existing Commonwealth dental programs and the subsidy for private dental services through the 30% Private Health Insurance Rebate (over \$500 million per year in total) and establish a Commonwealth Dental Program which provides as a minimum, one check-up for every Australian each year and remedial dental for low income people.

Private health insurance

The Commonwealth and State governments have recently agreed to increase performance reporting of public hospitals. This will greatly increase accountability and transparency for consumers and taxpayers. The Commonwealth Government will subsidise the private health insurance industry by almost \$4 billion in 2008-08. It would be reasonable to demand similar accountability and transparency from private health insurance funds and private hospitals.

The Government should also consider ways to improve the cost-effectiveness of the 30% Private Health Insurance Rebate, make it more efficient and equitable. CHOICE believes the government's \$750 million subsidy for extras insurance is inequitable and could be redirected to more urgent needs. Capping the rebate to a fixed dollar amount would provide additional incentives for funds to contain costs, improve their business model and make their products more attractive to younger and healthier consumers.

Quality and safety

Public reporting of performance will drive improvements in quality and safety. If it is to enable consumer choice it must be accessible, understandable and usable for consumers.

The National Joint Replacement Registry has greatly increased understanding of the effectiveness of joint prostheses. A national cardiac register must also be established. Consideration should be given to the application of similar registers in other areas.

Workforce

Implement all recommendations of the Productivity Commission report, Australia's Health Workforce have been largely ignored and should be implemented. In particular, we need to look for ways to make more effective use of the workforce we have, in particular, making more use of nurse practitioners.

E-health

The Government must ensure all parts of Australia's e-health infrastructure evolve in a planned and coordinated way. Allowing private sector interests to develop and control e-prescribing systems is not in the interests of consumers or the health system.



CHOICE member consultation

CHOICE is pleased to provide a submission to the National Health and Hospitals Reform Commission in relation to the draft principles and terms of reference. In preparing this submission we surveyed CHOICE members and consulted directly with our Health Policy Members Group (comprising around 750 people across Australia).

We asked CHOICE members to rate the importance of a range of issues in the health system. Three emerged strongly as areas the CHOICE members we surveyed felt were the most important. They were:

- a health system that provides access to services based on need and not ability to pay;
- a greater focus on prevention in the health system; and
- access to affordable medicines.

This is consistent with previous community consultations on health policy. CHOICE is a member of the Australian Health Care Reform Alliance (AHCRA). One of AHCRA's key platforms has been the need to conduct a deliberative discussion with the community to identify what it wants from the health system. In 2006, AHCRA conducted a small pilot of such a consultation in 12 sites around Australia. This found that the community is concerned largely about issues of equity and access.

In this submission CHOICE has focused on issues where it has expertise and knowledge. This does not represent the full range of issues which relate to consumers in the health sector, particularly those with specific conditions, eg mental illness, or from particular populations, eg indigenous Australians.

Comment on draft principles

The principles articulated by the NHHRC are sound. CHOICE believes they represent a good foundation for reforming the health system. This submission includes discussion of issues CHOICE believes are important to put these principles into effect.

A person-centred health system

CHOICE strongly supports the inclusion of 'people and family centred' as a principle for the health system. However, it is sometimes not clear what this means in practice. It is tempting to think about the problem as one of systems. If we improve the systems then the patient can be brought to the centre of the system. However, we must keep in mind we are dealing with people and that people have needs beyond what systems can provide. We also need a cultural change in the way people are treated in the health system.

Currently, the system is largely focused on the treatment of illness. The community wants more effort put into health improvement, disease prevention and wellness. This is supported by CHOICE's consumer consultations. Such a focus would encourage treatment of the individual and not just treatment of their specific symptoms at a point in time.



To develop a system that is focused on wellness rather than illness, we need a significant reform of primary healthcare and investment in preventive health. This needs to be supported by shared electronic personal health records and a health literate population with access to reliable health information.

The patient's perspective

It is useful to consider how the system works from the patient's perspective. When people do need health care, they usually confront a confusing array of fragmented programs. Let's consider two case studies - one minor injury and a chronic condition.

Case study 1

Cathy is 32 years old and seeks medical attention for a minor weekend sporting injury to her ankle. Her treatment may include:

Service provider	Number of visits	Location	Funding
GP	2	Private rooms	85% of the scheduled fee with an open-ended top-up payment
Diagnostic imaging	1	Public hospital	85% of the scheduled fee with an open-ended top-up payment
Pharmacist	2	Shopping centre	A capped copayment with PBS subsidy up to the price
Physiotherapy	4	Private rooms	Private health insurance set fee with open-ended top-up payment

Unless she is willing to wait in a public hospital casualty room, she probably has to wait until Monday even to make an appointment. She will spend much of her time waiting in line, and some of that time filling in forms, repeating her name, address and other basic details. Someone else will transcribe this into unlinked databases, with possibilities for error all along the way.



Case study 2

Jack¹ is 55 years old and has recently been diagnosed with Type 2 diabetes. He requires the following care over a 12-month period:

Service provider	Number of visits	Location	Funding
GP	5	Private rooms	85% of the scheduled fee with an open-ended top-up payment
Pathologist	2	Private rooms	85% of the scheduled fee with an open-ended top-up payment (although these services are likely to be bulk-billed)
Specialist	2	Private hospital	85% of the scheduled fee with an open-ended top-up payment
Pharmacist	6	Shopping centre	A capped copayment with PBS subsidy up to the price
Public hospital clinic	3	Public hospital	Service funded by State government
Podiatrist	2	Private rooms	Private health insurance set fee with open-ended top-up payment
Dietician	3	Community health centre	Service funded by State government

Jack will also initially spend time waiting in lines and filling in forms. Hopefully, after the first treatment with each provider, they will have his records correct and will keep them up-to-date. However, Jack is likely to need to visit his GP a number of times over a year just to obtain referrals (eg the pathologist) and repeat prescriptions.

Rebates, copayments and safety nets

Both Cathy and Jack are required to receive care in various locations, from a range of health care providers. There are no direct links between most of the providers. They will both be required to pay for many of these services up-front and claim back from either the government or their private health insurance (if they have it). Each program and funder will use different formulas and fee structures to reimburse them.

In addition to benefits under Medicare, the PBS, and possible private health insurance, there are a number of safety nets which may apply if Cathy or Jack has high spending in any area:

- The Medicare Safety Net has two components. The first starts once a 'gap' amount of \$367.50 has been reached in a calendar year. The gap amount is the difference between the Medicare benefit and scheduled fee. Once the threshold is reached, Medicare covers 100% of the scheduled fee.

¹ This case study is taken from Doggett J (2007), *A new approach to primary care in Australia*, Centre for Policy Development Occasional Paper Number 1, available at <http://cpd.org.au/paper/new-approach-primary-health-care-australia>

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- The second Medicare Safety Net starts when \$1058.78 in out-of-pocket expenses is reached (\$529.30 for concessional patients) in a calendar year. The out-of-pocket amount is the difference between the Medicare benefit and the amount the doctor charges. Once the threshold has been reached, Medicare covers 80% of out-of-pocket costs.
- The PBS Safety Net threshold for general patients is \$1141.80 (\$290.00 for concessional patients) in a calendar year. Once the threshold is reached PBS medicines can be purchased for \$5 (or free for concessional patients). General patients reach a second threshold after a further \$290 (52 scripts). Medicines are then free for these patients.
- The Medical Expenses Tax Offset provides a tax offset of 20 per cent of net medical expenses over \$1,500 in a financial year.

These various rebates, safety nets and other financial benefits are complex and inconsistent.

These cases highlight the absurdity of the current arrangements. Imagine if, when your car develops minor mechanical trouble, you had to go to one place for a diagnosis, another for parts, another for some repairs, another for some other repairs, with different bills from each provider - and with the complication of having to drive around in a defective vehicle to obtain all these parts.

This is what would happen if your car was being treated in Australia's antiquated health program structure. Program divisions are based on providers' demarcations, rather than consumers' needs.² There is no consistency to the way the payments are structured and there is a confusing range of programs. This is detrimental for consumers and a significant obstacle to a person and family centred health system.

Primary health care

Primary care is the best first point for obtaining health information, managing one's own health and managing chronic disease. It is also the only contact many people have with the health system in any year. As shown above, from a consumer point of view, the primary care system is uncoordinated and unnecessarily confusing.

Cathy may have been able to attend a wellness centre on the weekend rather than waiting or going to a public hospital emergency department. Jack would receive more services in one place. There would be more coordination between his GP and his other health professionals.

Consumers must negotiate their way through a maze of providers, payments and programs.

We need to significantly change the approach to primary care in Australia. This should involve the establishment of multidisciplinary 'wellness' centres. These would build on Australia's existing GP structure but ensure they are supported by other health care professionals. This would include dentists, nurses, pharmacists, physiotherapists, psychologists, dieticians and possibly some specialist services. Some centres would provide 24-hour outpatient/casualty services to handle cases which did not

² This discussion is based on earlier work for CHOICE by Ian McAuley in 2005, see <http://www.home.netspeed.com.au/mcau/academic/confs/pbsproblem.pdf>.



require immediate hospitalisation.³

Each wellness centre would be established to service a defined population (eg 100,000 people) and would include most of the services that population would need. Australia's health needs are not homogenous, so it is important that centres are flexible and can adapt to the needs of their population. In urban areas the centre may be in a single location. However, in regional areas it may be more appropriate to have a number of centres in major towns. Nurse practitioners, as discussed below, could provide services in smaller towns.

The wellness centres would need to be genuinely multidisciplinary. The government is in the process of implementing its election commitment to establish GP Super Clinics. This measure is welcome and it may increase access to GPs in areas of need. However, it is not truly multidisciplinary care. There has been no change to the structure of care delivery or access to non-GP primary care.

Both New Zealand, with Primary Healthcare Organisations (PHOs), and the UK, with Primary Care Trusts, have attempted similar models of primary care. While neither of their approaches is perfect, we can learn from their experience.⁴ Aboriginal Community Controlled Health Organisations and the South Australian GP Plus Health Centres provide examples of multidisciplinary primary care models operating in Australia and we can also learn from those experiences.

Establish multidisciplinary primary care health centres providing a full range of primary health and prevention services to a defined population.

Structure of Medicare

Medicare is currently structured around a fee-for-service model. This works well for the vast majority of consumers who only visit the doctor occasionally for a check-up or due to an acute illness such as influenza. It also works well for doctors because it involves a minimal amount of red tape. However, Medicare is not so well designed for the management of chronic disease.

Chronic Disease Management (CDM) Medicare items have attempted to address this problem. GPs are rewarded for establishing and managing care plans. However, there is no payment linked to patient outcomes nor are payments adjusted for the complexity of the patient's needs. These items do provide some coordination of services for people with chronic conditions but do not guarantee the plan improves the patient's health. There have also been concerns about the level of red tape they impose on GPs.

CHOICE believes that Medicare could be retained in its current form for consumers who require episodic care (eg Cathy) but that we need to refocus the CDM items to improve the

³ An example of such a proposal is suggested in Doggett J. (2007), *A New Approach to Primary Health Care for Australia*, Centre for Policy Development Occasional Paper Number 1, <http://cpd.org.au/paper/new-approach-primary-health-care-australia>

⁴ See McDonald J, Cumming J, Harris M, Powell Davies, G and Burns P (2006), *Systematic review of comprehensive primary health care models*, Australian Primary Health Care Research Institute (ANU) and Research Centre for Primary Health Care & Equity (UNSW), available at http://www.anu.edu.au/aphcri/Domain/PHCModels/Final_25_McDonald.pdf.

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outcomes for people with chronic diseases (eg Jack). A pay-for-performance model would provide GPs with an incentive to establish a care plan and work with a multidisciplinary team in a wellness centre to improve the patient's health outcomes. For complex patients this must also extend beyond GPs and allied health professionals to community based support such as social workers and home care.

Cathy would probably be very happy to pay for all her services on a fee-for-service basis. Jack needs assistance managing his condition and coordinating all the health professionals he needs to see. He needs his GP to develop a plan and take a strong interest in stabilising his condition. A case manager could help him navigate the system.

Swerrisen and Taylor⁵ have proposed such a model for Australia which is based on Kaiser-Permanente's triangle for chronic care. Kaiser-Permanente divides people with chronic conditions into 3 levels.⁶ Level 1 includes people with stable conditions who are managed by a GP only. But those in Level 2 and 3 are provided with case managers who work with them over an extended period to improve and stabilise their condition. Such an approach would assist people with chronic conditions to access services. People at Level 3, who have multiple chronic conditions, also receive home-based support.

With appropriate incentives, including outcome-based payments, a system such as Kaiser-Permanente's could be implemented in Australia. This could involve the registration of people with chronic diseases with a specific GP (or practice/wellness centre) who is then responsible for helping them manage their chronic disease. This should go beyond the addition of new Medicare items and consider some form of block funding for the management of different conditions and complexities. To reduce red tape, GPs would need to be supported by administrative staff and nurses who would perform much of the day-to-day management and coordination of a patient's care, leaving the GP to undertake more complex medical tasks.

Retain fee-for-service arrangements for episodic care and simple consultations. Provide incentives to manage chronic disease which includes pay for performance.

⁵ Swerrisen H and Taylor MJ (2008), 'Reforming funding for chronic illness: Medicare-CDM', *Australian Health Review*, vol. 32, no. 1, pp 76-84.

⁶ Bodenheimer T, Wagner EH and Grumbach K (2002), 'Improving primary care for patients with chronic illness', *JAMA*, vol. 288, no. 14, pp. 1775-1779.

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The role of nurses in primary care

Many services performed by general practitioners are routine. These include immunisation, blood pressure tests, health advice and possibly prescriptions for stable chronic conditions such as hypertension. In many GP practices, a nurse has been engaged to undertake some of these tasks (although not prescription). This is good because it frees up the GP's time to see patients and manage more complex conditions.

However, nurse practitioners are not as widely used. Nurse practitioners are highly trained nurses who can potentially fulfil the role of the doctor on a wider range of tasks (eg repeat prescriptions for stable chronic conditions, general health advice, recording symptoms, basic initial diagnosis).

In many cases nurse practitioners would be able to work in practices with GPs, providing a complement to the GP and other health professionals in the practice. However, if nurse practitioners were permitted to work separately to a GP practice, it would provide an opportunity to improve the provision of primary health services in areas where there may be no doctor (eg in rural and remote Australia or even parts of metropolitan Australia).

The Productivity Commission's 2005 research report, *Australia's Health Workforce*, included a chart which showed the proportion of health professionals to the population across a range of professions in regions Australia by remoteness. This shows that the ratio of practitioners to population declines rapidly to further you move away from the centre of the major cities for all medical professions except nursing. There is a similar ratio of nurses to population in remote areas as there is in the major cities.⁷ GPs are absent in many towns and regions in Australia. Consumer access to primary care would be greatly enhanced if we made the best use of the available nursing workforce.

Make greater use of nurse practitioners, particularly in rural and regional areas, to increase access to primary health.

Preventive health

There are a range of activities which are considered preventive health. These include immunisation, screening, education and counselling.

Australia has performed very well in relation to immunisation. Immunisation rates of over 90 per cent of children have been achieved though improved record keeping and incentives for general practitioners to immunise.

Jack could see a nurse practitioner instead of a doctor for repeat prescriptions for his condition and referrals to the pathologist. He may be able to get an appointment more quickly and it may be cheaper or even bulk-billed where a GP consultation may cost \$30 after the rebate.

⁷ Productivity Commission (2005), *Australia's Health Workforce*, Research Report, Canberra, p XXVII.



We have also seen the introduction of a range of screening initiatives, in particular for various forms of cancer. There is a risk that screening can lead to unnecessary invasive procedures or stress as a result of a false positive test. However, overall we support screening for common detectable causes of mortality such as bowel cancer and breast cancer. The government should continue to look for opportunities to fund effective screening programs.

CHOICE is pleased that the Commission has recognised people's health goes well beyond the care they receive when they are unwell. It includes the lifestyle choices they make and environment they live in on a day-to-day basis. For example, we must consider local town planning laws to provide attractive, safe, user friendly areas for active leisure and physical activity; or the ability to walk to the local shops instead of drive. However, ultimately to prevent chronic disease we need to change behaviours.

Behaviour change is difficult. Telling people what constitutes a health choice through health promotion campaigns is not sufficient. Taxing so-called 'sin' goods is often proposed as a measure to reduce their consumption. CHOICE supports taxation as a public health initiative if the money raised is spent on measures to support people to change their behaviour - however consumer behaviour is often not rational. A slight increase in cost for unhealthy foods (which will likely still be cheaper and easier to prepare than healthier alternatives) is by itself unlikely to deter a majority of consumers.

There are an array of powerful influences that undermine people's rational desire to make healthy choices. The powerful influence of advertising on adults is widely accepted, if for no other reason than industry would not waste billions of dollars on an activity that did not work. With Australia now facing an alarming increase in the number of overweight and obese children (currently one in four), it is time to seriously consider the impact of food marketing to children.

The Coalition on Food Advertising to Children reports that roughly one in three television advertisements during children's viewing times in Australia are for food - and that of those, between 55 and 81 per cent are for foods that are high in fat and/or high in sugar. Marketing helps define what is normal. The advertised diet is in stark contrast to the Government's health eating messages. We also note that food marketing to children extends beyond television to every available media form (eg magazines, websites, product labels), using every conceivable tactic legally available.

In March 2008, a CHOICE commissioned Newspoll survey found that 88 per cent of Australian parents believe the marketing of food specifically to children contributes to difficulties parents have in ensuring children develop healthier eating habits. Furthermore, 82 per cent are in favour of increased government regulation over the way high sugar/high fat foods and drinks are advertised and marketed to children, including 67 per cent who are "strongly in favour".

CHOICE continues to campaign for real restrictions on the marketing of unhealthy foods to children - recognising that constant enticements for foods that are high in fat, sugar and salt normalise junk food, undermining parents' attempts to instil healthy habits at best, and at worst -helping to kick start a life-long struggle with obesity, poor nutrition and related health problems.

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We believe this is one example of an initiative which will start to change behaviour and attitudes from a young age. However, it is by no means the only solution. It needs to be combined with other measures to support people (in communities, schools, workplaces etc) to make healthy food choices and increase their physical activity.

Shared electronic personal health records

In our view, the development of an effective and workable electronic personal health record is instrumental to the development of a patient-centred system. It is also likely to assist in the management of chronic disease.

At the recent 2020 summit, delegates in the health stream proposed the idea of a Healthbook. This is an online record similar to the popular social networking website Facebook. The private sector has already developed such a system. In Australia, mymedicalrecords.com.au provides a service similar to Healthbook. Both Microsoft Health (www.microsoft.com/health) and Google Health (www.google.com/health) are providing online health records similar to Healthbook. Neither is providing the service in Australia. They enable consumers to store, manage and share their personal health records online as well as access health information. CHOICE understands that the National E-Health Transition Authority has also been working on an electronic personal health record in Australia.

Jack could use his electronic personal health record to make sure his GP knows what advice his dietician and podiatrist have given him. It also gives him a record of his tests and current medications. This would make sure he knows when he is due for his next test and minimises the likelihood of different medical practitioners providing him with prescriptions for medicines with adverse interactions.

The biggest issue for consumers in this area is privacy. Many CHOICE members have told us that they believe electronic personal health records are a good idea but that they are concerned about privacy. CHOICE believes it is fundamental that consumers' privacy is protected in a way which gives them confidence in the system. This means they must have total control over the data and the level of access they provide to various health professionals.

Cathy was treated for depression in her early 20s. Her shared PHR should allow her to give her GP access to those records but not her physiotherapist.

In CHOICE's view, national leadership and investment, as part of a national e-health strategy, is needed to make such a system a reality. The Commonwealth Government should ensure that ePHRs evolve in a coordinated and controlled way in Australia. There are potential risks from allowing the private sector to control such an important aspect of Australia's health infrastructure. It must

remain free from any commercial interests such as pharmaceutical promotion. This would not preclude the government from partnering with private sector interests to establish the system.



Medicare Australia already collects much information on consumers' interaction with the health system. This is accessible to consumers on request. The Government could initially establish ePHRs which include this information. Incentives would need to be provided to ensure that health care providers and consumers build on these records.

Investment to encourage a shared electronic personal health record which gives every Australian control over their own medical records.

Health literacy

Evidence suggests that people with higher levels of health literacy have better health overall.⁸ People who are more aware of how to maintain their own health are more likely to make positive lifestyle choices. Health literacy should be seen as an important part of the focus on preventive health and a health system which is person and family centred.

This kind of capacity development is well-accepted in relation to the financial services industry. In 2006, the Commonwealth Government provided \$21 million over four years to establish the Financial Literacy Foundation⁹ in the Department of Treasury. The Foundation is responsible for research on financial literacy and the development of programs to raise the level of financial literacy in Australia. The Foundation conducted an information campaign in 2007 to raise awareness of financial literacy issues.

The Financial Literacy Foundation is also working with schools and State Departments of Education to develop school-based financial literacy programs. Financial literacy will be included in the curriculum for years K-10 from 2008. In CHOICE's view, this early intervention approach is likely to improve financial literacy in the long term. Health literacy should be tackled in a similar way. The World Health Organization has found that programs promoting health in schools and educating students about health are beneficial (although some seem to be more beneficial than others).¹⁰ These types of programs should be provided systematically in schools across Australia.

⁸ National Center for Education Statistics (2006), *The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy*, U.S. Department of Education, Washington DC.

⁹ See www.understandingmoney.gov.au

¹⁰ Stewart-Brown S (2006), *What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promoting schools approach*, World Health Organization Regional Office for Europe, Copenhagen, available at <http://www.euro.who.int/document/e88185.pdf>.



Health literacy is particularly important for people with chronic disease. People with chronic disease who have low levels of health literacy are less able to manage their condition.¹¹ CHOICE believes we should provide people with chronic conditions education and training to increase their ability to manage their condition. This could be included as part of the funding for CDM items discussed above.

An emphasis on health literacy including:

- schools-based initiatives to increase health literacy; and
- funding, through Medicare or some other means, for people with chronic conditions to have a session with a health educator or nurse to discuss the management of their condition.

Access to health information

Consumers also need access to reliable information to assist them to manage their own health. The internet has increased consumer access to information. Research has shown that health websites are among the most used on the internet.¹² We believe this is a positive development for consumers because it has provided them with easily accessible information about medical conditions and their treatment. If the information is reliable it will help empower them to manage their own health.

Most internet users only access the first few links provided by a search engine.¹³ These will not necessarily be the most credible sites. In addition, it is very difficult for consumers to discern credible trustworthy information from that which is unreliable.

The government has attempted to address this issue. HealthInsite, a web-based portal, directs consumers to reliable health information. The information is assessed by a committee before it is listed on HealthInsite. The Government also pays for Australians to have free access to the Cochrane Library. This is considered the 'gold-standard' for health information. According to the National Institute of Clinical Studies, Australians are the highest per capita users of the Cochrane Library in the world.¹⁴ CHOICE believes that to improve health literacy and promote consumer empowerment in health, the Government should invest more in HealthInsite to make it a 'gold-standard' source of health information for Australians and promote HealthInsite and the Cochrane Library.

¹¹ Williams MV, Baker DW, Parker RM and Nurss JR (1998), 'Relationship of functional health literacy to patients' knowledge of their chronic disease. A study of patients with hypertension and diabetes', *Archives of Internal Medicine*, vol. 158, no. 2, pp. 166-172.

¹² Wilson, P. (2002) 'How to find the good and avoid the bad or ugly: a short guide to tools for rating quality of health information on the internet', *British Medical Journal*, vol. 324, pp. 598-602.

¹³ Eysenbach, G. & Köhler, C. (2002) 'How do consumers search for and appraise health information on the world wide web? Qualitative study using focus groups, usability tests, and in-depth interviews', *British Medical Journal*, vol. 324, pp. 573-577

¹⁴ www.nhmrc.gov.au/nics



Pharmaceuticals

The Pharmaceutical Benefits Scheme has been a major part of the Australia publicly funded health system for over 50 years. For some time, the PBS was growing rapidly. In recent years this has slowed but the PBS is still projected to grow strongly in the future. The government has previously made efforts to reduce the cost in the PBS. This has included increases in the patient copayment. However, this merely shifts risk on to the consumers. It may also reduce access to medicines. There is some evidence that consumers in Australia have not filled scripts because of concerns about cost.¹⁵

A number of changes to the structure of the PBS have recently been introduced. These divided the PBS into two formularies. Formulary 1 (F1) includes medicines for which there is no competition. This is mainly 'originator' brand medicines which are still under patent. Formulary 2 includes medicines for which there is more than one manufacturer (ie off-patent drugs). This has been divided further into two parts. Formulary 2A (F2A) includes medicines for which there are low levels of competition in pharmacy price discounting and formulary 2T (F2T) includes medicines for which there are high levels of competition in pharmacy price discounting.

Price decreases will be applied each of the formularies from 1 August 2008. These will be applied as follows:

Formulary	Discount
F1	<ul style="list-style-type: none">• No mandatory price reduction on 1/8/08.• A new listing (post patent expiry) will trigger a 12.5% reduction in price and reclassification to F2A.
F2A	<ul style="list-style-type: none">• Three price reductions of 2% each on 1/8/08, 1/8/09 and 1/8/10.
F2T	<ul style="list-style-type: none">• One-off price reduction of 25% on 1/8/08.

Naturally these price reductions will produce savings to the PBS. However, these savings will not be passed on to consumers (except where the price moves below the general copayment).

The new PBS structure removes some medicines from the reference pricing arrangements. This is appropriate for 'blockbuster' drugs. However, for these drugs there should be no change. They are a new treatment and therefore have no reference on the PBS. However, where there are already medicines to treat a condition and a new medicine is developed which is no more effective, it is appropriate that its price is determined with reference to those existing treatments. Pharmaceutical companies will want their drugs on F1 and may become increasingly litigious to achieve that. This is likely to lead to higher prices for some medicines which are no better than existing medicines. Logically, we would assume this

¹⁵ Blendon RJ, Schoen C, DesRoches CM, Osborn R, Scoles KL & Zapert K (2002) 'Inequities in health care: a five-country survey', *Health Affairs*, Vol 21, No. 3, p 185.



doesn't matter because cheaper medicines would be preferred. However, the weak price signals to consumers and GPs and the heavy promotion of new medicines to GPs interfere with this.

For example, Pfizer has been successful at arguing that atorvastatin (Lipitor) is superior to other statins on the market and should therefore be excluded from the reference pricing arrangements. This is despite limited evidence that it is superior to other statins.¹⁶ Atorvastatin has been included in F1, whereas most other statins are in F2T. This means that it will not be subject to the 25% price decrease on 1 August 2008. Atorvastatin is the most prescribed drug in Australia by volume and over \$125 million per year in savings to the PBS could have been realised.

Furthermore, F2T is fixed and there does not seem to be any mechanism to move medicines from F2A to F2T. It is not clear how greater competition for F2A medicines will affect the price. There does not appear to be any systematic way to reduce the price as competition increases.

The new arrangements for the PBS have undermined the reference pricing arrangements and may in the long term be detrimental for consumers. We believe the Government should seek to reintegrate the formularies over time and restore the reference pricing system.

Consider ways to reintegrate the formularies over time and restore reference pricing arrangements for medicines which provide the same health benefits.

Medicines priced below the general copayment

A further consequence of the price reductions, particularly in Formulary 2B, is that many medicines will be priced under the level of the general copayment. The general copayment is indexed each year on 1 January and is currently \$31.30. As this increases and medicine prices come down more medicines will fall below the threshold. This is good for consumers but may lead to less price transparency. Pharmacists are able to charge effectively up to the copayment but because they cannot advertise are not openly subject to competitive pressures.

The sale price for pharmaceuticals priced below the copayment is in theory regulated by the Community Pharmacy Agreement. There is no legal barrier to pharmacists charging more than what is stipulated by the Agreement. The Agreement is not embedded in legislation and the Commonwealth is unable to enforce compliance by individual pharmacists. Research undertaken by CHOICE in 2006 found that for below co-payment medicines, some pharmacists charge a higher price for drugs than the prices set out in the Agreement. A copy of the article on this issue which appeared in CHOICE magazine is at Attachment 1.

CHOICE surveyed 4.5% of pharmacies across Australia asking for the prices of five commonly prescribed below co-payment prescription medicines. CHOICE found that between 5% and 26%

¹⁶ Zhou Z, Rahme E and Pilote L (2006), 'Are statins created equal: evidence from randomized trials of pravastatin, simvastatin, and atorvastatin for cardiovascular disease prevention', *American Heart Journal*, vol. 151, no. 2, pp. 273-281.



(depending on the medicine) of pharmacists were charging above what was stipulated in the Agreement.

For example, our research found that the PBS 'dispensed price' for the brand name drug amoxicillin, a commonly prescribed antibiotic, was \$11.55. Because this drug was below the 2006 co-payment of \$29.50, pharmacists could add an extra \$0.99 cents for the 'recording fee' and \$3.45 for the 'extra allowable fee'. The maximum price pharmacists could charge (which includes all the allowable extra fees as set out in the Agreement) for this drug was \$16. Yet CHOICE found that 26% of pharmacists were charging above this price. The highest price for this drug that we were quoted was \$19.90. This means that some consumers were paying \$3.90 more for this drug than they should have to.

In January 2005, the Pharmacy Guild told CHOICE that for pharmaceuticals priced below the patient co-payment 'market forces apply and pharmacists can compete with each other as to what price they might charge'¹⁷. However, it is not real competition when pharmacists are not allowed to advertise prices for prescription medicines and it is difficult for consumers to compare prices. In fact, consumers may not even be aware that prices differ between pharmacies. The Government should consider measures to increase price transparency and competition.

Consider measures to increase price transparency for medicines priced below the general copayment.

Dental health

Oral health is fundamental to overall health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment. The impact of oral disease on people's everyday lives is pervasive, affecting eating, sleeping, work and social roles.¹⁸ Many CHOICE members suggested dental services should be included under Medicare.

The government has attempted to address concerns about dental health by introducing two new dental programs. The Teen Dental Plan will provide \$458 million over the next four years for people between the ages of 12 and 18 to have a check-up once a year. The Commonwealth Dental Health Program will provide \$290 million over four years to provide dental services to low income people. This will supplement existing state programs to provide public dental services.

The government also subsidises dental services for people with private health insurance. In 2007, private health insurance funds paid \$1.3 billion in benefits for dental services for members. This includes preventive check-ups, major dental surgery and orthodontic services. Assuming the government share of this is 30% (the PHI rebate), then the government subsidy is \$385 million.

¹⁷ Correspondence from Pharmacy Guild of Australia to CHOICE, 28 January 2005.

¹⁸ Australian Health Ministers' Advisory Council (AHMAC) (2001), *Oral health of Australians, National planning for oral health improvement: Final Report*, South Australian Department of Human Services on behalf of the Australian Health Ministers' Conference, Adelaide.



Private health insurance members, in some funds, have benefited from preferred provider networks which allow them to access dental (and other allied health services) with no out-of-pocket costs. However, there is a gap in publicly-subsidised dental services for those who cannot afford private health insurance, or choose not to take it up, but are not covered by one of the public dental schemes. They face very large out of pocket costs for dental care. CHOICE believes all current Commonwealth programs subsidising dental care (over \$500 million per year) be abolished and a dental care program fully funded as part of Medicare. The program should provide as a minimum, one check-up for every Australian each year.

Establish a Commonwealth Dental Program which provides as a minimum, one check-up for every Australian each year and remedial dental for low income people.

Private health insurance

It is impossible to consider reform of the Australian health care system, without considering the role of private health insurance. The government makes a significant contribution to the cost of private health insurance through the 30% Private Health Insurance (PHI) Rebate. It also provides other incentives for people to take out private cover including Lifetime Health Cover and the Medicare Levy Surcharge.

The government progressively introduced these policies in the late 1990s in response to dwindling private health insurance membership. The Medicare Levy Surcharge was introduced in 1997, Lifetime Health Cover in 1999 and the 30% PHI Rebate in 2000. These policies were effective in increasing private health insurance membership from 30% in 1997 to 44% in 2000, although most of this increase occurred in the six months to June 2000. There are now 60% more private health insurance members than there were in 1997.

While the Private Health Insurance Administration Council collects a large amount of data on the operations of the private health insurance industry, there is little in the way of performance information. This is in contrast with recent efforts to improve accountability and transparency of performance in the public hospital system. If the government is to continue subsidising the private health insurance industry by nearly \$4 billion per year, it must take steps to demand more accountability and transparency from private health insurance funds and private hospitals.

Demand greater accountability and transparency from private health insurance funds and private hospitals

The stated intention of the government's policies to increase private health insurance was to take pressure off the public system. However, there is evidence that the policies have done little to reduce the burden on public hospitals.¹⁹ There is also evidence to suggest that the policy has led to a preference for privately insured patients in the public system.²⁰ This is

¹⁹ Lu M & Savage E (2006), *Do financial incentives for supplementary private health insurance reduce pressure on the public system? Evidence from Australia*, CHERE Working Paper 2006/11, Centre for Health Economics Research and Evaluation, Sydney.

²⁰ Goodall S & Scott A (2008), *Is hospital treatment in Australia inequitable? Evidence from the HILDA survey*, Melbourne Institute Working Paper 5/08, Melbourne Institute of Applied Economic and Social Research, Melbourne.



detrimental for people without private health insurance and does little to take pressure off the public system.

CHOICE has concerns about the cost-effectiveness of the 30% PHI Rebate. We support people's right to purchase insurance which enables them to pay for private treatment with other benefits such as choice of doctor. However, we are concerned that subsidising this product is an inequitable and inefficient use of public money. The policy has not achieved its intended outcome of reducing the pressure on the public system.

In the short-term, we would like to see changes to make the 30% PHI Rebate more cost-effective and put pressure on private health funds to improve their business model and be more competitive. In particular to remove the rebate from extras cover and to cap the rebate at a fixed dollar amount.

Extras cover

The 30% PHI Rebate is paid on general treatment insurance (extras or ancillaries) as well as hospital insurance. Extras insurance covers a wide range of allied health services such as physiotherapy and dental. These services do nothing to directly reduce the pressure on the public hospital system.

Most of these services are not covered by Medicare or are covered in limited circumstances. Physiotherapy is covered by Medicare for people with chronic conditions and only with a doctor's referral. Dental services will be covered under publicly funded schemes to provide services to targeted groups such as low income people or young people. Extras also covers treatments with limited evidence of efficacy such as naturopathy, iridology and homeopathy. These services are not covered by Medicare for anyone.

Total benefits paid for extras in 2007 was \$2.5 billion. The government subsidises 30 per cent of this, or \$747 million. This is approximately 20 per cent of the Private Health Insurance Rebate, which is subsidising treatments of questionable benefit or which aren't covered for publicly insured people.

Extras cover could allow private health insurance funds to engage in preventive activities. Physiotherapy and other services can be preventive but this is restricted by the structure of extras cover. Benefits are generally simple fee-for-service and are capped at relatively low levels per year for each type of service (ie \$200-300). There is also little scrutiny of the quality of services provided or the outcome of a course of treatment.

We support the right of individuals to choose to purchase private health insurance which covers them for these types of services. However, it is not consistent with the principle of equity that the government subsidises these services for people who can afford to purchase private health insurance and not for those who can't. We believe the 30% private health insurance rebate should be removed on extras cover. This would free up around \$750 million which could be directed to address other areas of need in the health system.

Remove the 30% Private Health Insurance Rebate on extras cover.



Capping the rebate

The 30% PHI Rebate currently increases each year in line with premium increases and growth in the insured population. Each year, the government approves premium increases but in reality has little control. It has no control over benefits paid and must allow funds to remain solvent and maintain capital adequacy.

Removing the rebate would result in an immediate 43 per cent increase in premiums. This would penalise consumers who have private health insurance. It would also be likely to result in a large exodus of members from private health insurance funds. This is undesirable, particularly if there is no method in place to handle treatment for patient who will rely on the public system.

Changing the rebate from 30 per cent of the total premium to a fixed dollar amount (indexed annually by CPI) per policy or per insured person would cap the commitment of public funds without immediately penalising PHI members. It would put more pressure on the private health funds to contain costs and offer products which are attractive to younger and healthier consumers.

Cap the 30% Private Health Insurance Rebate at a fixed dollar amount per policy indexed annually by CPI.

Funding private hospitals

Private hospitals are an indispensable part of the health system. If the community's means of funding private hospitals are to become fairer and more sustainable, it must find a process that delivers access to everyone on the basis of need rather than ability to pay, and that ensures that the nation obtains acceptable levels of value for money from the services it buys from this sector. This would do more to reduce pressure on public hospitals.

Gans has proposed a shift to funding private hospitals directly rather than through private health insurance funds.²¹ He argues that private health insurance is effectively a tax in-kind which high income earners are forced to pay. He believes that it would be more transparent if we used the tax system directly instead and would empower consumers by giving them real choice.

CHOICE supports Gans' proposal and in 2004 considered alternative means of funding private hospitals. The only alternatives are personal funding by individuals paying for their own care, and some form of government program. While self-insurance is an increasingly attractive option for some people becoming disillusioned with the funds, it is not a viable or equitable way of funding a health system.

²¹ Gans J (2004), *Does Australia's health insurance system really provide insurance*, paper available at <http://www.mbs.edu/home/jgans/papers/Policy-Health.pdf>.



Some possible alternative patterns for direct government funding include:

- Block funded contracts between government and individual hospitals or hospital groups. This invites providers to manipulate the figures and cherry-pick patients.
- Service-based payment founded on casemix (AR-DRGs) would provide fair and consistent payment for both private and public hospitals. However, the cost-base in private hospitals is higher than in the public system from which the casemix system is derived: there is a question whether the private system could cope immediately with public hospital-level funding. Not only do investors have the right to expect a reasonable return on their investment, but capital infrastructure must also be paid for. Therefore, a system based solely on AR-DRGs would be unsustainable and would be rejected by hospital operators. (There could, though, be some transitional assistance.)
- A more appropriate scheme would involve fee-for-service payment in accordance with AR-DRGs, augmented with block funding to recognise the total cost of running a hospital, including infrastructure and return on investment. Block funding contracts could be reviewed periodically to reflect real costs and the changing nature of the marketplace. As with Medicare, a schedule fee would be set for each item, with the benefit being paid to the patient with the capacity to assign that benefit to the provider if the provider elects to bulk-bill.

Consider mechanisms to fund private hospital services directly rather than subsidising the private health insurance industry.

Quality and safety

In 1995, in response to significant concerns about the safety and quality of healthcare the Australian Council (now Commission) on Safety and Quality in Health Care was established. However, in 2005, an editorial in the *Medical Journal of Australia* questioned whether any improvement had been achieved in the previous 10 years.²²

Performance reporting

CHOICE supports the introduction of public performance reporting in the health system as a measure to drive improvements in quality and safety. The focus of this debate has mainly been on hospitals to date. However, we wish to see reporting on all aspects of the health system develop, in particular measures of quality and safety. The agreement between the Commonwealth and the States is a good start. There must be continuous improvement in the quality of measures.

There is some research which has shown that consumers have made little use of performance reports in places where they are available. Many performance reports which have been

²² Van Der Weyden M (2005), 'The safety of Australian healthcare: 10 years after QAHCS', *Medical Journal of Australia*, vol. 182, no. 6, pp. 260-261.



produced were based on non-standardised measures, drew on a variety of sources, and, in many cases, were not user friendly.²³

Studies indicate that the way information is presented or 'framed' strongly affects whether consumers understand it, how they evaluate it and whether they use it²⁴. Simple league tables would be one of the most effective ways to assist consumer comparison and choice. Consumers can't be expected to weigh up measures against a wide range of indicators to rank providers. There is some resistance to the development of league tables or rankings. However, if they are not provided, it is likely that the media will develop them.

As performance reporting develops and is made available to the public, consideration needs to be given to how best to present this to the public in a way that makes it understandable. Dr Foster (www.drfooster.co.uk) is a UK website which provides information on hospitals in the UK. This website contains a large amount of information. However, in CHOICE's view, this website would be unapproachable for a consumer trying to choose between providers. The UK Healthcare Commission (www.healthcarecommission.org.uk) provides a much simpler presentation. It measures a small number of indicators on a four-point scale. This is more consumer-friendly because the measures are presented in a simple and understandable way with some form of ranking.

Minister Roxon has indicated that performance information is partly about consumer choice. If it is to enable consumers to choose, the information needs to be presented in a way which they can understand. To determine what will work best for Australian consumers, the government needs to test options on the public. However the information is presented, it will need to be accompanied by an awareness and information campaign.

Ensure public reporting of performance of the health sector is accessible, understandable and usable for consumers

Registers

One of the most successful measures in monitoring safety in the health sector has been the National Joint Replacement Registry. This has greatly improved our understanding of the performance of different types of joint prostheses. Other registries should be established, in particular a cardiac register.

Establish a national cardiac register and consider the application of similar registers in other areas.

²³ Peters E, Dieckmann N, Dixon A, Hibbard JH and Mertz CK (2007), 'Less is more in presenting quality information to consumers', *Medical Care Research and Review*, vol. 64, no. 2, pp. 169-190.

²⁴ Lubalin JS and Harris-Kojetin L (1999), 'What do consumers want and need to know in making health care choices?', *Medical Care Research and Review*, vol. 56, no. 1, pp. 67-102.



Workforce

Health is our largest industry and is estimated to employ around 600,000 people. There are reported shortages in a number of areas (eg nurses, GPs). To address this skills shortage there are opportunities to employ overseas trained health workers. However, there are global workforce shortages in a number of areas. Australia needs to identify ways to maximise the use of the existing health workforce as well as plan for the future.

The Productivity Commission has said we need to develop new models of care because demand on the health workforce will increase and the labour market will tighten. The Commission also says that it is critical to increase the efficiency and effectiveness of the available health workforce and improve its distribution. These are significant concerns. However, most of the PC's recommendations have not been implemented. CHOICE believes they should be.

Implement all recommendations of the Productivity Commission report, Australia's Health Workforce

We have already discussed one initiative that we believe is important to make more effective use of the health workforce - a greater role for nurse practitioners. There are also other opportunities to make better use of the existing workforce. The following two areas are examples but by no means the only opportunities.

Pharmacists

The clear separation between doctors and pharmacists is no longer justified. The separate roles evolved at a time when pharmacists were preparing medicines. Their role has now changed to one of mainly dispensing pre-packaged medicines and other healthcare products.

The Pharmaceutical Society of Australia has proposed that pharmacists could be placed in the GP Super Clinics and claim from Medicare. This would be an individual pharmacist not allied to a community pharmacy. This pharmacist's role would be to ensure Quality Use of Medicines, it would not necessarily be a dispensing role. In particular, this would develop a more direct relationship between GPs and pharmacists, which could lead to improved prescribing practices and QUM.

Pharmacists should be placed in multidisciplinary clinics and work directly with GPs and other health professionals to improve prescribing and review patients' medications. This should be funded through Medicare.

Midwives

Trained midwives are able to deliver most care which is required in childbirth. They can do this more cost-effectively than obstetricians and there is no evidence of a reduction in safety. CHOICE members regularly raise concerns about the large out-of-pocket costs faced when delivering a baby in a private hospital. Consideration should be given to the role of midwives in childbirth, particularly in the private hospital setting.



E-health

Shared electronic personal health records were discussed earlier in this submission. These are an important aspect of e-health from the consumer point-of-view. These need to be part of an integrated national strategy on e-health which aims to improve information management and coordination in the health system.

Boston Consulting Group, in its review of the National E-Health Transition Authority, recognised the need to establish a national e-health strategy. In the 2008-09 Budget, the government provided an additional \$60 million to the Department of Health and Ageing to 'work with the states, professional groups and consumers, to address the aspects of e-health requiring national leadership and coordination. This includes the development of a national e-health strategy'²⁵. This is welcome as progress to date has been slow.

It is important as part of the e-health strategy that systems evolve in a planned and integrated way. It is not productive for aspects of the e-health infrastructure to be developed privately in isolation from the overall e-health strategy. For example, a consortium has developed an electronic prescribing system which will enable GPs to send prescriptions electronically to pharmacies in a secure way. It is not clear how this will integrate with other systems. CHOICE believes an e-prescribing gateway is an important part of Australia's health IT infrastructure and should be controlled by Medicare Australia.

Ensure all parts of Australia's e-health infrastructure evolve in a planned and coordinated way.

²⁵ 2008-09 Budget papers