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AUSTRALIAN CENTRE
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ON HEALTH

Reforming Hospital Financing: A Medicare Hospital Benefits Scheme?

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Overview

- Current hospital financing arrangements
- Turning to 2008 ...
- Motivation for reform
- Medicare Hospital Benefits Scheme – General Features
- Some specifics
- Financing
- Conclusion



Current hospital financing arrangements

Public hospitals

- State funding (50%)
- Commonwealth funding (AHCAs) (42%)
- Other non-government (8%)

Private hospitals

- State funding (4%)
- Commonwealth funding (37%)
- Other non-government (59%)



Turning to 2008 ...

- Hospital financing is a topic of public policy debate
- Previous Australian Govt: Buy one public hospital
- New Australian Govt: Additional \$2bn for hospitals + “take control” of public hospitals if performance benchmarks are not achieved (Commonwealth financing and ownership?)



Motivation for Reform

"... the core issue is the extent to which private funding should be seen as, or in fact is:

- *replacing* public funding (e.g. private patients in private hospitals); or
- *topping up* public funding to provide extra dimensions of service (e.g. doctor of choice, or private room)."

(Industry Commission (1997, p.23) (emphasis in original)



Rephrasing, is it a substitute for, or complement to, cover for public patients in public hospitals provided by Medicare?

Answer: Neither.

- Does not 'replace' Medicare cover – those with private health insurance are still covered for treatment in public hospitals
- Does not 'top up' Medicare cover - because insurance is provided against the full cost of a hospital episode in a private hospital and not the extra cost (cost over and above that funded by Medicare)

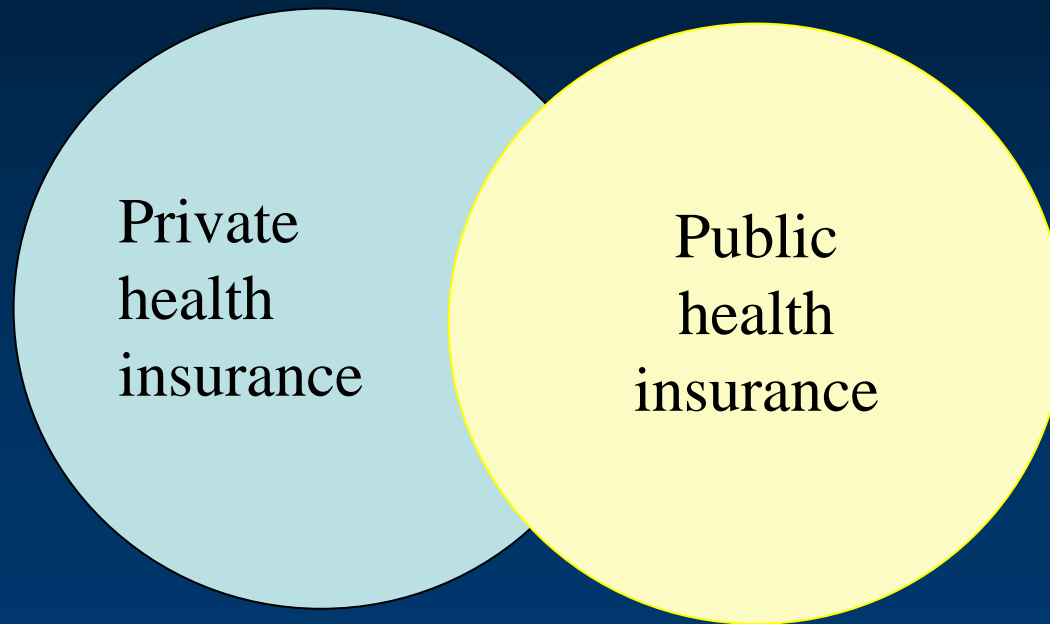


Upshot: Duplicate coverage

If insurance cover for private hospital treatment is purchased, insurance cover for treatment as a public patient in a public hospital is still compulsorily retained

Which direction to move to eliminate duplication in coverage?

- Reduce private health insurance coverage?
- Reduce public health insurance coverage?





Which direction to move?

Private health insurance only

Public health insurance only

45% of population have Private Health Insurance for hospital treatment

Private Health Insurance funds 11% of expenditure on hospitals

Individuals fund 2% of expenditure on hospitals (out-of-pocket expenses)





Table 34: Funding of hospitals^(a), current prices, by broad source of funds, 1995–96 to 2005–06 (per cent)

Year	Government			Non-government			Total
	Australian Govt	State/local govt	Total	Private health funds	Other non-govt	Total	
1995–96	37.4	35.9	73.3	17.8	9.0	26.7	100.0
1996–97	35.6	38.1	73.7	17.5	8.8	26.3	100.0
1997–98	38.2	38.2	76.4	14.7	8.9	23.6	100.0
1998–99	41.9	36.0	77.9	12.3	9.8	22.1	100.0
1999–00	43.8	35.8	79.6	10.5	9.9	20.4	100.0
2000–01	45.0	34.9	79.8	10.9	9.3	20.2	100.0
2001–02	44.0	35.0	79.0	12.4	8.6	21.0	100.0
2002–03	43.5	37.5	81.1	12.0	6.9	18.9	100.0
2003–04	42.6	38.0	80.6	12.1	7.2	19.4	100.0
2004–05	42.3	38.4	80.7	11.7	7.5	19.3	100.0
2005–06	40.6	40.5	81.1	11.1	7.8	18.9	100.0



Two broad options to address duplicate coverage

1. Reduce private health insurance coverage with public coverage taking up the 'gap'

2. Reduce public coverage with private coverage taking up the 'gap'



Medicare Hospital Benefits Scheme – General Features

- Remove s.96 grants for hospitals
- Remove private health insurance rebate
- Replace with a hospital benefits scheme
- A hospital benefit of pre-determined value would be paid for each hospital admission
- Commonwealth role would be financing, not provision, so ownership of public hospitals remains with the States



- Develop a Hospital Benefits Schedule (HBS)
- HBS items would be casemix-based
- Each item would have a defined rebate as in MBS
- Rebate can be set to ensure public hospital patients face no charge for an inpatient episode as at present



Eligibility

- Eligible hospitals – public and private hospitals could be included in the scheme (hospital benefit would be portable between public and private hospitals)
- Eligible patients – all eligible residents as defined for Medicare Medical Benefits Scheme



Some specifics – HBS items

- Casemix classification scheme - DRGs an obvious candidate
- Rebates would be per episode and not per diem
- Hospital typologies could be incorporated in the Schedule to differentiate DRG rebates by hospital type



Some specifics – HBS DRG fees

- If full coverage (zero out-of-pocket expense) in public hospitals is an objective, set DRG fees accordingly
- Private hospitals could charge above DRG schedule fee but could also opt to bulk bill
- Two-part tariff could be used (and may be desirable), e.g. flat fee per admission + DRG-specific fee
- Commonwealth would have considerable monopsonistic power in fee setting



Some specifics – gap cover

- Role for PHI in providing gap cover for private hospital charges in excess of HBS DRG fees (in addition to ancillary cover)
- No public subsidy
- No Medicare Levy surcharge
- Removes duplication in insurance



Some specifics – medical services

- Pay medical practitioners on fee-for-service basis in both public and private hospitals? (remove current 'uncertainty' about status of outpatient clinics)
- Would give public patients choice of doctor
- BUT how can public patients then be guaranteed zero out-of-pocket expenses for treatment?



Some specifics - utilisation

- If private hospitals included, increase in utilisation can be expected from those previously without PHI
- Public hospitals also have an incentive to increase throughput
- Moral hazard unlikely to be as severe as for medical services (lower price elasticities)
- Upside – reduced waiting times



Some specifics – quality

- Scheme gives Commonwealth greater leverage over quality
- All hospitals must be Approved Providers to qualify for HBS rebates
- Individual hospitals can be disapproved if quality (however measured) is sub-standard (cf. nursing home experience)
- Commonwealth can directly target avoidable deaths in hospital (200 avoidable deaths per week)



Financing

- Scheme entails considerably greater Commonwealth financing than at present
- Sources of expenditure savings for Commonwealth:
 - 1) Reduction in SPPs (M/care Agreements)
 - 2) PHI rebate



Sources of expenditure increase:

- 1) State share of public hospital financing
- 2) Public and private hospital financing formerly covered by PHI
- 3) Increase in private hospital utilisation



Indicative financing requirement, 2005-06

Funding requirement (\$ billion)		
1. Public hospitals (incl. psychiatric)	24.3	
2. Private hospitals (formerly covered by PHI)	3.1	
3. Private hospitals (utilisation increase)	1.6	
<i>Total</i>		29.0
Sources of funds (\$ billion)		
5. Existing Comm expenditure on public hospitals	9.9	
6. Removal of PHI rebate	3.2	
7. Other (↓SPPs? ↑M/care levy? ↓GST to States)	15.9	
<i>Total</i>		29.0



Net funding requirement: \$15.9 bn

In 2006-07:

- Medicare levy revenue: \$7.3 bn
- GST payments to States: \$39.6 bn



Conclusion

- Medicare hospital insurance is one option for reducing duplication in insurance coverage under current arrangements
- It increases Commonwealth involvement in hospital financing without necessitating C'wealth ownership of hospitals
- Another option – increase role of private health insurance by allowing 'opting out' with risk-adjusted subsidies for PHI