CEO COMMENTARY

22nd July 2015

Private health & private hospitals: how does the new landscape look for patients & equity?

Walter Kmet is CEO of WentWest, which is both a Regional GP Training Provider and Western Sydney Primary Health Network, and a National Councillor, Australian Healthcare and Hospitals Association.

In the article below, **Walter Kmet – CEO of Western Sydney's Primary Health Network WentWest** – says the current payments system and contractual arrangements for private hospitals and private health insurers were built for another time and that a much greater hands-on approach from private health funds to the health of their members should lead to improving patient-centred care and system equity, investment in primary care, and structural reform that preferences value not volume.

"There are national health and equity consequences if the private sector does not function efficiently and continues as another silo in a fragmented health funding and affordability landscape," he warns.

The full article can be found at: http://blogs.crikey.com.au/croakey/2015/07/22/private-health-private-hospitals-how-does-the-new-landscape-look-for-patients-equity/

***

Walter Kmet writes:

Negotiations and tensions between private health insurers and private hospitals have been a way of life for as long as these health industry sectors have existed. Private health funds generally negotiate funding agreements with private hospital operators every 2-3 years and the upcoming rounds will throw up more challenges than ever before, as evidenced by the current dispute between Medibank Private and Calvary Hospitals. What this dispute is showing is that resolution will be increasingly unable to be found in the microeconomic contractual relationship that currently exists between insurers and hospitals.

WentWest Limited
Level 1, 85 Flushcombe Road
Blacktown NSW 2148

PO Box 5,
Blacktown Post Shop
NSW 2148

T: (02) 8811 7100
F: (02) 9622 3448
www.wentwest.com.au

ACN 099 255 106
ABN 80 099 255 106

It is not surprising then that different views of the funder-and-provider relationship are beginning to emerge – mainly driven by private health funds adopting a much greater hands-on approach to the health of their members. As this occurs improving patient centred care and system equity should be key considerations for hospitals and funds, and also for government. Strategic partnerships that consider the opportunity to invest in primary care so that patients have a better chance of staying out of hospital, and structural reform of the way in which we pay for health care so that value not volume is a central objective, will also be key considerations.

Structural reform in private insurance/hospital sector has not occurred in any significant way for nearly 20 years except for two notable examples. In the mid 90s there was a shift in the model of funding from *per diem* funding to case payments appropriately reflecting the largely elective case mix being funded. From 1999, when health insurance coverage had declined to around 31 per cent, the government began introducing subsidies and rules to encourage uptake of private health insurance membership. These subsidies have now grown to over $6 billion (see Table 3.1). In the meantime all of the factors that drive demand, complexity and cost have built up like a pressure cooker which inevitably cannot be sustained by a payments system and contractual arrangements built for another time.

These pressures materialise as impacts on affordability. Private health insurance premium increases have been steadily above 5 per cent, even so not keeping pace with benefits outlays. This is likely to continue, unsustainably, unless the business model changes. That new business model will need to be progressively fine-tuned to outcomes not occasions of service; with a recognition that that some of outcomes will be better achieved by avoiding hospitals altogether and reducing benefits outlays as a result.

Adding to the affordability impact is that while overall levels of private health insurance remains historically high there is evidence that more people are shifting to less comprehensive plans. The impact here is that out-of-pocket expenses, already very high compared to other countries, will increase further. A downward spiral of harsher policy restrictions and exclusions is not the long term answer as one of the consequences will be that these services will potentially become the responsibility of the public system – a system which already sees very high levels of unplanned admissions. Alternately patients could delay or choose not to proceed with essential health interventions, also an undesirable situation.

Integrated, patient-centred care will have to be embraced

All of this does not bode well for private health insurers and private hospitals on either a business or political scale. This is supported by fact that the value and impact of this sector of health, in which both private and not-for-profit providers have a significant stake, has never been greater. Therefore what happens in this sector cannot be put down to being of only a private and commercial concern. There are national health and equity consequences if the private sector does not function efficiently and continues as another silo in a fragmented health funding and affordability landscape.

WentWest Limited
Level 1, 85 Flushcombe Road
Blacktown NSW 2148

PO Box 5,
Blacktown Post Shop
NSW 2148

T: (02) 8811 7100
F: (02) 9622 3448
www.wentwest.com.au

ACN 099 255 106
ABN 80 099 255 106

Developing models of integrated and patient centred care is being increasingly seen as a solution and will have to be embraced in private and commercial relationships. Integrated care will involve overcoming barriers between primary and secondary care, physical and mental health, and health and social care to provide the right care at the right time in the right place, supported by meaningful long term engagement and investments; not pilots and disconnected programs that add another layer of complexity for consumers.

Consumers already experience being shifted and referred across various system-generated boundaries. Many of these boundaries exist within private service providers themselves, let alone across payers and providers in the public, private and not-for-profit systems. Integrated care seeks to impose the patient's perspective as the organising principle of service delivery; too often this is determined by system and funding boundaries in place. This includes making the care accessible so that the impact of health literacy and affordability, amongst others, is eliminated. These are a reasonable system goals.

There is evidence of a recognition by private insurers and private hospitals that moving to models of integrated care, properly supported by policy and competently implemented, are essential. For example, Medibank Private and St Vincent's Private Hospitals are embarking on a Care Transitions Program specifically targeting the critical period around hospitalisation. Private insurers and hospitals that are able to embrace these models in partnership with primary care will have a much greater chance of success through the positive impact that continuity of care has.

In doing so they should seek to be inclusive of a diverse primary care landscape, not attempt to capture sections of it. This could be done by working with newly formed Primary Health Networks as they seek to improve the capacity and capability of primary care and its relationship with other parts of the health and human service systems.

Achieving shared responsibility for better health outcomes

Ultimately the need to coordinate care beyond the walls of a hospital has never been greater. Public hospitals systems have seen the impact of unplanned admissions complicated by chronic conditions for some time. In New South Wales the State Government has responded with specific investments in models of integrated care. The challenges here of the State working across jurisdictional boundaries with the Commonwealth will be akin to that faced by the many private insurers and their many private hospital providers. There are also the difficulties of moving the balance of expenditure from an expensive secondary and acute system to more effective early interventions in primary care, which will be the same.

In the US, which is a largely private healthcare system, a recent compact between payers and providers to move from volume to value is perhaps an indication of the kind of strategic partnership that needs to be put in place. It recognises that the current payment paradigm is not fit-for-purpose and is unsustainable and inequitable. In Australia this is supported by the fact that insurers see significant variations in costs amongst providers, let alone a coterie of interventions for similar conditions. The Choosing Wisely campaign, background work published by Professor Adam Elshaug,

WentWest Limited
Level 1, 85 Flushcombe Road
Blacktown NSW 2148

PO Box 5,
Blacktown Post Shop
NSW 2148

T: (02) 8811 7100
F: (02) 9622 3448
www.wentwest.com.au

ACN 099 255 106
ABN 80 099 255 106

and work being progressed by the ACSQHC are indications of where a start can be made in reducing cost and improving outcomes at the same time.

Private hospital operators themselves will not be able to stand behind their current business model, the traditional focus on volume and cost efficiency. In light of the evidence around variations in quality it will be not be enough. There will need to be a shared responsibility to ensure that consistently better health outcomes are achieved, ideally in an atmosphere of quality improvement not punitive contractual terms. In addition there is an inevitable consideration of whether a hospital stay is the most cost effective way of handling a health condition and whether the patient would like to consider other options. Palliative care is an obvious area: interventions and admissions can be much better planned and managed by improving the capacity of primary care and general practice. Simply taking a view that funding is not available for alternatives to hospital based care is unsustainable and inequitable at a number of levels.

Again in palliative care there are examples of the system moving but in particular the not-for-profit sector has a real opportunity to take leadership, particularly in the eastern states where rates of people dying at home are much lower than in the west, and concentration of specialist palliative care units is not equitable. At present while 70 per cent of people say they want to die at home, only about 14 per cent do so. Structured investment in primary care is the key to changing this, as is the dependence of many of the providers in keeping people in hospital, because that is how they are paid, rather than caring for them at home.

For health insurers a realisation that integrated care will cost before it pays is understood but making the transition to this will require more than some of the blunt funding instruments that they have at their disposal, such as sanctions for 28 day potentially preventable readmissions. Payment systems have the ability to more equitably address payers' concerns to achieve value driven outcomes. Measuring results should include whether evidence based medicine has been followed such as has been achieved by the Healthcare Marketplace Collaborative. Whatever the case a journey should involve investing in better patient care through quality improvement not sanctions, shared goals and recognition that some of the solutions require investment in change management techniques such as HealthPathways, utilised by a number of primary healthcare organisations in New Zealand and Australia.

Primary care: 'part of the solution, not just source of referrals'

There is a good opportunity for insurers and private hospitals to join regional communities in strengthening the regional capacity of health systems through programs like HealthPathways. This will be better for patients than an approach which attempts to create a system within system, which will only diminish capability to make care patient-centric by increasing, not removing, system boundaries. Health outcomes are dependent on more than what any one part of the system can achieve on its own. This is particularly true when episodic outcomes are influenced by co-morbidities, which are now becoming the norm. In this regard partnerships across system boundaries are critical to success. These discussions should engage primary care providers and see them a part of the solution not just as a potential source of referrals.

WentWest Limited
Level 1, 85 Flushcombe Road
Blacktown NSW 2148

PO Box 5,
Blacktown Post Shop
NSW 2148

T: (02) 8811 7100
F: (02) 9622 3448
www.wentwest.com.au

ACN 099 255 106
ABN 80 099 255 106

Regionally based primary health care organisations with their mandate of commissioning are well placed to play a role in this environment. They are well placed to engage with plurality of primary care providers and ensure that potential improvements are equitable and considerate of those that don't have access to health insurance. Some are actively investing in both models of integrated care and the Patient Centred Medical Home for which strong evidence exists as to the benefit of taking such approaches. There is all the reason to collaborate on such initiatives. In any case, across both private hospital and health insurance levels, the opportunity to engage and invest in capacity and capability of primary care so that patient needs can be met in the community either as part of a hospitalisation or as an alternative to it should central to the current debate.

Consumer and patients have every reason to demand integrated care as a given. Relationships across the health system, not in the least those that exist between private insurers and hospitals, need to facilitate this. Pressure on the current health business model will make a move from volume to value inevitable and this will include a realisation that hospital operators and their funders will have to embrace innovation, looking out to primary care as part of a long term solution. Primary Health Networks with their recent inauguration are well placed to support this agenda across diverse regions with differing needs right across Australia.

Walter Kmet, CEO WentWest

--- END ---

WentWest Limited
Level 1, 85 Flushcombe Road
Blacktown NSW 2148

PO Box 5,
Blacktown Post Shop
NSW 2148

T: (02) 8811 7100
F: (02) 9622 3448
www.wentwest.com.au

ACN 099 255 106
ABN 80 099 255 106

For more information please contact:
Gemma Aborele
Marketing and Communications
WentWest Limited
P: (02) 8811 7182
E: gemma.aborele@wentwest.com.au

About WentWest

WentWest was established in 2002 to provide the Australian General Practice Training (AGPT) program for general practice vocational training in western Sydney. WentWest has a team of experienced medical educators who are all in active general practice and assist registered doctors to become vocationally registered general practitioners.

WentWest's focus on providing better health care in the community was strengthened with its appointment as a Tranche 1 Medicare Local in July 2011 to now operating as the Primary Health Network. WentWest has built on its experience as a Division of General Practice in supporting GPs and their practices, connecting health services to meet local needs, and striving for better health outcomes for western Sydney.

The population living in western Sydney is culturally, linguistically and socio-economically diverse, and we also have the largest urban Aboriginal community in Australia. WentWest works closely with doctors, allied health professionals, the Local Health District and many others to improve the coordination of local health and human services for these patients and their families.

WentWest has partnered with the Western Sydney Local Health District and the Aboriginal Medical Service Western Sydney to address the common health priorities within the region through joint planning, capacity building, programs and strategies. This work is critical to building a better primary health care system that the evidence shows is fundamental if we are to reduce this burden of disease and keep people out of hospital.