Injury Schemes Seminar

Balancing Outcomes

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Medical Rates Benchmarking

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Agenda

- Context
- Method
- Results of a sample of the benchmarks
- Aggregate results
- Harmonisation?
- Next steps

Context

- National view of medical expenditure
- Regulated schemes
  - Regulated costs – varies by scheme
  - Commercial comparisons
  - Curiosities from 2009, 2010, 2012
  - Discussions around national efficient pricing, revision pricing for prosthesis
- Payment system(s)
  - National system of health payments
  - Scale of payments varies across parts of the system

Health payment system

Tax rebates
Tax rebates(a)
Out-of-pocket payments & copayments
Individuals
Specific purpose payments
State & territory governments
Direct grants and expenditure
Contributions
Non-government service providers
Private hospitals
Medical practitioners
Pharmaceutical retailers
Dental practitioners
Other health practitioners
Administration
Research
Australian Government (includes DoHA, Treasury) and others
Direct payments and subsidies to non-government service providers
Purchase of services for veterans
30–40% rebate on private health insurance premiums
State & territory government providers
Public hospital services
Patient transport services
Dental services
Community health services
Public health services
Administration
Research
Direct grants and expenditure
Benefits paid
Payments for services
Australian Government Department of Veterans' Affairs
Purchase of services for veterans
Out-of-pocket payments & copayments
Injury compensation funds
Payments for services
Benefits paid
Contributions
Benefits paid
Benefits paid
30–40% rebate on private health insurance premiums
Private health insurers
Government flows
Non-government flows

Figure 1.1: The structure of the Australian health care system and its flow of funds

Funding of total health expenditure in 2010-11

- Government: 69%
- Private health insurance funds: 8%
- Individuals: 18%
- Other non-government including funding by injury compensation insurers and other private funding

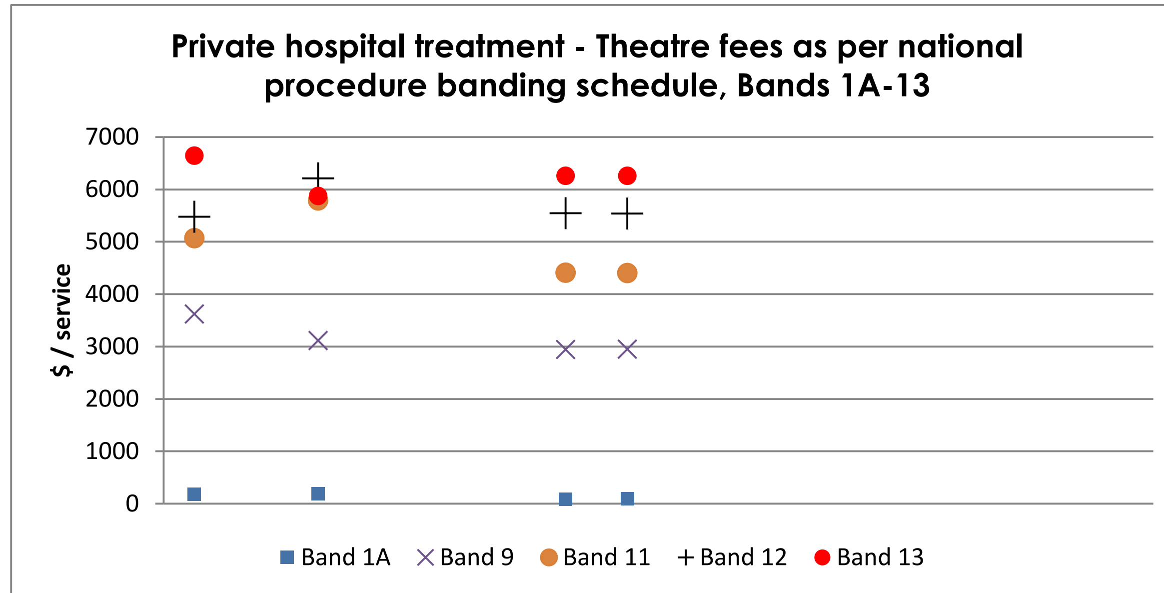
Health expenditure Australia 2010-11,
Health and welfare expenditure series no.47,
Australian Institute of Health and Welfare, p.3, p.31

Method

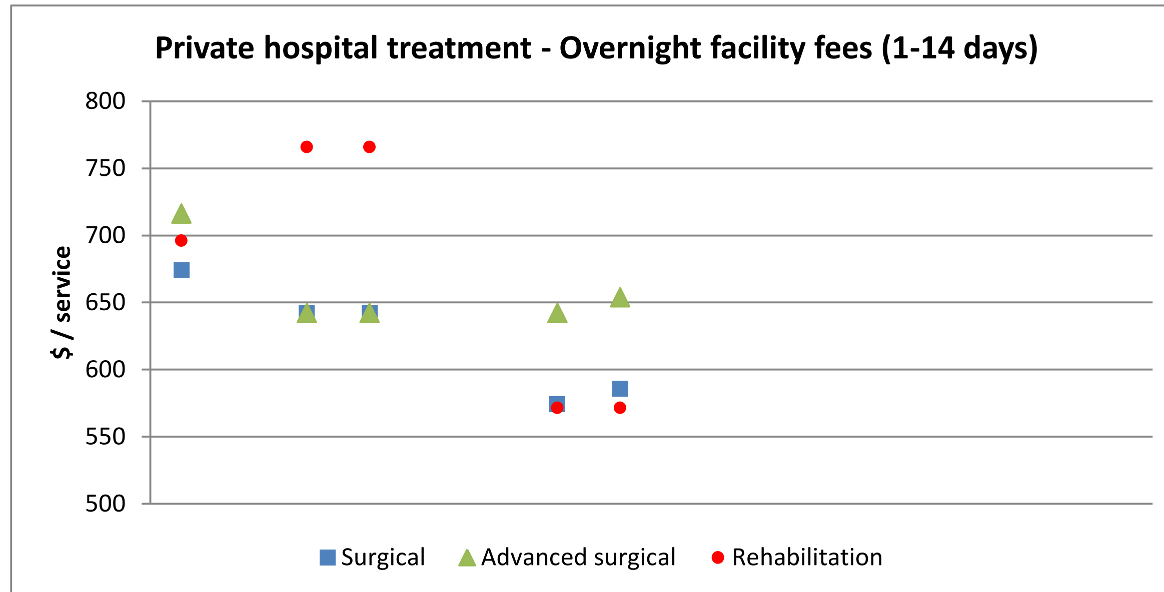
For benchmarking

- Payments types
  - GPs, Medical specialists, Allied Health, Hospitals public & private
- Benchmarked schemes/systems
  - Publicly available scheme data, interviews, private health insurance data, Independent Hospital Pricing Authority (casemix)
- Scheme types
  - Motor personal injury; workers compensation
- Selected services
  - Ranked by comparative significance of services
  - Availability of useful data

Comparisons across Australian states/territories



Comparisons across Australian states/territories



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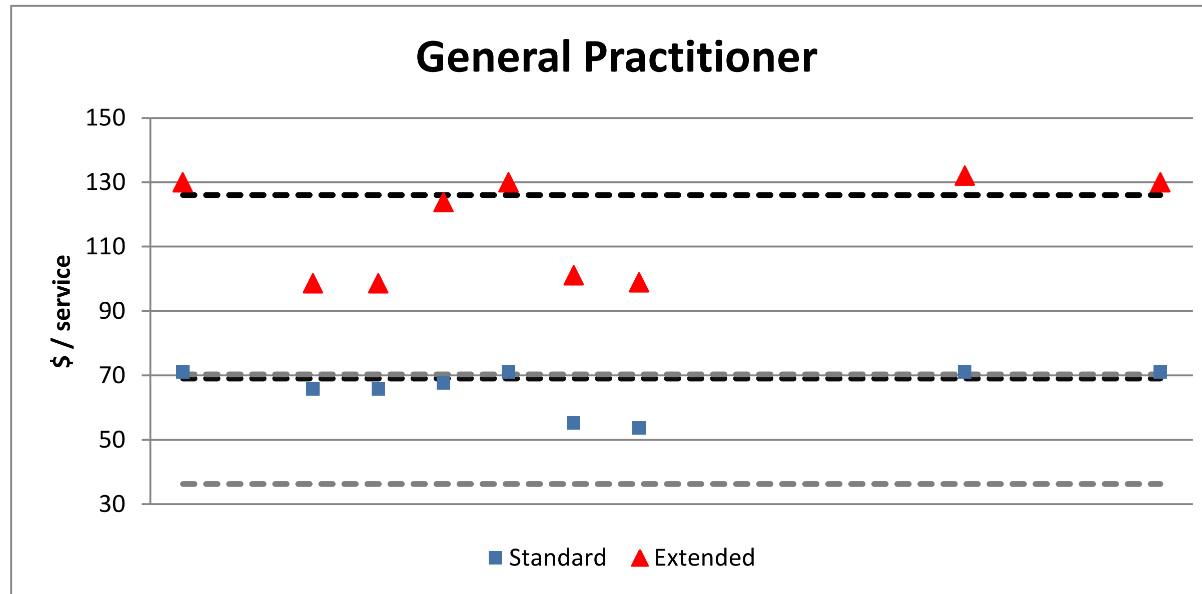
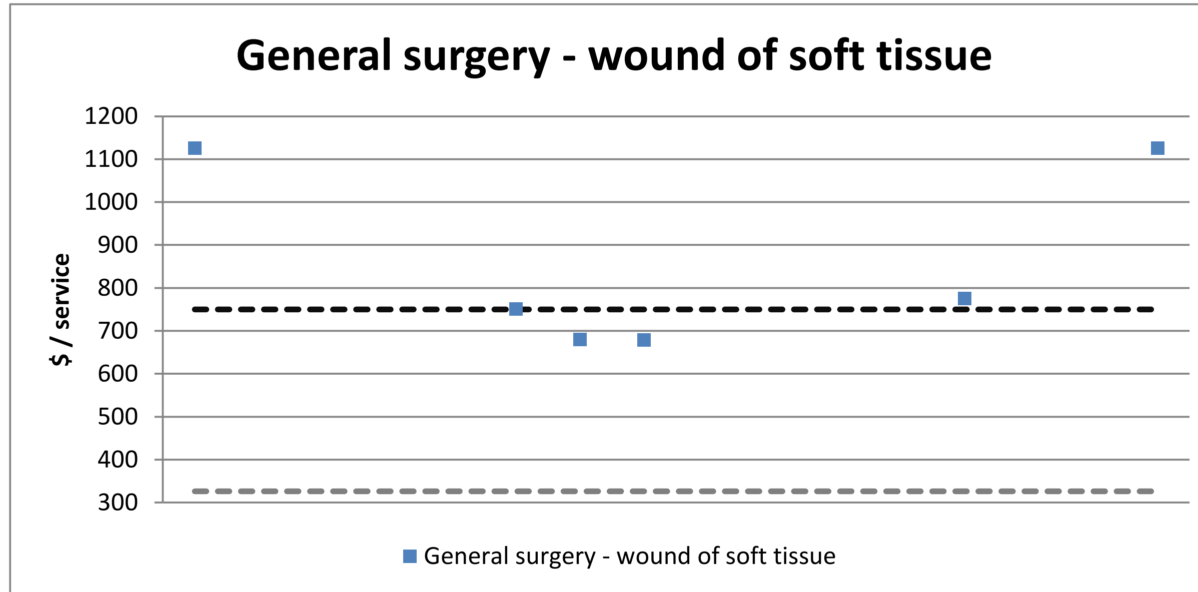
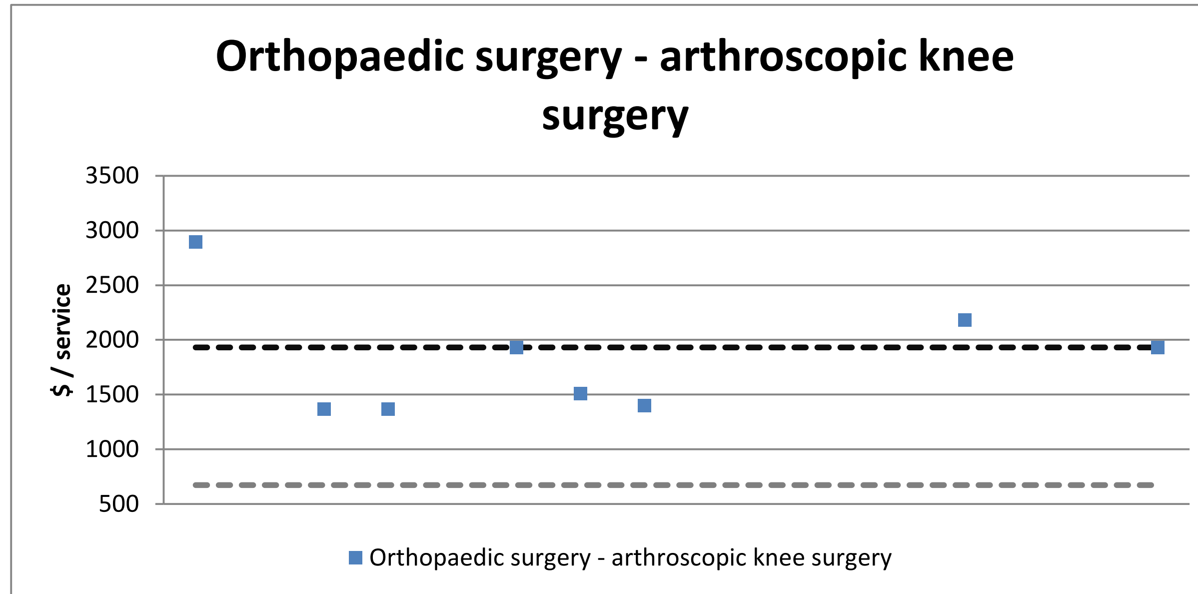


- For medical services: dark line indicates AMA fee, light line indicates MBS fee

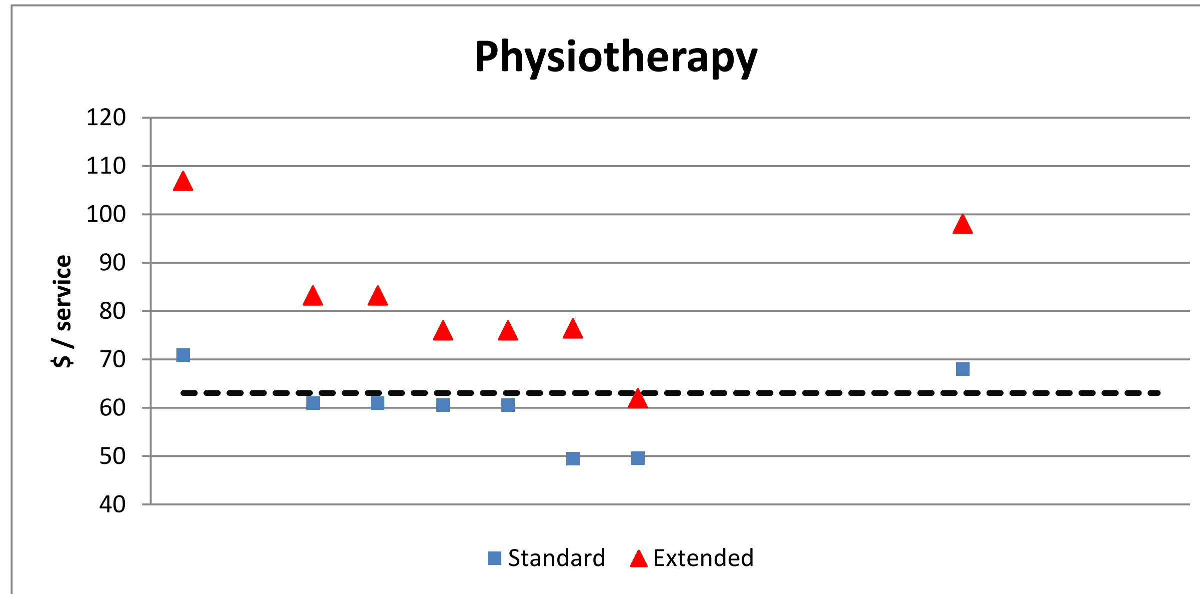
Comparisons across Australian states/territories



Comparisons across Australian states/territories



Comparisons across Australian states/territories



- Line indicates average comparable fees for private health insurance
- For some schemes, rates are not regulated and a “reasonable” fee is permitted

Summary of potential savings

%	Workers Comp	CTP
State	8%	8%
State		-8%
State	17%	
State		
State	8%	12%
State		13%
State	21%	
State		
Total	**12%**	

Harmonisation (of rates)

Why?

- Known payment structure nationally?
- Single negotiation point nationally?
- ‘Fair’ negotiated payments when dealing with any scheme/insurer
- Limits price leakage
- Administratively easier?

Or not?

- New overheads
- Regular updating required
- Allow the market to determine the rates

Harmonisation (of rates)

What?

- Which rates, and why not all rates?
  - Medical rates already have a structural basis from commonality
  - Allied health rates least structured from 'government' perspective
  - Hospital rates have several existing approaches available
- Impediments
  - Cost base variance across and within jurisdictions – is fairness a factor?
  - Different mixes across schemes
    - i.e. Motor personal injury typically higher triage hospital user
  - MBS rates are marginal, so create a system that utilises as a basis

Harmonisation (of rates)

Leakage

- In this context defined as:
  - An overpayment that could have been prevented
  - An ultimate settlement cost that an above average claims (manager) would have avoided with access to appropriate information and resources
- Leakages can occur in may forms including:
  - Paying more than the scheduled rate
  - Behaviour from service providers (over-servicing; multiple billing)
  - Whole of claim leakage (poor management of the claim resulting in more services being required to treat the claimant)

Harmonisation (of rates) - Hospital example

- Independent Hospital Pricing Authority established 2011 to contribute to reform of Australian public hospitals, including national Activity Based Funding for public hospitals
- IHPA calculates the National Efficient Price, model provides relative adjustments
- Number/type of activities undertaken in the hospital setting are recorded, and related costs also recorded, assigned to several variables/cost allocation units
- Cost per allocation unit can then be calculated according to a variety of types of units
- Benefits of National Efficient Price
  - Basis for determining government funding
  - Benchmarking of cost basis and efficiency

Harmonisation (of rates) – Physio example

- Cost savings is not the only goal
- Quality of service and return to work outcomes are other goals
- Case study
  - "Review of TAC Victoria Schedule of Fees for Physiotherapy Services (Private)" - presented to the Transport Accident
  - Provided to the TAC, May 2013, submission by Australian Physiotherapy Association

Harmonisation (of rates) – Physio example

- "Review of TAC Victoria Schedule of Fees for Physiotherapy Services (Private)"
  - "TAC's failure to pay reasonable fees is incompatible with the physiotherapist's objective to provide quality care focussed on early rehabilitation and return to full function.
  - "Poor remuneration offered to physiotherapists for treating injured road users is a disincentive to treat such patients.
  - "This drives many highly qualified and experienced physiotherapists away from the TAC funded scheme and compromises best health outcomes for patients."
  - "Victorian physiotherapists are the lowest paid physiotherapists in Australia when treating injured road users... The APA contends that fees for service in Victoria should be significantly higher and brought into line with the national average fees."

Harmonisation (of rates) – further issues

- Working with State Health departments
  - Funding mechanisms i.e. bulk billing, block funding, activity based funding
- Working with providers
  - AMA, medical colleges, state employers, associations
  - State hospitals, private hospitals
  - Prosthesis
- Changes within schemes, resourcing, state issues
- Comparison against private health insurers
  - National hospitals vs state based
  - For profit hospitals vs cost driven/block funding
  - National PHI footprint vs state and fragmented schemes

Next Steps

- Ongoing research:
  - Supporting medical data collection in schemes
    - Service level data is very powerful
  - Interaction between medical treatment and ongoing claim outcomes
  - Linking providers across claims and provider types
- Exploring alternatives
  - Links to health insurers – hospitals/providers
  - Centralised supporting services – scheme based/across schemes
  - Medical practitioners are the ‘least’ controlled in the medical system
  - Focus on the edges – create containment
  - Measure on an outcomes basis

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