Institute of Actuaries of Australia

# Managing Medical Costs:
# Scheme Perspectives

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# 1 Background

## 1.1 Synopsis

Accident compensation schemes are facing upwards pressure on medical costs. Costs increases of the last decade have been significant, and these are expected to continue.

The main aim of this paper is to share some of the experiences of accident compensation schemes in Australia and New Zealand in their management of medical costs.

To set the context, we first outline the pressures on the wider health system and look at recommendations from the 2009 report on health reform by the NHHRC which are of particular relevance to accident compensation schemes. We then examine the importance of accident compensation schemes in the context of national health expenditure as well as the importance of medical costs to a typical accident compensation scheme. Finally, we consider the impact that the compensation environment has on health expenditure.

We then look at specific feedback from accident compensation schemes including WorkCover NSW, WorkSafe Victoria, Transport Accident Commission Victoria, Department of Veterans' Affairs and Accident Compensation Commission New Zealand.

The schemes provided feedback in a number of areas, including:

- Current funding approaches for medical, hospital and allied health expenditure
- Impacts of the current environment on treatment outcomes and billing practices
- Controls used to help manage medical costs
- Wider system issues such as managing stakeholder relationships

We thank these schemes for sharing their knowledge and expertise. Whilst the information provided was cross-checked with each Scheme, any misstatement is the responsibility of the authors.

## 1.2 Trends in the broader health system

Health care systems are under pressure, needing to evolve to be sustainable into the future. Key influences within the sector include:

*Increasing demand and rising costs*

Health care costs are rising, and are projected to continue to rise.

In Australia, real growth in health expenditure for the decade to 2006-07 is 4.9% pa, or 3.6% pa growth per person. The growth in medication expenditure was particularly strong, at nearly twice the average growth. Real growth in expenditure by injury compensation insurers is 2.8% pa over the same period.[1]

Heath and aged care expenditure in Australia is projected to increase by 189% (constant dollar terms), or 3.5% pa over the next 30 years[2]. The most significant factors contributing to the projected increase are:

[1] *AIHW*, 'Health expenditure Australia 2006-07' (full publication)

[2] Goss, J. 2008, 'Projection of Australian health care expenditure by disease, 2003 to 2033', *AIHW Health and expenditure series, Number 36*

- Increase in projected volume of services per treated case (50% of the increase). The increase assumes that past changes in technologies, such as new drugs and new procedures, and in treatment practices, such as shifts from hospital to out-of-hospital, will continue to impact the volume of services.

- Population aging, including changes in the mix of diseases (23% of the increase)

- Absolute increase in the population (21% of the increase)

- Excess health price inflation (5% of the increase).

The projected increase in expenditure for injuries is lower, at 116%, or 2.5% pa. The components of the increase are similar, at:

- Increase in projected volume of services per treated case (60% of the increase)

- Population aging (15% of the increase)

- Absolute increase in the population (30% of the increase)

- Excess health price inflation (10% of the increase).

- Somewhat offset by lower incidence (20% of the increase).

Note that the study from which these findings have been drawn projects expenditure by ICD-9 disease category. Thus the projected injury expenditure includes non-compensable injuries, but excludes compensable diseases. Therefore the projected real increase in health expenditure for injuries is not directly translatable to accident compensation schemes.

In particular:

- The ICD-9 injury category includes ‘falls’, many of which are age-related and therefore not relevant for compensation schemes.

- Conversely, the medical spend for compensation schemes includes attendant care costs, mostly associated with catastrophic claims. Care costs do not appear to be included in the AIHW projection.

- Increases in the population is not relevant for the outstanding claims liability, which has a predefined exposure (claims already incurred), whilst increases in the incurred cost due to population increases can be offset by the larger premium income base.

- The coverage for medical costs varies across the Australasian schemes. For some schemes, coverage effectively ceases a moderate number of years post-injury, for other schemes, coverage continues until death, but only for medical costs related to the originating injury. These controls on coverage may limit the cost pressures from aging and from volume of services.

*Challenges around quality, efficiency and consumer trust*

There are growing concerns about safety and quality, workforce shortages, and inefficiency in providing health services, including:

- inconsistent quality

- duplication of services

- inefficient processes

- overly expensive inputs
- lack of transparency in quality and pricing
- lack of communication between health organizations

Government reform in the hospital sector, both public and private, is seen as having the greatest potential to improve efficiency.[3] The cost of providing care varies significantly between Australian hospitals, with differences within individual states as well as between different states and territories. Moving to activity-based funding is regarded as key to driving efficiency. Victoria, with the longest history of funding on a case-mix basis, has the lowest public hospital cost. The lower cost follows from the incentives to reduce the length of stay associated with the case-mix funding approach.

Government funding of hospital, medical and pharmaceutical benefits distorts treatment use. Even where alternative treatments through allied health may be more effective, uptake will be low.

*Information Technology*[4]

There is an increasing focus on information technology as a means to:

- Improve care integration, by making electronic patient records available to clinicians across all care settings.
- Reduce duplication and administrative inefficiencies. For example, the HIC has introduced an online system which is expected to reduce administrative costs for hospitals and payers. The provider can access relevant cost and co-payment information, whilst GPs can use the system to process patient claims electronically.
- Accelerate standardization and knowledge transfer of administrative and clinical information. By providing comparative clinical performance data back to health services, continual quality improvement is achievable.

## 1.3 Impact of reform recommendations on schemes

In Australia, the Government established the National Health and Hospitals Reform Commission in 2008, reporting in June 2009 on a long-term health reform plan to provide sustainable improvements in the performance of the health system.

Key initiatives of particular relevance to accident compensation schemes include[5]:

*Building comprehensive primary health care centres*[6]

Primary health care encompasses the first level of care for consumers. It is the services delivered by GPs, nurses, allied health providers and pharmacists outside the hospital.

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[3] 'The Australian Health Care System: The Potential for Efficiency Gains' (background paper prepared for the *National Health and Hospitals Reform Commission*)

[4] *PricewaterhouseCoopers*, 2005, 'HealthCast 2020: Creating a sustainable future'

[5] *National Health and Hospitals Reform Commission* , 'A healthier future for all Australians',

[6] *Australian Government Department of Health and Ageing* , 'Primary Health Care Reform in Australia'

Health services are seen as currently being structured more around the provider, rather than around the community. The traditional organisation of health care is based on a clear divide between general practice medical care and more specialised care provided on referral by consultant physicians and specialists. However, this is largely out of step with the mix of services required by patients. Many patients now receive a mix of out-of-hospital services – including GPs (for ongoing primary health care), allied health, specialists or consultant physicians (as required for more specialised treatment).

It is usually the patient who must find a way of accessing multiple providers across various locations, rather than providers functioning as a team, providing care around the whole needs of a person. A priority then is to better connect hospitals, primary and community care to meet patient needs, improve continuity of care and reduce demand on hospitals.

The goal is to redesign health services around people, so that people can better access appropriate care. As part of this goal, establishing comprehensive primary health care centres is recommended, whereby a multidisciplinary range of primary health care and specialist services are brought together. Services would be coordinated to promote better continuity of care. The care centres are seen as better able to manage the care needs of people with chronic health problems.

Use of a single primary care centre is seen as strengthening the continuity, coordination and range of multidisciplinary care available to deliver optimal outcomes.

*Well-designed funding and strategic purchasing models*

As part of this reform process, changes to the funding arrangements are regarded as necessary, with increased accountability for performance. This requires a shift from the fee-for-service payments, to mixed models incorporating capitation, patient co-payment and incentive payments.

Medical and other health services:

- Are currently largely on a fee-for-service basis.
- Establishing Comprehensive Primary Health Care Centres enables other funding approaches.
- Whilst this would continue to include fee-for-service, funding could be expanded to include grant payments, outcome payments and episodic payments.
    - Outcome payments would reward improvements in outcomes for patients
    - Episodic payments would bundle together the cost of packages of care over a course of care, creating greater freedom for health care services to take a long-term view on managing health.

As care centres and the associated outcome-based funding arrangements develop, managing medical treatment for compensated patients will need to evolve. Could the claim manager role be part of the function of the care centre? In terms of efficiency and care integration, having one centre being responsible for a patient's care and health outcome seems preferable to splitting the role across a care centre and a claim manager. Consideration should be given to consistency in the funding approach, and in the outcome measures, for compensated and non-compensated patients across Australia.

Hospital services:

The hospital sector is seen as having major potential for efficiency gains. Activity-based funding, using casemix classifications, is recommended to improve the efficiency of hospitals.

*Better management of health information*

eHealth and other technologies are seen as key enablers to improving health care. This includes:

- Use of electronic health records, allowing information to be easily shared amongst providers. This is particularly important for patients with chronic health conditions. eHealth records for compensated patients will facilitate integrated care across the various funding systems.

- Making up to date evidence-based guidelines readily accessible to clinicians. Compensation schemes are data rich, with the capacity to compare and contrast alternative treatment pathways. Schemes have a role in developing and disseminating evidence-based guidelines.

New care models which take advantage of e-technology, such as tele-medicine, e-consultations, and online information. E-technology improves access, allows consumers to become more active in their own health management, and can be cost-effective. There are isolated examples where these technologies have been used, to good effect. A recent example is an internet therapy trial program for people with depression, where e-therapy was found to be twice as effective as seeing a psychologist or psychiatrist in person.

*Embed prevention and early intervention*

The current health system is skewed more towards managing sickness rather than encouraging wellness. Establishing an Australian Health Prevention and Promotion Agency is proposed, with the responsibility of driving a health-promoting society. For example, many chronic diseases are influenced by potentially modifiable lifestyle choices. The Agency would have responsibility for setting goals and driving action to promote prevention.

The workplace is seen as an opportunity to support wellness. By encouraging the workforce to remain healthy and energized, workplace productivity and reduced sickness and injury follows. Further, the morbidity of workplaces injuries increases where there are other health conditions, such as obesity and mental health problems. Health outcomes are also shown to be worse co-morbidity exists.

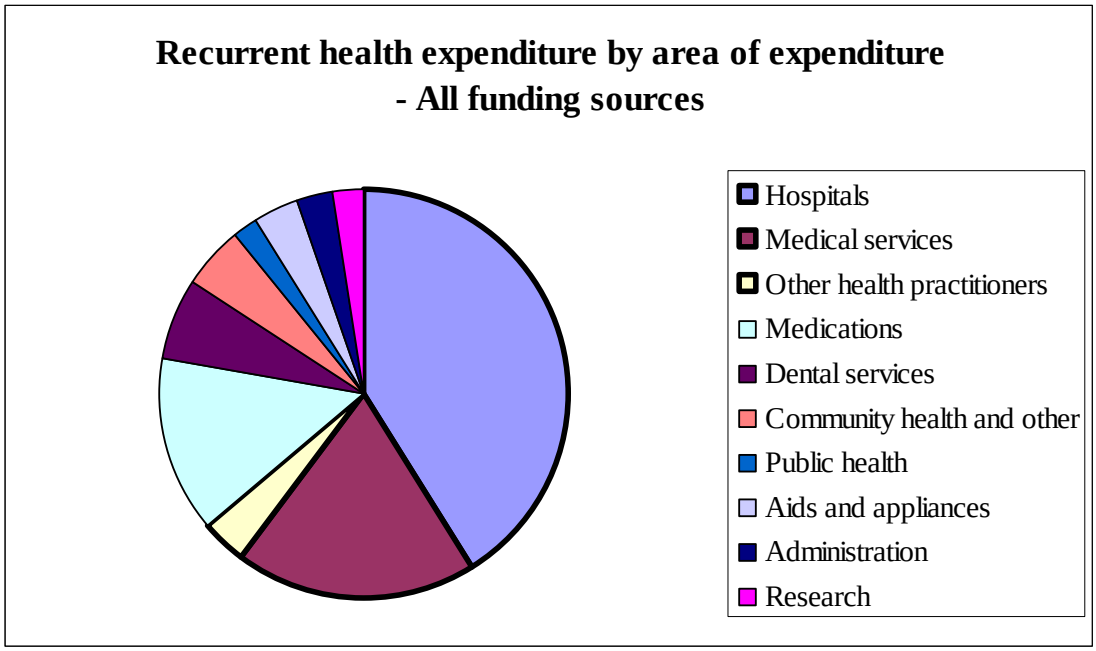
## 1.4 The importance of medical costs in accident compensation schemes

*Australian health expenditure breakdown*

Total health expenditure is $94b (2006-07), or $4,500 per person.

Hospital, medical and other health practitioner services are around 60% of total recurrent Australian health expenditure[7].

[7] *AIHW*, 'Health expenditure Australia 2006-07' (full publication)



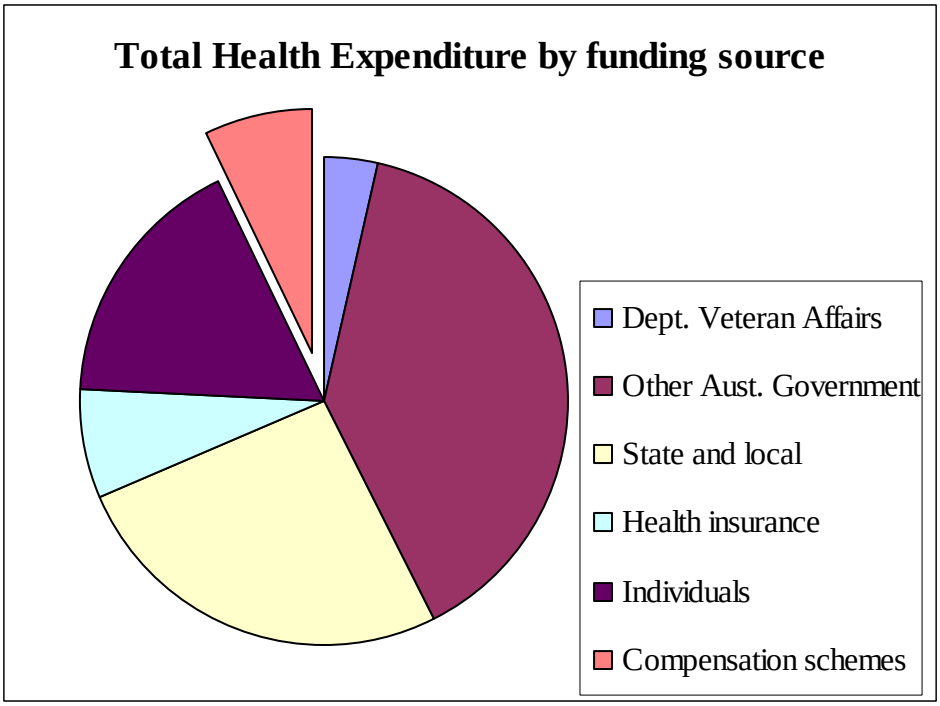

Definitions:

Hospitals – includes services provided to a patient who is treated by a hospital

Other health practitioners – Services provided by health practitioners other than doctors and dentists. These include chiropractors, optometrists, physiotherapists, speech therapists, audiologists, dieticians, podiatrists, homeopaths, naturopaths, practitioners of Chinese medicine.

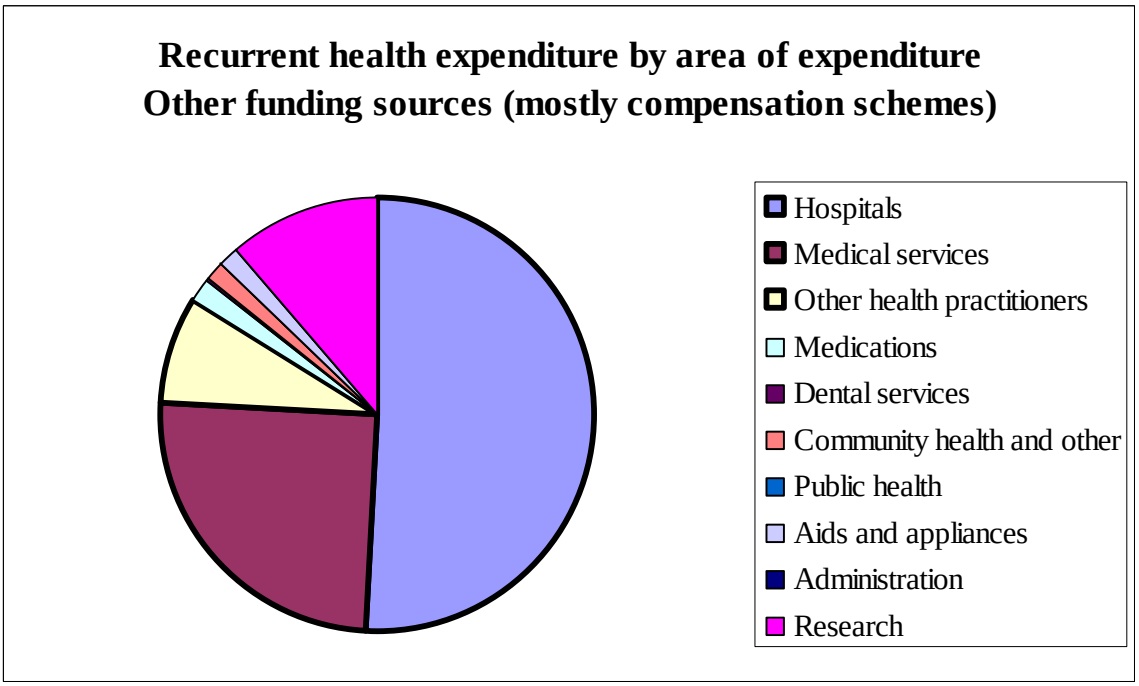
*Expenditure by source of funds*

The government funds 69% of total expenditure (recurrent and capital), including funding the Department of Veteran Affairs and the Private Health Insurance Premium Rebate, individual out-of-pocket is 17%, private health insurance funds 7% and others (mainly compulsory motor vehicle third-party and workers' compensation insurers) fund 7%.




*Accident compensation schemes expenditure*

Hospital, medical and other health practitioner services are around 80% of recurrent health expenditure of accident compensation schemes.




*Profile of accident compensation scheme expenditure*

Whilst differences in the nature of accidents / illness, and in the scheme design will lead to differences in the medical spend across jurisdictions, typically

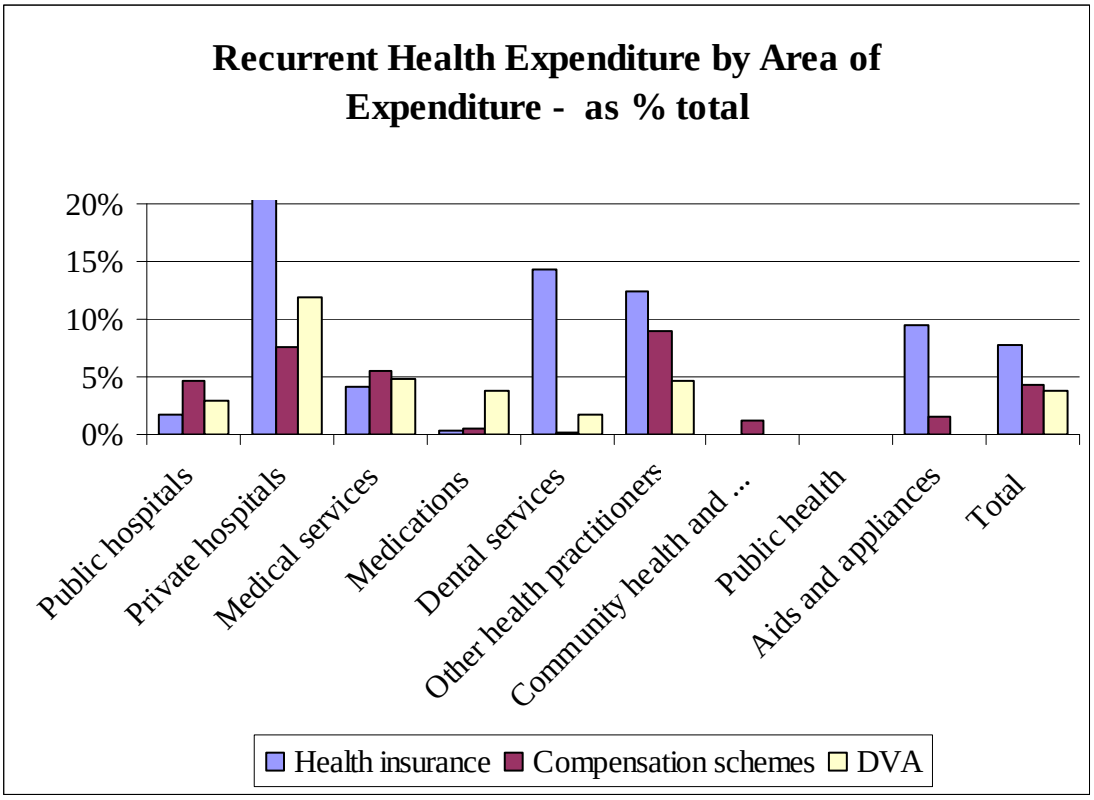
- Medical spend is around 25% of total scheme costs.

- Around 50% of medical spend is within the 1st year of the accident, and 50% thereafter.
- Around 10% of medical spend is 5 or more years after the accident, including a significant spend on surgery.

The number of unique services provided per annum, and the number of individual providers servicing the claimants, is large. The broad range of service items and providers makes monitoring risks and measuring performance a challenge.

*Implications for compensation schemes*

In general, compensations schemes are a small source of funds for providers. The same is true within the broad expenditure categories. This contrasts with Health Insurance funds, which are a very significant funding source for private hospitals, providing almost 50% of the total private hospital funds.




Thus compensation schemes generally lack the market power required to be a strong negotiator.

From discussions with compensation schemes, there may be some specialties where schemes become a more significant funder, and hence can have greater influence with the providers. Such specialties include physiotherapists, hand surgeons, and orthopedic surgeons.

## 1.5 The impact of a compensation environment on health outcomes

*Research studies*

Various studies have concluded that compensated patients have worse health outcomes than non-compensated patients.[8]

The cause of poorer health outcomes for compensation claimants is not clear, but factors put forward as contributing to the poorer outcomes include:

- Psychosocial environment at the time of injury (e.g. job satisfaction, social networks) and post injury (e.g. attitude of workplace and family)
- Initial response to claimant by insurers (treating claimant as fraudulent promotes defensive attitude) and physicians (expectations around treatment and/or return to work)
- Case management (e.g. providing unnecessary treatment, ignoring psychosocial problems such as depression)
- Length of time away from work (e.g. loss of sense of identity, social networks, economic control, independence, social status and/or financial security; employer's reluctance to take on anyone with pre-existing injuries)
- Adversarial court system (both sides focused on result of court case and not on rehabilitation of worker, incentive for injured to remain inactive to maximize settlement, sense of powerlessness)

The research emphasizes the importance of psychosocial factors in long-term disability. The degree and length of disability can be improved where appropriate, coordinated early intervention is available.

The health outcome being considered depends on the study, but includes:

- Return to work, return to prior activities
- Subjective perceptions of pain, depression
- Functional capacity, change in functional ability,

A similar finding exists for surgery patients[9].

The SOuRCe meta-analysis involved a review of 211 research papers examining the association between compensation status and outcome after surgery. The study found that 175 papers stated that compensation was associated with a worse outcome, 35 did not make any conclusions or noted no difference, and 1 paper stated that compensation was associated with beneficial outcomes. The meta-analysis had no limits on the type of surgery, and the outcome was divided into satisfactory or non-satisfactory based on author of each study's own criteria.

Hence, the vast majority of studies into the effect of compensation on surgery outcomes found that a compensation environment was associated with worse outcomes for patients.

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[8] *The Royal Australasian College of Physicians*, 2000, 'Compensable Injuries and Health Outcomes'

[9] Harris, I. 2004, 'The effect of compensation on outcome after surgery'

*Scheme response*

Some examples of how schemes have responded include:

- Accepting provisional liability. This allows for payment of benefits to commence quickly after the injury, providing immediate support to the claimant.

- Incentives to improve early notification of an injury, such as removing the employer excess for early reports. This assists with early implementation of claim management strategies.

- Providing an alternative dispute resolution process to reduce the adversarial environment, such as the MAAS medical assessment process, and the CARS resolution process used by the MAA.

- Payment of periodic benefits. Compensation paid as periodic rather than lump sum reduces the adversarial nature of settling compensation entitlements.

- Education and training for case managers and medical providers.

- Providing guidelines for treatment pathways.

Scheme design and treatment pathways have been shown to influence health outcomes. For example, a whiplash study[10] conducted for the MAA found that the 1999 legislative change to the Act, designed to reduce compensation and to encourage early treatment, led to improved recovery from whiplash, with a beneficial effect on disability, pain and global recovery.

Schemes have available a vast amount of socio-demographic, treatment and outcome data available that can be mined to better understand the linkage with a view to developing a 'best practice' model.

[10] Johnson, S. Feyer, A. 'Whiplash claimants health outcomes and cost pre and post the 1999 NSW CTP legislative reforms' (paper written for the XIth Accident Compensation Seminar)

# 2 Feedback from the schemes

## 2.1 Funding approaches

This section reviews the funding approaches adopted by some of the Australasian compensation schemes, and considers some possible areas for change within the existing funding arrangements.

General characteristics of alternative funding approaches and definitions are presented in Appendix A.

### 2.1.1 Hospital funding

Hospital costs, including the services provided while a patient is in hospital, are typically 50% of the medical spend for compensation schemes. Hospitals have been identified as the area with greatest potential for efficiency gains, with a move to case-mix funding put forward as a driving force to the efficiency gains.

The *Department of Veteran Affairs* has a broadly similar spend to compensation schemes, when the latter is considered in its entirety. The DVA approach to medical services in general is to have as wide a range of providers as possible, to make access easy for veterans, with no copayments.

For public hospitals, the DVA has an arrangement with each State and Territory. Funding for inpatient services is primarily via case-mix funding, with other forms of funding for some non-acute and outpatient services.

Private hospitals are on individual contracts, with prices for tier 1 hospitals negotiated approximately every 4 years. Prices are indexed annually, with the DVA using subsections of suitable health indices as the starting point for the annual negotiations. Alternative inflation may be applied to the hospital contract where the provider can demonstrate higher cost pressures, such as particular enterprise bargaining agreements.

Most hospital services do not need prior approval. Hospitals servicing DVA patients agree not to require copayments.

*WorkCover Queensland* funds public hospital using a grant, covering all services. Private hospitals are compensated at scheduled rates.

*WorkCover NSW* funds public hospital services at the rates gazetted for non-Medicare patients by the NSW Department of Health. Private hospital services are funded at scheduled rates. Scheduled rates were increased significantly in 2006, with no planned revision to the rates. The rates are a source of contention, with some private hospitals arguing the rates are not sufficient, and one hospital considering withdrawing services. However, the Authority has not received information from the private hospitals to substantiate a pricing review.

For the *ACC*, public hospital emergency services (inpatient and outpatient) are bulk-funded. The ACC is a small player, and believes there is room for improvement in the transparency of its required contribution. Public and private hospitals are on contracts with a budget for elective surgery. For elective surgery, the ACC has a larger market share, with more influence on price. Despite the additional market power, the ACC has experienced pressure on surgery including increased coding of complex surgery cases increasing over time. Alternative arrangements for elective surgery are now being put into place.

*WorkSafe Victoria* and the *Transport Accident Commission* fund public hospitals using the WIES rates (case-mix funding), including a loading for the higher severity of accident claims. This funding arrangement is consistent with the funding of public hospitals throughout Victoria. Rates are indexed annually to a health-related CPI. Private hospitals are mostly on contracts, with scheduled rates applying. Rates are again indexed annually.

### 2.1.2 Doctor and allied health funding

Doctor and allied health services are around 30% of the medical spend for accident compensation schemes.

The *DVA* has a similar medical and allied health service spend to that of compensation schemes, where the latter are considered in its entirety. The DVA funds on a fee-for-service, using scheduled rates established in consultation with the AMA or other relevant provider association. One rate applies across Australia. The scheduled rates are then indexed in line with increases in the MBS rates.

*WorkCover NSW and Queensland* use fee-for-service, with scheduled rates indexed annually. For Queensland, medical services are generally at 90% of the AMA rates. For NSW, scheduled rates are set after consideration of the customary community rates, with an additional allowance to cover the cost of preparing injury management plans.

The *ACC* is also fee-for-service, with, in some cases, a co-payment from the claimant. Providers are either on regulated rates, or on higher contracted rates. The contracted rates impose additional obligations on the providers.

*WorkSafe Victoria* and the *Transport Accident Commission* mostly use scheduled rates, indexed annually. In 2008, the Victorian schemes began to move to network providers for some allied health services, notably for physiotherapists. Providers are funded through fee for service, or a package of care, with targets linked to KPIs and additional reporting requirements. The aim is to enable the therapists to build expertise in management of injured workers, having more of a 'whole-of-person' focus, with provider incentives aligned to scheme targets. The schemes will shortly be in a position to being considering the effectiveness of the network approach.

Most schemes allow simple treatment without prior approval up to a maximum number, with approval from the claim manager needed for further treatment.

### 2.1.3 Possible changes within the existing funding arrangements

*Compiling fee schedules and associated rules*

Scheme websites include fee schedules and associated approval rules. However it is complex to compare rates across the States, with different definitions of a provider service and different item numbers.

For example, the 1st service provided by a physiotherapist is variously described as follows:

DVA

PH10 – Initial consultation $57.55 (ex GST, 1 November 2008)

WorkCover NSW:

PTA001 – Initial consultation and treatment $72.80 (ex GST, 1 January 2009)

Means the 1st session in respect of an injury which includes

- History taking
- Physical assessment
- Diagnostic formulation
- Goal setting and planning treatment
- Treatment / service
- Clinical recording
- Communication with referrer, and
- Preparation of a management plan when indicated

WorkSafe Victoria:

PY100 –Initial consultation new patient $85.30 (ex GST, 1 July 2009)

History, examination and treatment, including Physiotherapy Management Plan to employer, Agent and medical practitioner

Transport Accident Commission:

| | |
|---|---|
| PY600R –Initial consultation | $53.50 (ex GST, 1 July 2009) |

WorkCover Queensland: $66.99 (ex GST, 1 January 2009)

100021 Initial consultation, including activities:

- History reporting
- Physical assessment
- Assessment results
- Treatment
- Communication

ACC:

Per consultation $24.48 (incl. GST)

Direct treatment includes

- Assessing and/or reviewing the claimant's injuries
- Developing a treatment plan, if this is done with the claimant
- Applying direct hands-on treatment

An Australian compilation of schedules and rules may be informative, similar to that produced by the American Workers Compensation Research Institute (WCRI).

The WCRI tabulations by state include:

- Cost containment strategies, indicating type of service where regulations or fees apply
- Fee schedules for selected services / items
- Limits on service provision
- Gatekeeper roles for treatment approval.

*Scheme partnership for negotiating fees and schedules*

Clarity around the existing fee arrangements may highlight service areas where a common set of fees and rules could apply across Australia. This is similar to the DVA approach, with Australian fee schedules. This would increase Scheme's size in the market, and may lead to administrative savings for both the Schemes and providers.

*Partnering with other funders*

Larger health insurers negotiate individually with private hospitals. Most smaller health insurers negotiate as a block. It may be possible to join with a health insurer, or for accident schemes to operate as a block, for negotiating with private hospitals.

## 2.2 Impacts of the current environment on treatment outcomes and billing practices

In the majority of cases, the current environment is dominated by the fee-for-service model. Of necessity, a large amount of trust is placed in medical providers. There is trust in the competency of providers in providing appropriate treatment, and trust in the honesty of providers in billing appropriately. The trust extends to the clinical governance systems in which providers operate.

*Impacts on treatment*

**Fee for service** rewards clinicians for activity, rather than outcomes. Thus there is the incentive to maximize income by maximizing activity. Possible impacts on treatment include:

- Providing care beyond what is needed

The risk of GPs over-servicing is regarded as low. There is a shortage of GPs across Australia, and therefore most GPs have a sufficient volume of work with little incentive to increase service levels.

Over-servicing can be more of a risk with allied health.

To ensure care is appropriate and reasonable, Schemes may make use of clinical guidelines, albeit few are available, or, alternatively, clinical frameworks.

Where guidelines apply, treatment is then available up to the guideline level, with additional services requiring pre-approval. Whilst it will then be up to the case manager to consider the appropriateness of further treatment, the case-by-case control should be followed up with Scheme-wide monitoring of treatment levels. Research indicates adherence is low[11].

Guidelines can be purchased, or developed. Schemes have training available for GPs on both the administrative and the clinical side. WorkCover NSW, for example, has training modules conducted in partnership with Sydney University

The ACC cited an example of the number of physiotherapy treatments extending beyond the guidelines on the introduction of new contracts in 2005, which removed co-payments for claimants.

An alternative is to approve treatment that is reasonably necessary, with providers required to demonstrate the outcome to be achieved from the intervention. Rather than guidelines, *WorkSafe* use Clinical Frameworks for best practice. This avoids the continual updates needed for clinical guidelines.

- Applying experimental and new technologies to compensated patients

  A number of Schemes perceive a tendency for clinicians to explore new technologies where a 3rd party funder is available. Some examples mentioned included prosthetic disc replacement, computerized leg, and implantable pain therapy on long-term back strain claims.

- Providing top of the line products eg titanium knee replacements, and top-of-range hearing aids. The problem is exacerbated by drug and prosthetic manufacturers targeting providers with product incentives.

- Incentive for cream-skimming i.e. serving more profitable patients in preference to less profitable patients

- Compensable patients jump the public hospital waiting lists.

*Impacts on billing practices*

Fee for service also raises the possibility of opportunistic billing[12]

The Victorian Ombudsman report cited many inappropriate billing practices, particularly relating to surgery. These included:

[11] Buchbinder, R. Stables, M. Jolley, D. 'Doctors With a Special Interest in Back Pain Have Poorer Knowledge About How to Treat Back Pain'

[12] *Victorian Ombudsman*, 2009, 'An investigation into the Transport Accident Commission's and the Victorian WorkCover Authority's administrative processes for medical practitioner billing'

- Breaches of MBS rules, relating to after-care, complete treatment, step-down rates and using mutually-exclusive items
- Multiple accounts for the same service on the same day
- Billing for services not provided.

Following the Ombudsman's report, the Victorian Schemes initiated a comprehensive program of work; including focused compliance audits of surgical billing practices and the introduction of billing controls at a system and claims level. This program of reviews has now extended to encompass all medical (radiology, pathology etc) and all allied health providers.

In the early 2000s, *WorkSafe* experienced large cost increase in pharmaceuticals. In 2003, new invoicing and mark up rules were put in place resulting in significant liability release. These changes have been progressively complemented through the introduction of IT system capability to ensure appropriate review of pharmacy items on an item by item basis and a focus on appropriate prescribing and dispensing under the PBS.

Other Schemes mentioned problems with the use of after-care, with increased coding of treatment as after-care.

## 2.3 Controls used to help manage medical costs

*Monitoring treatment and billing under fee for service arrangements*

This will be data intensive, with thousands of providers and hundreds of services.

Data is required at a transactional level. This hasn't necessarily been available in the past. For example, *WorkCover NSW* updated its data repository in 2006, moving to individual transactional level data. For schemes with a reasonable history of transactional-level data, tracking intervention outcomes is feasible.

With detailed transactional level data, monitoring can be performed as follows:

- Tracking billing
    - For consistency with MBS rules
    - Schemes have own fee schedules, so tracking programs not readily transferable between Schemes
- Monitoring and benchmarking
    - Average number of episodes of care
    - Frequency, amount, type of service by specialty
    - Trends in type of service
    - Comparisons between claim managers
    - Comparisons of care and after-care by providers
- Outlier investigations
    - At both a claim level and a provider level.
    - Cluster analysis of providers involved with outlier claims. Links between providers, which can drive outlier behaviour, become evident.

- Schemes mentioned a variety of focus areas, including hand surgery, shoulder surgery, knee surgery, radiology, pathology and anesthetic services. Surgery and related costs such as MRI were mentioned as a problem by a few schemes, with both an increase in frequency and cost per item. A trend in repeat surgeries was also noted.

- Requires in-house investigation of outliers

    - Investigating surgery outliers involves collecting theatre reports, employing theatre nurses to review the notes, and review advice from external surgeons. Even with expert advice, investigation is difficult without access to patient.

    - *WorkSafe* have an internal clinical panel to peer review allied health providers, with in-house physiotherapists, chiropractors, osteopaths and psychologists. The review process is continual, with approaximately 3000 cases pa are reviewed inline with the Clinical Framework for the Delivery of Health Services. The review process has assisted in turning around 10%+ pa growth in allied health.

- Quality review of file notes. With the aid of clinical panels, provider case notes may be reviewed as a check on quality of service.

- Monitoring trends and investigating outliers is a continual process. One scheme mentioned that reducing the reviews and follow-up discussions with providers reduces the tension in the market. Providers quickly recognize diminishing presence of the activity, and quickly revert back to old practices which can lead to increased costs.

- Opportunity for Schemes to share learnings from benchmarking / outliers

*Use of treatment guidelines*

Schemes have sourced / developed treatment guidelines. Whilst the appropriateness of guidelines in individual cases remains a matter for the professional judgment of a treating doctor, with prior approval generally needed from the claim manager for additional treatment, it is reasonable to monitor service levels compared with treatment guidelines at a Scheme level.

Similarly, one Scheme noted a trend towards referrals from one specialty to another, overriding the role of the claim manager.

*Use of medical panels*

Some Schemes have Independent Medical Experts (IMEs)which can be used to mediate between the treating doctor and the claims manger where the appropriateness of treatment is under question. Other Schemes are moving away from the use of IMEs, as these are seen as harmful to the Scheme's relationship with the treating doctor.

*Use of contracts*

In the ACC, most rehabilitation services and some treatments are purchased under contract. Fees for treatment are at a higher rate than the regulated rate. In return, the provider commits to additional quality standards, and in some cases, is incentivized under the contracts.

*Use of co-payments*

This can be explicit, as occurs with some ACC medical services, or implicit, where a claimant elects to use the services of a provider whose fees exceed the scheduled rates.

Co-payments act to limit treatments.

*Driving improved compliance*

Pursuing fraud is a last resort for Schemes. Legally, fraud is difficult to prove. Legislatively, it is also difficult for Schemes to prevent medical providers from providing services, even where investigation may indicate over-servicing or questionable billing. Over-servicing remains a grey area. Schemes are starting to ask for refunds in a few cases, where billing cannot be supported by appropriate paperwork.

The alternative then is for Schemes to work with the specialties to educate and persuade as a follow-up from monitoring and benchmarking. There is a long lead time to changing the relationship with the providers, and, ultimately the provider performance. Schemes will also challenge particular providers where servicing appears excessive, with the aim of reforming individual provider behaviour.

*Outcome fee overlay*

In practice, Schemes regard demonstrating improved outcomes at a provider level is difficult. Outcome fees are not regarded as achievable.

## 2.4 Wider system issues

*Relationship between scheme, provider and claimant*

A compensation environment can be disempowering for the claimant and the provider.

For the claimant, the treating doctor is generally the gatekeeper to medical and allied health services, with additional controls on reasonable treatment imposed by the scheme. Thus the claimant loses some ability to pick and choose the preferred treatment option. Some other Schemes have extended the gatekeeper role, for example, the ACC also uses physiotherapists, and other overseas examples exist.

Being in a compensation environment may also influence claimant expectations. For example, some soft tissue injuries will continue to cause pain for many years. Having a funder of medical treatment available can lead to increasingly radical surgical options being pursued.

Schemes are looking at ways to better manage claimant expectations, and to improve outcomes. The DVA introduced a discharge planning program in late 2007, with increased remuneration available to hospitals that could demonstrate improved clinical outcomes. Chronic disease management is an area also being pursued by private health insurers, with Medibank's recent purchase of AHM and merger with HAS assisting Medibank to build its health management capabilities. There may be an opportunity for partnership with a private health insurer to further build schemes' outcome capabilities.

For the provider, compensation introduces a third party into the patient / provider relationship. The relationship between the provider and the scheme is often one of tolerance at best, mistrust at worst.

Providers may be reluctant participants in the compensation system, with treatment reports being filled out with little enthusiasm. Alternatively, providers may see themselves as patient advocates, viewing their role as one of defending the patient's interests in a battle against the scheme.

This seems less of a problem in ACC NZ, due to a single scheme with universal no fault coverage.

*Injury versus wear-and-tear*

For long-term injuries, it can be difficult to differentiate between work-related and age-related aspects of the injury. Commonly, this includes arthritic conditions in workers' schemes, and decreased brain function in transport accident schemes. To secure funding, the provider and the claimant have an incentive to classify the injury as being work-related. Provisional liability may exacerbate the tendency for wear-and-tear type injuries to be paid for by the compensations scheme.

*Electronic efficiencies*

The ACC NZ has electronic forms, reducing the paperwork burden for providers and claimants, increasing timeliness of payment, and providing the opportunity for early intervention.

For some other schemes, there is much more double-handling. The medical bill can be paid by the claimant, with paperwork submitted to the agent for reimbursement. This compares with private health insurers, which have electronic claiming direct from the providers for many services. Is there an opportunity to link in to existing capabilities to enable electronic claiming for the schemes?

*Agent risk*

Using multiple agents to manage claims spreads specialist knowledge too thinly.

A number of schemes mentioned the possibility of moving to specialized managers for high severity claims. As a portion of medical spend, catastrophically injured are perhaps 5-10% of the total cost, and a larger portion of the outstanding claims. Fair and reasonable management of the catastrophically injured claimants is an important social obligation for schemes. The aim of using specialized managers was to improve care, rather than for cost control per se.

*WorkSafe Victoria* outsourced the management of catastrophic claims to the *TAC* from 2007. Early experience has been, for some claims, an increase in costs probably reflecting poor management in the past. The higher initial costs are seen more as one-off, as expenditure on neglected home modifications and the like occurs. WorkSafe have reported increased satisfaction from claimants and their families following from claim management changes.

*Fragmented system*

Most provider associations operate nationally over Australasia. Where possible, use of a standard set of schedules and requirements would simplify arrangements, particularly where schedules can be aligned with MBS codes. Similarly, is there a possibility of scheme-wide contracts with private hospitals?

## Appendix A. Funding alternatives

There are multiple available funding approaches, each with their own inherent advantages and disadvantages, as summarized below[13]:

| | Cost control | Administrative simplicity | Ability to use incentives for: | | | | Specific attributes |
|---|---|---|---|---|---|---|---|
| | | | Efficiency | Product-ivity | Quality | Patient Satisfaction | |
| Salary (for GP's and physicians) | Yes | Yes | No | No | No | No | Physicians unable to avoid more complex patients |
| Capitation | Yes | Yes | Yes | No | No | No | Could encourage underutilization of care |
| Case payment (DRG) | No | No | Yes | Yes | No | No | May encourage admissions, early discharge |
| Fee for service | No | No | Yes | Yes | No | No | May encourage unnecessary services |
| Budget | Yes | Yes | No | No | No | No | Dependable source of funding, but incentive is to spend full budget |
| Pay for performance | No | No | Yes | No | Yes | Yes | Incentives can be misaligned if they become too complex |
| Day rates, per diems (for hospitals) | No | Yes | No | No | No | No | Encourages admissions and length of stay |
| Fees | No | No | Yes | Yes | No | No | May encourage unnecessary capital investment |

[13] *PricewaterhouseCoopers' Health Research Institute,* 'You get what you pay for'

Definitions:

| | |
|---|---|
| Capitation | Fixed amount of money paid to providers per registered enrollee for a period of time. |
| Case payment | Fixed amount of money paid to providers for care given to a patient related to service provided per inpatient visit. An example of a case payment is diagnosis-related groups (DRGs) |
| Fee for service | Amount of money paid to providers for each service |
| Pay for Performance | Payments to providers for meeting agreed upon quality and efficiency targets |