This 'Ideas Piece' was originally one chapter of 'A Blueprint to Advance Australia Collectively' originally written in 1999 to 2000 and released publicly in January 2001. It has not been adapted or updated from the original. The 'Ideas Piece' format is designed to help generate discussion around areas of social interest.

The Hospital System

What an issue to tackle what with an aging population, longer life expectancy and greater demand for quality of life.

There have been many attempts at revamping our health institutions. Unfortunately almost all of them have taken the same approach but from differing angles. We've decided to take a 2 pronged approach to the challenge.

The Public System

The common theme that governments and business have taken when assessing the way to improve our health system is one of funding the public hospital system and keeping up to date with the ever increasing demand being placed upon it. In other words, it's a fiscal approach.

As this idea poses, tackling the issue from a fiscal approach alone can NEVER address the issue of how we maintain access and quality for all. The Private Health funds are not helping as they too are coming at the problem from an unworkable angle.

So for consideration, please assess this concept –

- ✓ Everyone should be able to access the Public Hospital System at no charge at least some of the time, and know that the quality of that access is high.

- ✓ People and businesses within the industry also have a right to earn a living from the system, even though it is a publicly funded operation.

So how do we address this paradox of funding and quality of access?

Well the key word that most people so far are failing to address is the word 'ACCESS'. The debate over funding should revolve around access first and then address the issue of funding.

What we have seen with the push to private medical insurance is that now we have 2 hospital waiting lists – one in the Public System and a new one in the Private system.

By shifting attention to the Private System what we now have is a group of consumers who are demanding value for their investment. Where as before they may have put off the niggling shoulder, hip or knee, now they are demanding their 'fix'.

Chaos has ensued. Part of the problem is the perception of a sheer lack of value that people get from having Health Insurance. (That will be addressed in the second component of this concept).

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To tackle the problem of access (the volume of which determines the demand for funding) we need to shift our perception of **worthwhile** usage of the system.

By beginning to address the expectations that each person has with regards to how they use the health system, we have a greater chance of establishing habits that reward health, rather than habits that encourage sickness.

The need to address these expectations comes down to ACCESS to the system. By highlighting the way people use the system and changing their expectations of usage, we make available to the country, an opportunity to relieve the pressure the system is being placed under by lower government funding and higher public demands.

Approach

At the start of the year, as part of the Medicare set up, each person will be given say, 5 free days in the public hospital system. Permanent residents arriving later in the year will receive a pro-rata rate. Permanent residents will also receive 3 days even if travelling overseas, but not if working full time overseas. These days will accrue annually.

After someone has used all of their assigned days, the individual will need to fund the remainder of their stay them selves.

People will also receive say, 6 annual visits to a GP (funded as part of the current Medicare arrangements). Again these days would accrue annually so that people could begin to stockpile for a later stage. After someone has used their visits they'd need to pay for their next visit. This would also apply to anyone without a Medicare card, or unable to produce one.

It is likely that the fee to be charged will be slightly higher than current established rates. For the most part, GP's deserve a raise, though as part of this agreement I'd like to see each new GP spending a couple of years in country zones. Not necessarily full time but certainly 5 days a fortnight. This would begin to improve access for people in regional areas to medical attention.

It is essential that we build in some flexibility to the model.

1. People would be entitled to transfer their days to another person or entity, as they desire.

2. People would also be entitled to sell days that they have accrued.

To stop people jumping from GP to GP in an attempt to access more days, each Medicare card would become a swipe card linked to a central database. All that would be recorded would be the card number, and the number of days available on that card. Each practice would enter card details into a computer that tells the GP how many days are available to the cardholder. To be able to issue a bill, the doctor would need to record the visit in the database and that adjusts the number of available days.

So what we have designed is a model that provides people with something for the taxes they pay and educates them as to both the value AND the costs associated with using the system. It also rewards people for staying out of the hospital system (either through luck or fitness). The ability to transfer days

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accrued also enables people to say donate a day or two to a social welfare organisation for them to assist others, or to assist a family member.

Accruing days also helps cater for people who anticipate lifestyle changes that may require hospitalisation at a later stage. It is likely that these days could be bequeathed.

Because the days can also be sold, we establish a health-based commodity that would enable people to profit from their health.

This concept attempts to shift our focus from sickness to health, still enables social benefits and financial reward and also begins to recognise those people who through their choice of a healthier lifestyle and living, take the pressure off the Public Health system.

The next concept builds on the potential likely to develop out of adjusting the paradigm that currently exists within the Private system.

Private Health Funds

This will become one of the biggest issues in the coming years if we do not begin to address the way we approach access to our Public system.

We have an aging population demanding greater access to medical facilities in order to maintain a quality standard of lifestyle.

We have a political environment aware of the burden of funding public hospital access.

In the past year, the Federal government has spent half a billion dollars in an attempt to 're-educate' the population and wean them off the publicly funded health system. Arguably, the education process hasn't worked. So what we have now is a taxpayer funded public hospital system with an extensive waiting list AND a taxpayer funded Private Health System, that now also has begun to develop its own waiting list.

Does that make sense to you?

The challenge is two fold.

Firstly - the expense of supporting a public hospital system catering to an aging population is increasing at a rate significant enough that it is starting to impact on other areas of society.

Second - The Health Insurance Companies who have been given a taxpayer-funded windfall, suffer a severe perception problem. They appear to provide very little benefit for the perception-based 'exorbitant' fees they charge.

In fact, their efforts to date have been so poor, that the only way they can increase their numbers is through the Federal Government taking financial action. It is not the job of the Federal Government to prop up poor performing businesses.

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We have arguably achieved 'World's Best Practice' in public health care. Interesting that for the best part of 2 decades the Australian worker has been urged to aim for 'World's Best Practice' standards and yet, having achieved it in the area of Public Healthcare, governments realised that the expense involved was going to be a bitter pill for the taxpayer to swallow.

The taxpayer will also soon realise (if we haven't already done so) that propping up private health funds at the expense of public systems is an even more bitter pill, and far less to our liking.

The onus of responsibility to improve rests with the Health Funds. It is they who need to improve the way they do business. They are the ones with a public perception of 'poor value' and only an enforced bribe has seen an increase in members.

So if you were a business that wanted to win more customers, what could you do to attract them?

If your business also carried an increased risk with every new customer attracted, how could you also LOWER that risk?

The solution could be surprisingly simple.

For any business that wants to attract more clientele, there are usually 2 choices -

- Lower your prices so that the value of what you offer is perceived to be higher
- Add additional products or services to your current structure so that the perceived value automatically increases.

The second option is a far more intelligent one because it allows you to maintain and even increase the cost to the consumer of what you provide, whilst maintaining and increasing the perceived value.

Not rocket science is it?

Now note that in the case of Health Funds, for every client they add, they also increase their potential risk even if fractionally. So here is a possible solution and one that requires a mid to long term view by the Health Insurance Companies.

To get over any hurdle existing due to short term focus (providing profits for shareholders) we'd extend any government subsidy of Private Health Companies for a further 3 months.

That puts us back into the position of having the Private Health System being an additional drain on the taxpayer. That can't continue.

Next we focus on lowering the risk that Health Insurance Companies face. Their fear of risk (and so lower profits) is the main reason they suffer from the image problem they do.

Instead of increasing the range of services and products they offer and thereby increasing the value to the consumer, they have shaved, deleted and lowered the areas they are prepared to 'insure'. They negotiate with Private Hospital networks and service providers over what services will be insured, what won't be insured and how much the insurance company will pay the provider for each service rendered.

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The Private Hospitals fall into the trap of shortening hospital stays to avoid the financial penalty and so render a lower quality of service to the consumer. The end result is that Insurance Companies are perceived as charging huge fees for absolutely NO value.

In order to lower the risk, Health Companies need to build a customer base with customers who have lower chances of requiring medical attention. In other words, the fitter and healthier, the better.

I am not talking about the current 'behind closed doors' push by Insurance Companies to gain access to genetic tests so that they can determine which diseases you are likely to get in later life, so that they can DENY insurance for that specific area.

In order to LOWER the risk we actually have to INCREASE the services that Private Health companies provide. That's right, it is only through increasing the range of services provided, that Health Insurance Companies (and thereby the private health network) can LOWER the risk they carry through insuring a customer.

The approach that most Health Insurance companies have used to date is a Fiscal model - to make money they cut costs and to cut costs they refuse to insure.

The model they need to use is a 'Health' model. Legally they cannot selectively choose the lower risk customers. But they can CREATE a lower risk customer from within the customer base they already have, by improving the HEALTH of that customer.

I find it fascinating to think that for an industry whose name incorporates the word 'health' they spend so much time focusing on sickness.

Health Insurance companies are stuck in the western world paradigm - you pay a doctor because you are sick. In places like China, when you are sick the doctor **doesn't** get paid! They only get paid when you are fit and healthy. It's the role of the doctor to keep you healthy, and it's this approach that Health Insurance Companies should take.

They have to begin taking on responsibility for *health*, and less for sickness.

So in order to enhance services (thereby increasing perceived value) whilst lowering the risk (thereby reducing costs) we need to make a few changes.

With your health insurance premium you could get the following -

1. FULL Health coverage, none of this 'gap' stuff. That is a doctor/insurer problem
2. Free Gym membership or a combination of alternative options like massage, chiropractic, stress management etc.
3. Subsidised access to healthy foods
4. Full annual check ups - bloods, cholesterol etc.

Now in order to qualify for FULL benefits as a member, you MUST attend a gym or undertake an exercise program say twice a week minimum. Your bar coded health membership card records what time and day you attended and what time you leave. You'd also have twice yearly fitness tests to keep you on track.

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The result is an increase in the health of members and a lower risk of needing medical attention.

If as a Private Patient, it turns out that you need a procedure, the Health Insurer pulls up your exercise history and establishes whether or not you have been 'looking after yourself'. If it turns out that you have been lax, then your premium or excess for the procedure is increased because YOU have chosen to increase the risk to the insurer. There is more chance that your stay in hospital will be longer, a bigger possibility of infections and post operative complications and the potential financial cost is greater.

So in this instance, you'd pay more through an excess fee.

On the other hand, if you'd been doing all of the smart things, exercising and the like, then you would not pay any excess for the procedure and have a lower cost policy because you have taken the steps to lower your risk to the Health Insurance company. It works both ways.

The combination of a health check up, exercise program and better living benefits the consumer and the Insurer wins through gaining a lower risk customer more likely to enable the Insurer to appease shareholders profit motives.

Society benefits because the increased value provided by Health Insurance Companies attracts a substantial number of new clients easing the burden on the taxpayer in funding the Public system, and importantly those who end up in the public system are the ones who really need it.

Unfortunately for the 19 million or so winners in this process, there'd be a few losers who, with profits at risk, will fight hard to prevent this idea getting off the ground.

The poorer our health, the greater the profit that pharmaceutical companies make. They have a vested interest in keeping us ill and a healthier Australia would make profits harder to come by. Prepare for a fight.

So the question - which of the Health Insurance companies has the courage to be first and begin offering a healthy lifestyle option, rather than an illness option?

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