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CORPORATISATION OF MEDICINE

- Managed, bundled, corporatised care
- Corporatisation of medicine: an Australian perspective
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- Bundled obstetrics care – throwing the baby out with the bathwater?

ASA
Australian Society of Anaesthetists

FEATURE

MANAGED, BUNDLED, CORPORATISED CARE – A ROSE BY ANY OTHER NAME?

If 2020 taught us anything it's that we have strength in numbers when it comes to advocacy and how healthcare workers coming together, across specialties, can have the strongest voices. As we head into 2021 there is a new threat on the horizon requiring another active alliance.

Over the past year 'under the cover of COVID' is how many practitioners have described the way in which the private health insurance industry has tried to introduce a new US-style system into Australia. While we were all busy in the face of a global pandemic, another menace to patient care and safety was looming. Insurers have tried without success for a number of years to bring managed care Down Under but in 2020 we started to hear of concrete initiatives. Many Australian anaesthetists were contacted by health insurers and hospital operators regarding bundled care service proposals.

Should we be worried?

Yes. Very much so.

This edition of *Australian Anaesthetist* contains a number of articles on what this will mean for our specialty and in particular for patients. These features will help explain why the ASA is determined to build a strong coalition against corporatised care.

Anaesthetists are in a unique position of working across many surgical specialties. We are well placed to reach 'across the drapes' and start having conversations with our colleagues about an issue that they may not fully appreciate. The role the ASA and our members now play will have enormous impact on the next generation of anaesthetists, so it is particularly important for our trainee members to also be part of this conversation. They need to understand the impact this could have on their future careers.

Over the past year 'under the cover of COVID' is how many practitioners have described the way in which the private health insurance industry has tried to introduce a new US-style system into Australia.

Our current fee-for-service healthcare system rewards patient contact and puts the patient's best interest first. Moving away from this and down the path of a US-style system could bring a frightening new reality of all the responsibility, risk and cost borne by individual practitioners. It would see the transfer of risk away from the health insurer to the health provider while at the same time transferring control away from the provider to the insurer.

With a strong and united voice, Australian doctors can help ensure that standards are not allowed to decline under managed care.

This would be a world where decision making is not based on patient care, there are no item numbers for post-operative care, and you can only work or refer 'in network' with preferred providers who follow an insurer's referral and billing practices. It will be the end of independent solo practicing specialists. Such models are a threat to the central place of the doctor-patient relationship as the foundation of medical care. They pose a real risk if clinical decisions are based on profitability. All the alarming American stories we have been hearing for so many years could soon be ours.

WARNING FOR ASA MEMBERS

We urge members to consider the following when evaluating bundled care proposals:

- Freedom of patients to choose their doctors.
- Freedom of doctors to refer to colleagues on the basis of clinical judgement, without external interference.
- Freedom of doctors to provide care to patients without external restrictions.
- Remuneration based on the Relative Value Guide (RVG), free from arbitrary and non-indexed inventions such as 'uplift fees'
- Freedom to opt-out without penalty

Don't hesitate to get in touch if you are approached with a proposal so we can help address your questions and concerns. Visit the ASA website for more information or join the discussion on the ASA Forum.

Australia has an enviable healthcare system. We have universal healthcare and patient options. We must protect it. Presenting a united medical workforce on this issue will make all the difference in ensuring healthcare is decided between a patient and their chosen provider without interference from their insurer.

The ASA is already working closely with the Australian Medical Association (AMA), the Council of Procedural Specialists (COPS), health insurers, hospital operators and consumer advocates to raise our concerns. With a strong and united voice, Australian doctors can help ensure that standards are not allowed to decline under managed care.

In November last year we hosted a webinar on the corporatisation of medicine and this obviously hit a nerve with many ASA members – it was the most popular event outside of our respiratory protection webinars. Despite the 'cover of COVID' it was clear anaesthetists were starting to see the threat posed by US-style managed care and the presentations on the US lessons were certainly 'sobering' as many commented.

Additional webinars on this topic will be promoted to members in early 2021 and we encourage you to learn more about what the future could look like if we don't act now. Knowledge and information will be your new personal protective equipment this year.

FEATURE

CORPORATISATION OF MEDICINE: AN AUSTRALIAN PERSPECTIVE

Like all industries, the healthcare sector is constantly evolving. However, recent initiatives in private health funding could rapidly take our industry down a path to diminished autonomy for doctors and reduced choice for patients. Even those driving this process could ultimately suffer from the fundamental changes it will bring about.

It's not too late to stop this process. Australia's healthcare system can maintain its standing as a world leader.[1]

The healthcare industry collectively must take stock of the strengths and weaknesses of our system. By identifying attributes essential to the success of Australian healthcare, reforms can be made without sacrificing the quality of care provided to patients.

Anaesthetists have more to offer in this process than many groups. We also have much to lose if the system spirals downward due to ill-considered changes.

WHAT IS CHANGING?

Health insurance companies are seeking to expand their role. Traditionally, these companies existed to assist members meet the expenses associated with hospital treatment. In this system, treatment is directed by doctors who are independent from both the insurer and the hospital where treatment is administered. Similarly, hospitals are autonomous entities operating independently from doctors and insurers.

By engaging in bundled care, preferred provider agreements and hospital ownership, health insurers are attempting to take control of the entire process of healthcare provision.

In the background, the ownership of private health insurers has undergone a fundamental restructure in recent years. Until the early 2000s, health insurance was the domain of not-for-profit organisations and the Commonwealth Government. Today's largest insurers are listed companies with a duty to earn money for their shareholders. The majority of Australian health insurance policies are provided by such firms.[2]

WHAT IS BEHIND THE CHANGES?

Health insurers desire greater control to contain costs.

While this sounds sensible and even

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laudable, there is danger inherent in one group possessing complete control of any industry.

THREE PILLARS OF PRIVATE HEALTHCARE

Power within the current system is shared by three influential groups:

- Doctors who bring patients to hospitals.
- Hospitals in which health fund members receive care.
- Health Insurers who assist policy holders to pay for their treatment.

In a system controlled by insurers, patients would be directed to preferred providers, who in turn would care for patients in designated facilities.

HEALTH INSURANCE FUNDING VS HEALTHCARE INDUSTRY STRUCTURE

When questioned about their motivation for these changes, health insurers cite a crisis in healthcare funding. They point to premium rises and out-of-pocket costs turning patients away from private health insurance. The solution, they say, is for them to provide bundled care and take over funding of the entire healthcare experience, providing certainty and containing costs.

This strategy rests upon several dubious assumptions, and has demonstrably failed in the United States. Furthermore, this line of reasoning disingenuously marries the issues of health insurance funding and industry structure.

Nobody would assert that our current health insurance funding formula is perfect. Community rating, where individual patients' premiums are equal regardless of health status, places pressure on funding. Stories of patients purchasing insurance shortly before receiving expensive care underline the challenges of balancing access with sustainability. Compounding this issue is the ever-increasing demand for ever-more expensive medical tests and therapies.

However, to suggest that health insurance funding problems can be addressed by handing unchecked industry power to health insurers is illogical and unwise.

A RACE TO THE BOTTOM?

The whole private healthcare sector is threatened by this ill-conceived strategy, not least the insurers themselves.

Australian patients have access to a world-class free public hospital system. Why then do people pay substantial premiums and out-of-pocket costs to obtain private health care?

Three factors account for the popularity of private healthcare in Australia:

- Choice
- Access
- Quality

Each of these attributes is threatened in an insurer-controlled system.

Patient and doctor choice will be the first casualty. Rather than referring to a trusted colleague or to one requested by the patient, general practitioners will need to check their patient's insurance before referring to a preferred provider for specialised care. Referrals outside these arrangements will likely attract less favourable rebates.

Access to care will also depend on the insurer, again obliging doctors to check their patient's eligibility for the recommended treatment.

Following the deterioration of choice and access, quality too is in the hands of health insurers under a bundled model. Reassurances about preservation of doctors' autonomy are hollow when the choice of specialist, hospital and treatment are subject to approval by an insurer holding all of the power.

Without three truly independent pillars, our system risks losing the very qualities to which patients are attracted.

TIT-FOR-TAT BUNDLING

Hospital operators will feel pressure to follow the insurers' lead, against their better judgement. Of course they would prefer to retain their independence but faced with insurers who can direct vital revenue to competitors, they will feel obliged to respond.

It is conceivable that hospital operators will assemble their own stables of preferred providers in order to tender for work in bulk. Arthroplasty and obstetric care will be the first to go down this path.

Hospital operators will feel pressure to follow the insurers' lead, against their better judgement.

WHAT DOES THIS MEAN FOR ANAESTHETISTS?

Health insurers are not able to affect all of the above changes at once. Opening moves have been focused on bundled care in obstetrics and arthroplasty. Individual doctors have been sounded out about no-gap arrangements where an 'uplift fee' is paid in return for signing up as a preferred provider. Although total remuneration would be considered satisfactory by most, acceptance of these offers is the first step in surrendering control to insurers.

LOOK FORWARD TEN YEARS

Australian anaesthetists enjoy the freedom to work as they choose. You may pursue full-time private practice, a mixture of public and private sessions, or a salaried public position with occasional private cases. Our fee-for-service payment model efficiently compensates you for the service

In order to avoid passively handing over control of Australia's private healthcare system, the whole industry needs to decide what is essential to preserve our excellent standards, and what is open for modification.

you provide. You are free to choose your surgeons and the hospitals in which you work.

The administrative burden on anaesthetists is modest. It is possible for a sole practitioner with a light workload to undertake his or her own office duties. Even large group practices are usually collections of individuals with unique practices and fees, simply sharing rooms and staff.

If health insurers are successful in their attempt to control our industry things will be very different. Practice administration will be more complicated as the universal structure of the Relative Value Guide (RVG) gives way to insurer-specific remuneration schedules.

The very nature of private practice will inevitably evolve to meet new challenges. Like the hospitals, doctors will find it necessary to bargain collectively for bulk work. The notion of being invited by a surgeon to do a regular list together will become antiquated as logistics are worked out at a group practice or hospital level, leaving little room for individuals. It is likely that most anaesthetists will be quasi-employees of large group practices, or actual employees of hospitals.

ANAESTHETISTS LEADING THE CONVERSATION

Why must anaesthetists become involved in this debate? What influence do we have?

Anaesthetists make up the largest group of hospital-based specialists, numbering over 5,600.[3] We also enjoy strong professional representation, with roughly half of ANZCA fellows choosing ASA membership. We are vital to the daily operation of hospitals and we have strong relationships with other key stakeholders including surgeons of all disciplines, procedural physicians and hospital administrators. We are ideally placed to have a strong voice in the conversation about the future of hospital care in Australia.

BIG QUESTIONS

Anaesthetists and other groups must use their voice to ask important questions about the nature of health insurance:

- How important is the doctor-patient relationship in private healthcare?
- Is it acceptable for insurers to pay vastly different rebates for identical services based on restrictive preferred provider agreements?
- Who decides what treatment is offered to patients?
- Who decides where patients receive treatment?

THE NEXT STEPS

In order to avoid passively handing over control of Australia's private healthcare system, the whole industry needs to decide what is essential to preserve our excellent standards, and what is open for modification.

The ASA is already working with medical associations, hospital operators and consumer advocates on this issue. If consensus can be found then a unified approach to the government can be made. In the short term a moratorium on further health insurance expansion would be helpful to facilitate a calm and thorough examination of the issues outlined above.

With a co-operative approach, Australian patients and doctors will continue to enjoy our world-class system.

Peter Waterhouse
Chair, Professional Issues Advisory Committee

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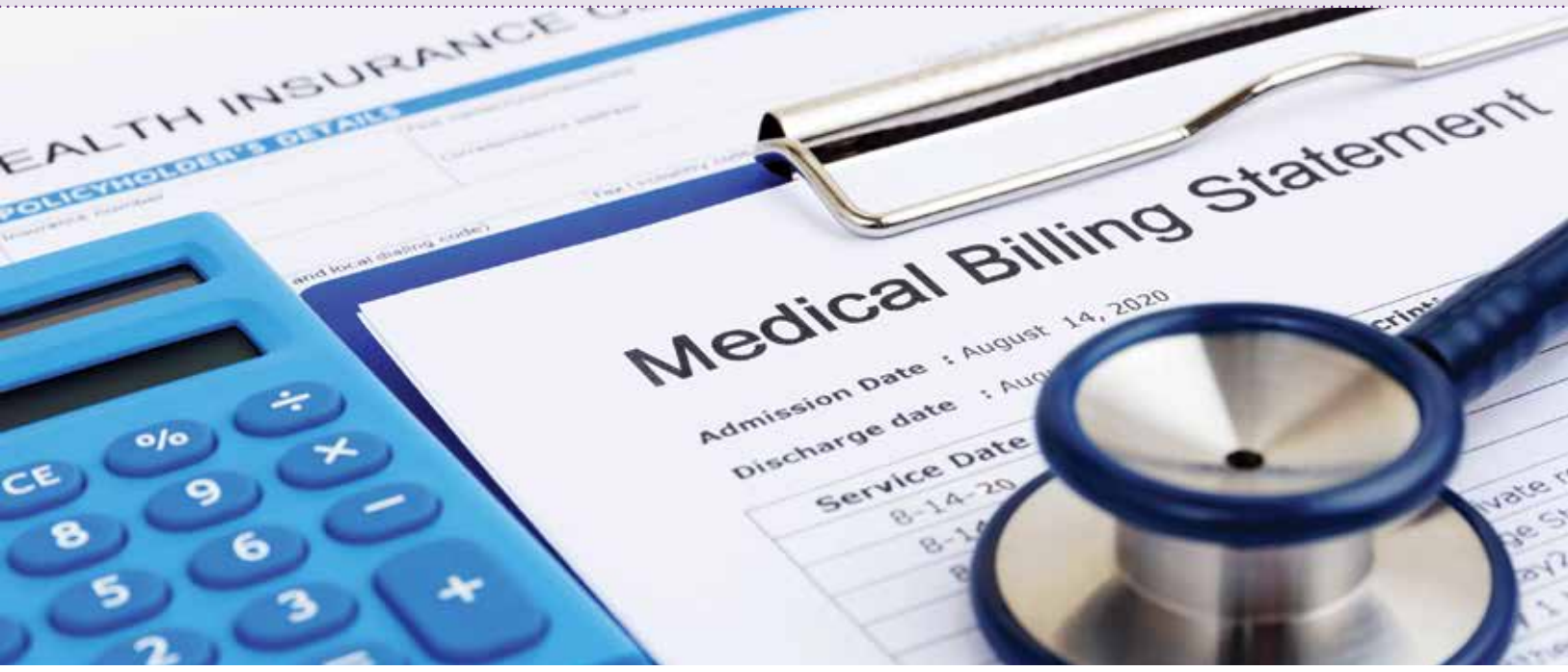

THE US EXPERIENCE AND LESSONS FOR AUSTRALIA

"These may not stop the slow-moving train but at least you'll know what's happening when it hits you". New York based Dr Jonathan Gal, Vice Chair of the American Society of Anesthesiologists' Committee on Economics did not mince his words during a presentation to the Australian Society's webinar on managed care late last year. He shared some valuable insights from a healthcare system that has been transformed over many years on the path to corporatisation and it's a concerning vision of what could be the future for Australia.

MORAL HAZARD

While our two healthcare systems may appear poles apart there are still striking similarities in what patients want from health insurance. The US patient priorities include:

- Choice of hospital or doctor.
- Control over visiting any specialist.
- Freedom to travel with coverage across the country.
- Flexibility to choose from different standardised plans.
- Value with help for out-of-pocket medical expenses.

To understand how the US insurers respond to this demand for choice means understanding their reliance on 'moral hazard'. Dr Gal explains insurers define this as the change in behaviour that occurs when a person becomes insured. For example, spending an extra day in the hospital or purchasing a good or service he or she would not have otherwise purchased had they not had the insurance.

"Basically, if the patient didn't have any insurance, they wouldn't actually be using it," Dr Gal said. "We see so much of that in the US. Those patients with insurance are more likely to then go for their follow-ups, go for their screens, colonoscopies or mammograms. Those without insurance wind up skipping all of that so this is part of the moral hazard insurers all lean on."

To the insurance companies the solution is to impose cost-sharing on consumers to constrain any unnecessary services. "They don't want patients just going for any check-ups or getting random services they may or may not need, and so as a result they try and impose some of the cost onto patients to try and make sure they don't take advantage. Every time you want to see your primary care provider or any sort of provider for that matter, you wind up having to pay even a little bit out of pocket each time."

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Managed care takes this one step further where insurers can sometimes deny care based on medical necessity when they believe it might be 'waste'. While this is the popular image that many Australian patients may have of US-style healthcare and can ring alarm bells for the public, there is a whole lot more at stake for healthcare providers.

Addressing the 'moral risk' of patients has seen insurers pushing more financial risk onto the providers, especially as the US healthcare system moves increasingly away from fee-for-service based systems. "There seems to be a big theme of transfer – transferring risk away from the insurer to the provider and transferring of control away from the provider to the insurer."

VOLUME TO VALUE

One of the many hats that Dr Gal wears is that of Medical Director, Clinical Revenue Initiatives for Mount Sinai Health System. From this position he has been able to closely study the large shift from volume-based healthcare to value-based healthcare causing many providers to fundamentally rethink their whole business model.

"Instead of just trying to get as many patients in the door as possible and charge a fee for service when they're here, the main drivers are now volume and efficiency. The faster you can do the cases, the more cases you can do, and the higher revenue you can earn. They'll give you money for the care, but you and the hospitals are the ones who need to try and keep the cost of the care down as much as possible. They've really shifted the risk away from themselves and onto the providers."

According to Dr Gal the shift from this fee-for-service to value-based healthcare is increasing exponentially in the US. In 2016, only about 30% of alternative payment models were based on value. In 2018, it jumped to 50%, and within the next four or five years, it is expected to be at 100% with not a single patient beneficiary not having some sort of value-based payment model associated with their care.

The fundamental restructuring of the relationship between these health plans and providers is having a major impact on the health workforce. Hospitals are increasingly becoming part of networks so they can mostly refer inside and to take care of their own population of patients. "The old model had a bunch of solo practitioners, solo smaller hospitals all by themselves, not collaborating. Shifting over to the new model where physicians are in groups, they're now in multi-specialty organisations, independent practice associations. They're joining together to try and help coordinate care much better as opposed to doing it one-by-one".

Rethinking business models from volume to value based

	Volume based	Value based
Incentives	• Share of high margin services • Optimise practice or department cost structure • Highest reimbursement rates	• Share of population managed • Optimise overall community health • Lowest total cost of care
Reimbursement	• FFS/DRGs • No payment for readmits, never events, etc.	• Outcomes & Quality based • Global payments
Organisational model	• Departmental • Specialty	• Populations • Conditions • Focused factories
Cash drivers	• Volume • Efficiency (on a procedure level)	• Quality and low variability • Population-level efficiency
Profit drivers	• Visits • Surgery / Procedures • Outpatient ancillary	• Wellness and prevention • Population management • Chronic condition management
Investments	• Capacity (in profitable services) • Revenue-producing assets • Patient referrals	• Health IT • Clinical integration • Commercialisation

BUNDLED BAIT AND SWITCH

Bundled payments are increasingly common in the US where an entire episode of care can either be related around the hospitalisation or the entire 90-day period associated with the hospitalisation. Dr Gal explained patients can come in for a surgery and any readmissions, rehab or other post-operative care they might need (at a skilled nursing facility for example) can be included in the bundled payments.

Although this plan is incentivised by volume, the insurers are taking a bait and switch approach. The example Dr Gal gives is an insurer approaching five different hospitals with 10,000 patients who are beneficiaries on their health plan. Each hospital is told they can get a 20% share and that's where the volume negotiations begin. "If you want to get more like 30% of the share of our 10,000 beneficiaries let's enter into this contract, and now 30% of our 10,000 are going to go towards you as opposed to just 20%. They'll negotiate a price, suppose it was going to be $1,000 an episode, and then say 'Okay, we're going to send you more patients, but we want to only pay you $950 per episode'."

In this scenario it is easy to see the hospital agreeing as they are going to get 1,000 more patients and will take $50 less for more in total aggregate revenue. The insurer is in a position to attract more beneficiaries with the lower-cost health plan with decreasing costs over these different bundled payment models. Then comes the catch. "Next year when we come back, we have 12,000 beneficiaries as opposed to just 10,000 because more people signed up with us as opposed to our competitor. It's how everyone increases their market share. But eventually, the margins start getting less and less. With each year they need to start keeping the premiums down and down, further and further. And so, 'Last year we paid you $950, this year we want to go $875. But you guys can do it, right? We're going to give you another 1,400 patients this time'. And so, it's a lot of that bait and switch that just keeps squeezing the margins more and more."

VALUE ADDING

Dr Gal said it is usually surgeons who often get approached by insurers because they're the attributing providers. The US experience saw the early adopters of managed care with primary care providers and some of the main specialty providers like obstetricians and orthopaedic surgeons doing some of the highest volume of care through the different insurance policies.

Those late to the table tend to be the non-attribution providers who do not initiate the episode of care like anaesthesiologists, radiologists or pathologists. When the episode of care or admission to hospital is not attributed to these providers it is essentially a cost for the insurer. And that's where margins really get squeezed.

"You need to demonstrate all those extra areas of value that you're providing for that entire episode of care, and why you deserve to be at the table for those conversations. Those value conversations at the hospital and health system level are going to be huge for every anaesthesiologist. This is when you start getting into the conversation – Okay, so for your total joints, I give you your actual anaesthesia, I give you a regional anaesthetic such as an adductor canal block so you can do physical therapy on day zero, have a length of stay of just two days, those are associated with less complications and you need to basically draw out for them all the extra value that you're providing so that all the other costs can come down."

And for all the added value that you can demonstrate, there will be the added joy of much more paperwork. Dr Gal admits under this new regime that practice administration has become rather burdensome between documentation, billing, claims, adjudications and legal paperwork. He warns Australian practitioners that any overheads they now have to take care of billing practices will probably have to triple within ten years.

"That's actually one of the highest rising costs in healthcare every year inside the US. There's a lot of just bureaucratic negotiations that you need to do. You have to enforce the contracts while you're just trying to provide quality care inside of an operating room or inside of a pain medicine suite. You're going to need to have a lot more of an administrative overhead for that."

For the Australian anaesthetists who have seen Dr Gal's presentation on the ASA webinar, these administrative overheads are probably the least of their worries.

About the presenter

Dr Jonathan Gal is an Assistant Professor in the Department of Anesthesiology, Perioperative, and Pain Medicine at the Icahn School of Medicine at Mount Sinai in New York. He is the Department's Director of Governmental and Reimbursement Affairs and also the Medical Director, Clinical Revenue Initiatives for Mount Sinai Health System in the Department of Clinical Business Intelligence & Implementation.

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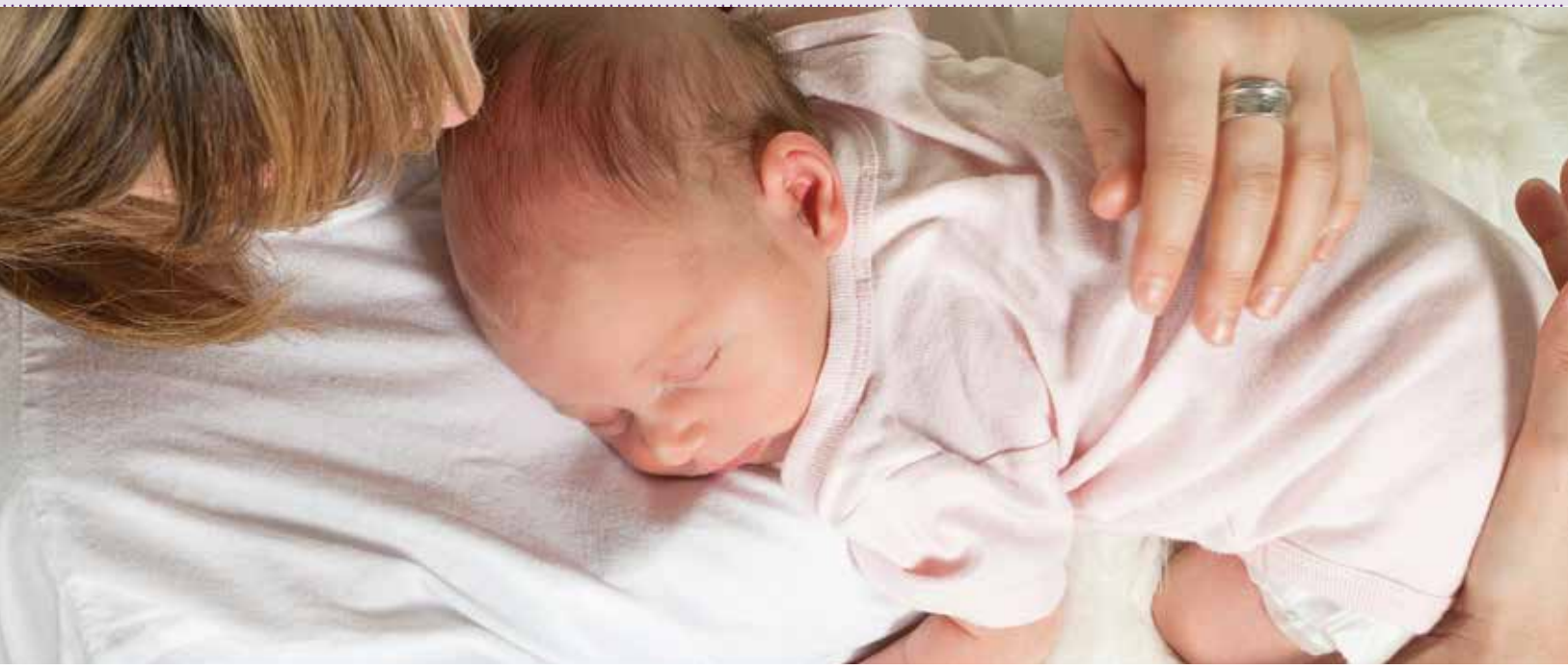

BUNDLED OBSTETRICS CARE – THROWING THE BABY OUT WITH THE BATHWATER?

Obstetricians have been the early adopters of managed care options overseas and Australian practitioners are watching closely as Sydney obstetrician Dr Andrew Zuschmann explains.

Anaesthetists work with a lot of different Medicare Benefits Schedule (MBS) item numbers as it was once explained to me by an old anaesthetist colleague who described himself as a taxi driver charging a flag fall and then a per-kilometre rate. I'm not sure what analogy would best suit the complicated billing practice of obstetricians but hope the following provides insight into our long and winding road.

Much of the complication comes from the fact that our care occurs partly in the community and partly in the hospital. In the community, we'll have the initial visits where the pregnancy is diagnosed and investigations ordered. Then there will be a number of routine antenatal appointments. Typically, this might involve eight or ten of these episodes during a pregnancy. There will also be bloods and scans, so we will be involving pathology, ultrasound and radiology colleagues, along with GP and paediatric appointments in the postnatal period as well.

Sometimes women present at the hospital during the antenatal period, which also attracts a fee-for-service. The actual birth itself will involve the obstetrician, the anaesthetist and a number of other specialties. Typically, it will also include the paediatrician who would review the baby after birth. If the woman is unwell with something like preeclampsia, she may also have an ICU admission.

OBSTETRIC ITEMS

Before the Extended Medicare Safety Net (EMSN) came into existence in 2004 simplified gap billing was common. Obstetricians would typically divide their fee over a number of visits during the pregnancy, and the patient would pay certain amounts per visit. The EMSN brought in item number 16590 for the 'Planning and Management of a Pregnancy' and this was basically to capture the gap payment that occurred in the community setting.

Initially, it was suggested this be split into the gap attributed to the antenatal and birth components so a typical pregnancy billing would look like:

- 16401 for an initial attendance;
- 16500 for each antenatal attendance;
- 16590 for planning and management of the pregnancy;
- 16519 for a simple birth;
- 16522 for complicated birth;
- 16404 postnatal attendance (in rooms).

Note that vaginal birth and caesarean sections attract the same fee. The complicated birth numbers include things like diabetes, significant hypertension, multiple pregnancy or bleeding. An elective caesarean in somebody with diabetes might be a fairly straightforward procedure and no different in those without diabetes.

We are all familiar with the different patient rebates between the MBS and the no or known-gap procedures, but you may not be aware of the true impact of going even a little over the no-gap rebate for birth as our patients are getting significant out-of-pocket costs.

The MBS rebate versus HCF no-gap, for example, has quite a difference:

- 16519 – MBS $536 vs HCF $1,908 or;
- 16522 – MBS $1,260 vs HCF $2,315.

COMMUNITY CARE

With there being three main types of private health insurance in Australia – hospital, extras and ambulance – there is nothing that covers care in the community. This feeds into one of the major public misconceptions about why their health fund is not paying more obstetric cover.

The majority of pregnancy care including 24/7 access to a specialist obstetrician and gynaecologist actually occurs in the community and is outside the remit of private health insurance. So we can see that health funds are really looking at ways of clawing this back to reduce members out-of-pocket expenses.

With most of the care being provided in the community, the community portion tends to attract a bigger gap, with a smaller gap being apportioned to hospital services. There's a big insurer mark-up on the 16519s, which prevents the large out-of-pocket costs or large out-of-pocket gaps in hospital because many obstetricians, certainly around Sydney, will no-gap the birth based on reasonable rebates.

UPLIFT FEES

It is becoming increasingly obvious that when it comes to bundled care arrangements the provision of uplift fees is dependent on all community consultations with the obstetrician service bulk billed, which means the EMSN rebate is lost for the patient. All bloods and scans must be at a bulk bill provider already in place with the health fund. Many pathology services will bulk bill, but high-quality pregnancy ultrasound typically has a gap because ultrasound and radiology rebates have been neglected. All anaesthetic services must be provided at no out-of-pocket cost to the patient, and this includes the no-gap plus and uplift fee.

From an obstetrician's point of view, the uplift fee is significantly less than many currently charge for the package of obstetric care we provide. Although there's a wide variation of fees charged in Australia for private obstetric care, for many this would represent a significant 25% reduction in income per pregnancy.

As a busy obstetrician, I'm comfortable with the workload that I'm doing and for me to take a 25% reduction in fees with the expectation that I'm actually going to increase the workload, is really challenging. Especially in the era of safe working hours and of work-life balance in medicine, it's just not particularly acceptable.

The other challenge that bundled care can create at some hospitals is needing to run two on-call rosters. One for the obstetricians, anaesthetists and paediatricians who want to participate in a bundled care arrangement and another for those who don't. You can imagine the issues this creates having to potentially run two anaesthetic rosters.

One of the key considerations to be taken into account is that many health funds consider women who are participating in a bundled care arrangement need to have exactly the same care arrangement from the obstetricians.

From the maternity care provision point of view, no two pregnancy journeys are the same. That the insurers are attempting to homogenise a woman having a baby speaks volumes to what their approach could be to so many other areas of healthcare.

About the author

Dr Andrew Zuschmann is an obstetrician, gynaecologist and fertility specialist working in both public and private practice in the Sutherland Shire, Sydney. He is Head of Department at The Sutherland (public) hospital, and O&G representative MAC, Kareena Private Hospital. Andrew is also Vice-President AMA (NSW), NASOG Councillor, and Chair RANZCOG NSW/ACT Training Accreditation Committee.