Private Health Insurance

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Michael Brennan, Chair

It's a great pleasure to be here and a privilege to have been invited.

As is usually the case, I find myself talking about a subject on which I am the least knowledgeable person in the room. But I thought I would spend my time today giving you some high level thoughts about your industry from my perspective.

In recent times the debate over the policy settings for private health insurance (PHI) have come to greater prominence and sharp relief. When words like death spiral enter the lexicon, you take notice, including of the range of solutions put forward.

My concern today isn't so much about those competing solutions. It's more a worry that we might be asking the wrong question.

For at least 25 years and probably more, PHI policy has been conducted on an implicit premise, which is that we need a viable PHI industry in order to take pressure off the public hospital system.

I am not saying that this is a false premise. Just incomplete.

It seems to me that it has led us down the path of a focus on what you might call 'premium policy' — that is, questions about the policy levers which can affect the net price of an insurance policy, such as:

- the level of rebates
- income thresholds for the rebate means test
- the Medicare Levy surcharge amount and threshold
- and the parameters of community rating, such as lifetime cover and the scale of permitted deductibles
- proposals to provide FBT concessions for employer-provided PHI are in a similar category.

In other words, the main question has been how, using a defined bucket of money, we might provide calibrated incentives for particular cohorts to take out cover to underpin the survival and sustainability of the industry. It implies a quite limited role for private insurance.

And it presupposes that we have our more general health policy settings about right — including the role the acute hospital system plays. I would contend that this proposition is looking more doubtful.

A better starting point — and the real question for policy — is to ask: what sort of health system do we aspire to, and what role can the private sector — including private insurance — play in achieving it?

And the supplementary question — particularly relevant for the member based sector — is: what policies would allow insurers to offer real value to members, in terms access to higher quality of care and, ultimately, better health outcomes?

It's that question I wanted to address today, though I am going to fall a long way short of answering it. I start from the position that there is a lot to like about Australia's health system. It delivers high life expectancy — and very high healthy life expectancy — for a comparatively low aggregate spend (that is, public and private) as share of GDP

Specifically, we spend an amount comparable to the OECD average (as a share of GDP) but have life expectancy at the high end. As a result, Australia out-performs the estimate of what our life expectancy should be if it was based purely on the amount of money we spend.

Specifically, Australians live on average about half a year more than would be predicted from our health spending. The average American lives 6 years less than would be predicted from their very high spend as a share of GDP.

So all this suggests that in some ways perhaps we are spending our dollars wisely.

One possible reason for this is that, believe it or not, Australia has had some modest success in keeping health price inflation under control. This is a relative point — health costs outstrip inflation everywhere.

But in terms of the level of health prices, across the OECD they tend to be correlated with national per capita income — Switzerland and Norway have high health prices while Latvia, Poland and Turkey have lower prices.

Australia's health price levels are around the OECD average, despite us having a per capita income which is well above the average. That suggests that, relatively speaking, more of Australia's health spend is funding extra volume rather than a higher price.

The OECD estimates that Australia delivers among the highest volume of services, third only to Germany and the US, who are of course spending nearly twice as much as Australia as a share of GDP.

In part, this reflects the fact that our system has a number of in-built features which try to control costs and ensure cost effectiveness. And they often do this by driving increased volume. We have ABF in public hospitals, to try and drive down cost inflation and fund activity. We have a fee for service MBS system which also funds throughput. We have a

PBAC process to ensure that drugs are listed only when cost effective. And we use government purchasing power to reduce listing costs.

We have also used government as a means to contain costs — through setting MBS schedule fees, and being a party to industrial agreements with health staff in the public system.

All blunt tools, but they have helped to direct our marginal dollar of health spending into extra services rather than higher unit costs. And it has arguably done this better than if we relied on a purely private insurance based system.

But as you know, this can be a mixed blessing, and our system is far from perfect.

I want to briefly mention four shortcomings of our system, which I think are symptomatic of a broader underlying problem. Those four symptoms are:

- the excessive focus on outputs rather than outcomes
- (relatedly) the extent of ineffective procedures and unjustified clinical variation
- the lack of integration between parts of the system — particularly between the primary and acute sectors but also with other health and non-health services, and
- the general passivity of the system as a whole.

My contention is that these are symptoms of a supplier-centric system, which has struggled to innovate in ways which could deliver new services and business models to the benefit of consumers.

So, I start with the focus on outputs. Our system is very reliant on its two big volume-based elements: the acute hospital system (with ABF for the public system; MBS and insurer payouts for the private system) and the fee for service MBS system for out of hospital services.

Since 2009, both public hospital separations and GP consultations have significantly outstripped population growth — even on an age adjusted basis, suggesting we are using more services per capita than we did a decade ago.

Why is that? You could point to the rising burden of chronic disease, but in a way this only reinforces the point: ours is a good system for dealing with episodic medical interventions.

But it serves us less well in dealing with emerging health challenges like obesity, diabetes, mental health and just chronic disease in general. Arguably we need a system which has a much greater focus on keeping people well, managing their conditions, preventing escalation and keeping people out of hospital.

While we have been critical of aspects of the Health Care Homes trial, it is at least a genuine attempt to shift away from the incentives that arise in a pure fee for service model. But it is only one of a number of potential reforms to funding models. For example, at present, neither GPs nor hospitals really benefit from avoided hospitalisations.

On the other hand, I have noted before to a different audience that private insurers generally do have such incentives, given that they find a portion of private (and increasingly public) hospital stays.

I mentioned clinical variation. Again, our volume based system has generated considerable efficiency in a narrow sense. But how much assurance do we have that the procedures being performed have strong clinical evidence?

Time and again we see staggering figures as to the proportion of procedures which are ineffective or even harmful to patients. The Atlas of Healthcare Variation produced by the Australian Commission on Safety and Quality in Healthcare has shown such a marked degree of variation in health practice by location that they cannot possibly reflect differences in the underlying health needs of the population. They are much more likely to reflect different clinical approaches. This suggests that the diffusion of best practice clinical evidence is slow and hampered.

On integration, it is notable that fewer than 20 per cent of Australian GPs are always notified when a patient was provided with a hospital discharge summary. This is much lower than countries like the UK, New Zealand and the Netherlands. The system isn't joined up. Data isn't shared systematically. And too often it's effectively the consumer who has to play the role of co-ordinator — often telling their story multiple times.

It's partly the culture of the system, but also partly about incentives. There are real limits on the ability of hospital networks to fund primary health care which would reduce hospitalisation. And of course there are also limits on the ability of private insurers to fund primary services where a Medicare benefit is payable.

And finally, the passivity of the system. It is notable that for the most part we have a health system that basically waits for people to present to it, rather than proactively trying to anticipate, inform and then meet consumer needs.

As one indication of that, the Productivity Commission estimated the cost to the economy from people sitting in GP 'waiting rooms' (it's around $1 billion a year). When you think about it, the very notion of a 'waiting room' is very specific to the medical profession — it's not something you find in most service industries. Some might say it's inconsistent with the very notion of a service industry.

The description of GPs as 'gatekeepers' is similar. The system gets by on low levels of health literacy among consumers.

Nor is there much information for consumers about the quality of, or fees charged by, specialists. Let alone genuinely patient-centred metrics like PREMs and PROMs, which could help inform funders, policy makers and patients themselves.

Now, as I alluded to earlier, all these symptoms:

- the focus on activity rather than wellness

- the prevalence of ineffective procedures and clinical variation
- the lack of integration, and
- the passivity of the system.

All highlight a supplier-centric system which gives inadequate priority to the interests of consumers. The great conundrum in health is that we don't seem to observe the sort of disruptive innovations and new business models that characterise other sectors of the economy.

It's not that technology and innovation are lacking. As we all know, there is tons of new technology in the health system. (Which mostly serves to make the system more expensive rather than cheaper.) The problem is that it's almost all focused on what Rohan Mead from Australian Unity once beautifully described as 'molecular innovation' — it's all about better drugs, devices, diagnostic tests, surgical techniques. While innovation and disruption of business models is nearly altogether lacking.

Both are important to patients. I don't mean to dismiss the huge medical advances of the last century, which have extended lives and relieved great suffering. I just note that the system is delivering a lot more of one type of innovation than another. Such that the fundamental model of health care delivery — the acute hospital setting, the one-on-one consultation with a medical practitioner, the physical dispensing of drugs etc. — has barely changed in the last century, despite massive changes in virtually all other sectors of the economy.

Another way to think of this is the distinction between the use of health-specific technology (new drugs etc.) which is ubiquitous, and general purpose technology (computers, digital solutions) which is arguably under-used in the health system. When a GP refers a patient for diagnostic tests, the pathology is cutting edge, but the referral is sometimes done by fax.

Similarly, the use of data in the context of a clinical trial can be highly sophisticated, but attempts at integrating basic patient data across the system face almost insuperable challenges.

In the area of mental health, the Productivity Commission has found a potentially significant role for practitioner supported online treatments, which makes targeted use of practitioner time, learning modules and patient input, delivered in a way that provides flexibility and convenience to consumers.

That involves using a general purpose technology (the internet) to change business models for the benefit of the consumer, and with no loss of clinical effectiveness. It breaks down the dominance of the one-on-one consultation with its inflexible block of practitioner time. Unfortunately at the moment there is no well-developed funding model to allow this sort of innovative treatment to expand.

So the problem is with government too — I don't want to just blame the sector. Too often in the face of an emerging health challenge, the solution is more beds, more hospital activity or a new MBS item.

So, returning to my original question: if we have a general view about how to improve the overall health system, what is the role of private insurance? Put another way, what are the distinct attributes that private insurers have, which allow them to play a role in a more integrated and value-focused health system? I can't fully answer that question today. I don't know. All I can do is sketch out a few basic outlines.

The industry is already playing a role through chronic disease management programs — focused on keeping members well and reducing hospitalisation. And often those programs involve some innovative and disruptive delivery methods.

Two policy issues arise:

- first, whether the current risk equalisation arrangements are undermining the incentive to provide these programs, and
- second, whether the regulations around what services can be funded are too prescriptive.

The Productivity Commission is on the record on both matters.

In our Shifting the Dial report from 2017, the Commission floated a few options to address the disincentives flowing from risk equalisation — moving to an ex ante risk equalisation approach based on age, or quarantining specified programs from the impact of risk equalisation.

In our Mental Health draft report, we proposed that the regulations which currently prevent insurers from funding community based mental health care be reviewed with a view expanding the scope for such programs where they would prevent avoidable hospital admissions.

In general there would seem a strong case for insurers to be more actively involved in these holistic wellness efforts. The industry could also conceivably play a role by not funding ineffective procedures and also shining a light on clinical variation. And it could help aid integration, particularly where a fund is delivering a chronic disease management program to one of its members.

Funds could be very well positioned to help members navigate the maze of primary care, allied health, specialists, pharmacy and hospitals — even if they are not funding every element in that chain. And it could help address the problem of passivity — funds are uniquely positioned in the Australian system because they have members. Other parts of the system (GPs, pharmacies, hospitals, PHNs) do not.

So funds can proactively offer services and support to their members. They can provide consumer information; they can help build health literacy.

I know that funds already do this, but I am arguing for it to be more central to their mission and for policy settings that facilitate and encourage this.

Aside from helping build a better health system, these are things which can offer genuine value to members, which is the ultimate determinant of the success of the industry.

That's another downside of an undue focus on rebates and surcharges: it can obscure the true long term goal, which is to provide a product that people genuinely want to buy.

I am not saying that reform to the rebate, the surcharge, lifetime community rating or deductibles isn't warranted. It's more that — using the medical analogy — these represent the surgical response. (Geoff Summerhayes, APRA, referred to it as the quest for a 'miracle cure').

Policy makers, like some doctors, often favour surgery because it's a one-off event that's clear and objective and you can then pause and observe whether it was a success (or whether there were any complications). And surgery might be part of the solution.

But more likely we need a more holistic approach focused on the wellness of the system as a whole. Our policy should cover that, with as few exclusions as possible.

I have strained the metaphor quite enough. You get the point. Thank you again for your time.