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Compulsory Health Insurance: Should government still be the health insurer of first resort?

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Executive Summary

Health in Australia currently costs the government more than $100bn every year and, as our population's wealth and life expectancy continue to improve, this contribution could rapidly escalate.

Private health insurers are excluded from directly funding primary health care, although insurers are now beginning to enter in the primary care space through more indirect initiatives. The commercial incentives for doing so should be well-aligned with desirable financial and social outcomes for the health system at large: insurers want to reduce expensive hospital claims by improving the effectiveness of primary care services, and want to improve their competitive status by achieving good health outcomes at a reasonable cost.

As such, we bring some financial facts to the table to assist in the debate around whether private health insurers should be allowed to fund primary care—how much might it save the government, and is there sufficient scope and volume for potential efficiency savings to have a chance? We looked at the financial impacts of private health insurance (rather than Medicare) having an increased role in primary care for all Australians, as well as scenarios for Australians earning more than certain income thresholds.

We found that only transferring GP costs away from government was unlikely to be effective. With a relatively modest income threshold of $60,000, the government would save only around $780m per year, and with higher income thresholds, even less. These savings would be insignificant to the government, and unlikely to be enough to provide room for efficiencies across the system. Savings of $4.8bn could be made if the change applied to all Australians, but from a social perspective is unlikely to be regarded as being fair.

However, transferring all primary care costs away from government has more potential, even if applied to only higher-income earning Australians. For example, at a $100,000 threshold $1.1bn would be saved, and at an $80,000 threshold $1.9bn would be saved. The amounts transferred to the private sector are potentially meaningful enough to encourage investment by insurers to deliver efficiencies and improved care outcomes. The application of an income threshold would help address fairness concerns.

Our Findings

1. Why can't government pay for everything for everyone?

Australia's total health expenditure is growing at around 8% per year [1, p. 6]—significantly faster than general inflation. Most of this growth is because more health services are being used as technology advances. This is because more sophisticated (and expensive) treatments are becoming ever more readily available at the same time as increasing wealth is making them more affordable. Costs will escalate even faster as the effects of population ageing in Australia begin to kick in [2, p. 7].

While medical advances and increasing life expectances are undoubtedly good news, the financial consequences can be challenging. At present, the government picks up around 70% of total health costs, and in 2012-13 this came to more than $100 billion. To put this into perspective, the government spends over a quarter of its total tax revenue on health [1, p. 14]. It is projected that, over the next 40 years, the government's contribution will more than double [3, p. 60].

Although the 2014/15 Budget included a range of proposed measures aimed at shifting government health expenditure towards individuals, it seems unlikely that many of these will be implemented and, even if they are, the government's health expenditure is still expected to grow rapidly.

Health care is sometimes classified as either primary (outside hospital) or secondary (inside hospital). While around half of Australians use private health insurance (PHI) to help fund their hospital treatment, PHI has a much more limited role in financing primary health care. In fact legislation prevents health insurers covering some key primary care costs such as general practitioner (GP) or specialist fees outside hospital.

The National Committee of Audit was established to review the performance, functions and roles of the Commonwealth government, and of course considered health spending. The Commission concluded there is a strong and vibrant health insurance market in Australia and, against this backdrop, "governments should not act as the insurer of first resort. Governments should help families and individuals manage risk on their own behalf." [4, p. 15]

The Commission's recommendations included:

- allowing health funds to expand into covering primary care;
- making PHI mandatory for high-income earners, who would use private insurance rather than Medicare to cover primary care costs;
- improving efficiency through a range of PHI deregulation.

In itself, transferring costs from government private health insurers or individuals wouldn't reduce health costs or the rate of health inflation. In order to achieve real benefits across the board, any changes need to improve the efficiency of the health system as a whole. This is why the Commission said health funds should be allowed

to become "genuine health care partners that support their members to navigate the health system and assist them to better manage chronic conditions."

At a basic level, insurers have a strong incentive to keep people well to avoid expensive hospital costs, and funding primary health care is an effective way to keep people well. It is hard to defend the current system where insurers are unaware of members' health needs until they have been referred for surgery, or even until a claim is received after surgery.

Some have argued against greater PHI involvement in primary care, with a range of social and political concerns including:

- Access: It is debatable whether all Australians currently have equivalent access to primary care services. However, there is concern that insurers could create a two tier system, where those with PHI have access to more or better primary care providers;
- Control: Insurers could have an inappropriate level of influence or control over patient care.

Neither of these outcomes are unavoidable consequences of allowing PHI to expand into primary care, as we expect minimum entitlements and the role of insurers would be set out in legislation. Insurers also have a strong competitive incentive to balance the needs of those requiring treatment and those paying for it. An insurer with high premiums (due to poor cost control), or seen as blocking the reasonable requests of policyholders and their doctors, would struggle to retain policyholders.

The arguments around insurers in primary care will continue to be debated in papers, articles and speeches. This paper doesn't set out to prove the case one way or the other, but rather to bring some facts to assist the debate. We investigate the financial and other implications of opening the door to private health insurers at the same time as removing access to Medicare-funded primary care services for certain groups of Australians.

Many insurers are interested in providing primary care services to their members, and have recently begun some trials in GP care. Section 2 sets out the current involvement of insurers in primary care. We then consider the effects of greater insurer involvement in Section 3.

2. What are insurers already doing in primary care?

Insurers have a significant role in helping Australians finance some types of primary care, for example, dental and optical costs.

While health insurers are prevented by law[1] from funding certain GP and specialist fees outside hospital, some insurers have recently commenced programmes in these areas.

This section summarises and comments on some of the initiatives in this area.

Medibank

Medibank introduced a 'GP Access' trial in late in 2013. This scheme provides the following benefits:

- No out of pocket expenses for general practitioner consultations (bulk-billing)
- Guaranteed GP appointments on the same day if arranged before 10am
- After-hours access to GP home visits within three hours
- Some one-off health assessments at no cost.

The scheme was provided with Independent Practitioner Network (IPN) Medical Centres, who exclusively provide the above benefits, and only available in parts of Queensland.

More recently, Medibank has partnered with the Victorian government to create another primary care related program termed CarePoint. The goal of this venture is to reduce hospital admissions by 25% within its targeted demographic—patients with chronic diseases with a history of multiple hospitalisations. The program will involve new health monitoring technologies and also preventative care provided at home. We understand other insurers are involved in or considering similar programs with state governments.

Bupa

Bupa has an arrangement with Healthscope GP clinics which has some similarities to Medibank's GP Access pilot. The benefits of the scheme are bulk-billed general practitioner consultations at certain clinics, together with discounts on health checks.

Bupa has recently opened a Bupa-branded GP clinic in the Sydney CBD. Unlike the other schemes, people using the clinic are not bulk billed, and there is no difference in the service provided to Bupa and non-Bupa customers.

[1] Division 69 of the Private Health Insurance Act 2007 (PHI Act) states that health insurance can only cover "hospital treatment" or "general treatment". The precise meanings of "hospital treatment" and "general treatment" are set out in the PHI Act and associated regulations. Clause 8 of Schedule 3 of the Private Health Insurance (Benefit Requirement) Rules lists treatments which are *not* regarded as Hospital Treatment, including the Medicare Benefit Schedule Items 20, 23 and 24 relating to GP consultations.

HCF

HCF's primary care related scheme is called 'My Home Doctor' and is an after-hours GP service that is also bulk-billed. The service is provided by the National Home Doctor Service with HCF branding, and is now available in Sydney, Melbourne, Brisbane, Adelaide and Canberra.

Primary Hospital Networks

The government has created 28 new Primary Health Networks (PHNs) to replace Medicare Local organisations. Some PHNs will be operated (at least in part) by private health insurers.

Examples of PHI partnerships in PHNs include HCF and Bupa (in Brisbane North, Perth North and Perth South), GMHBA (in Grampians and Barwon in Victoria) and Peoplecare (in South East NSW).

Reasoning

Some insurers have spoken publically about why they are becoming involved in primary care. The main reasons fall into one of two main categories:

- Preventative health measures to reduce hospital costs

Medibank revealed that 2% its customers account for 45% of the hospital and medical claims. Access to GPs could help customers manage health problems outside hospital.

- Attracting and retaining customers

Where schemes offer benefits that are not available from other funds, schemes may help attract and retain members. The schemes also demonstrate funds are interested in members' health.

Conclusion

The initiatives show health insurers are becoming more involved in primary care. However the initiatives are fairly limited in scope, taking on only a small element of member's primary care costs, or operating in only a limited geographic area.

None of the initiatives to date involve insurers becoming the "genuine health care partners" envisaged by the Commission of Audit. However, the initiatives lay the groundwork for more significant future developments.

3. Possible impacts of major reform

Approach

Our approach has been to:

a) Quantitatively model the financial effects on the government budget of changing the level of primary care rebates provided, considering a range of scenarios; then

b) Qualitatively assess the outcomes against four success indicators relating to government finances, the PHI industry, society and the efficiency of the health care system.

This process is described in more detail below.

Scenarios chosen

We have modelled the outcomes of the following two scenarios:

a) **GP only:** Government is no longer the insurer of first resort for any GP costs. We have modelled the financial reduction in the government's contribution if Medicare coverage of GP costs were to be removed for all Australians, or only those earning above $60,000, $80,000 and $100,000 per year.

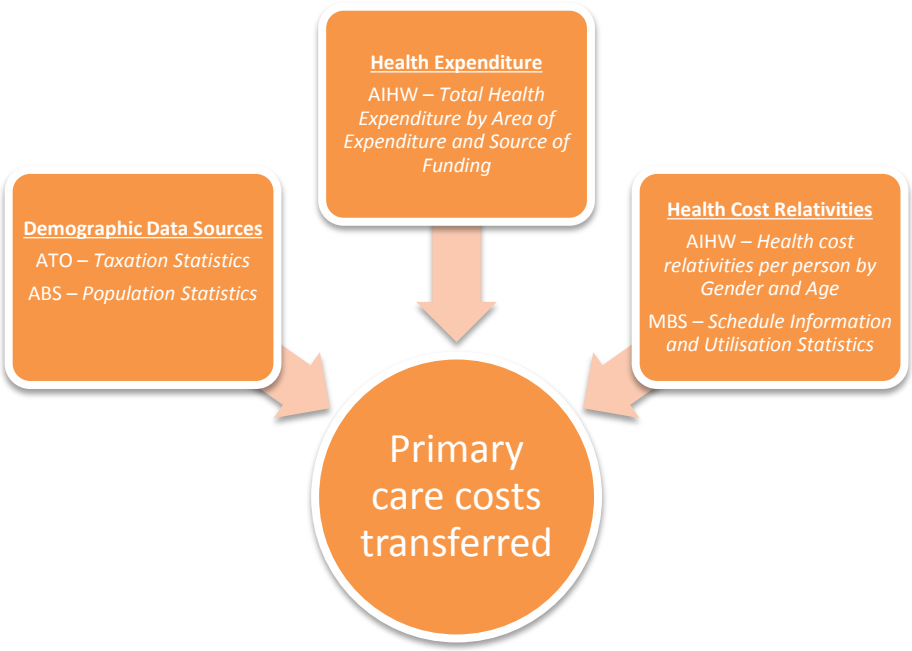
b) **All primary care:** Government is no longer the insurer of first resort for any primary care costs. Again we consider scenarios where this is applies to all Australians, or just those on higher than average incomes.

For each scenario, people might have the option of paying costs out of pocket as they arise, or taking out private health insurance. Alternatively these changes might be combined with some level of compulsory health insurance for the people impacted.

Data and assumptions

Figure 3.1 summarises how we combined different data sources to estimate the total value of primary care costs transferred under each scenario.

Figure 3.1 – Data sources



We examine the amount of government funded primary care costs that would be transferred to either private health insurers or Australians' own pockets under the two scenarios described above.

Scenario 1 – GP Only

We collected Medicare Benefits Schedule (MBS) information [5] on government fees paid for GP services (specifically, Medicare rebates processed under items 3, 4, 20, 23, 24, 35, 36, 37, 43, 44, 47 and 51 for the 2014 financial year FY14). This data is split by age and gender. We also collected Australian Taxation Office (ATO) data [6] for FY12 (the most recent year available) and Australian Bureau of Statistics (ABS) data [7] for 30 June 2014 from which we inferred the proportion of the population (eligible for Medicare) that earned more than each of the four income thresholds—this was also split by age and gender.

We joined the data sets to estimate the number of Australians by age, gender and income, and the GP cost rebated by government for each group. This allowed us to estimate the reduction in government costs if MBS rebates were no longer available for certain groups.

Any analysis of this nature requires a number of assumptions. The key assumption of this analysis is that, for a given age and gender group, utilisation of GP services does not vary by income. It may be the case that:

- People on lower than average incomes have greater utilisation of GP services. For example, people unable to work due to poor health might require frequent GP visits and have a low income

- People on higher than average incomes have greater utilisation of GP services. For example, this group may be highly engaged with their health (the "worried well"), taking a proactive approach to their health and regularly visiting their GP.

We also note that, while we used the most recently available statistics or report in each case, the data sets refer to different time periods (refer to the bibliography for more details).

On balance we feel our method should provide an indication of costs by claim type and income level, and the results are therefore reasonable for the purposes of our paper. Additional analysis such as detailed patient surveys could help refine the estimates.

The MBS data suggested total annual government rebates for these item numbers of around $4.8 billion. This compared to Australian Institute of Health and Welfare (AIHW) data [1, p. 78] indicating $7.4bn was spent on un-referred primary health care medical services in FY13, of which GP costs will be a significant part. We have seen other estimates which put taxpayer funding for GPs at around $6 billion. We base our analysis on the $4.8 billion estimated cost of the specific item numbers for which detailed claim statistics were available.

Scenario 2 – All Primary Care

AIHW [1, p. 78] also shows the Federal government spent $21 billion on primary care in FY13. This amount excludes veterans spending and money spent by state and local government.

We estimated the allocation of primary health care spending by age and gender using AIHW data [8, p. 56] on the allocation of total health expenditure by age and gender. We then used the other data sources to estimate the split of government primary care spending by income, using the same approach as scenario 1.

We note that the proportion of primary care spending for each group was similar to the number of GP visits. This suggests the number of GP visits may be a good proxy for overall health care needs.

Impact Assessment

Any proposal to involve insurers in PHI would be assessed against a range of factors, with each stakeholder having different priorities. We assessed each scenario against the following criteria:

- Government financials — whether the costs transferred are material relative to total government spending. Relatively small changes would not have an impact on the government health cost challenges noted in Section 1
- Insurer financials — whether the additional premium revenue is material, compared to current annual premium revenue in excess of $20 billion per year [9, p. 4]

- Fairness — whether the change would likely to be regarded as fair. Removing primary care subsidies from people on low incomes is unlikely to be regarded as fair, however an alternative would be for government to purchase (or subsidise) private health insurance for these people
- Potential for efficiency — as discussed in Section 1, simply transferring funds from government to insurers wouldn't necessarily reduce health costs or the rate of inflation. This criteria assesses the potential for increasing efficiency by having a single funder of primary and hospital care.

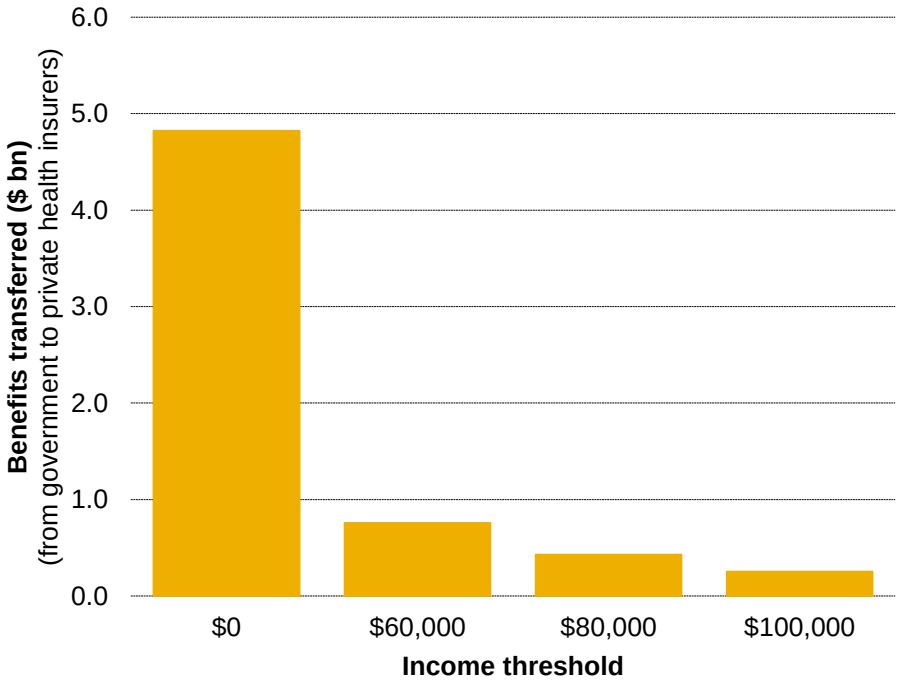
Clearly this impact assessment involves a level of subjectivity. We would welcome discussion on alternative assessments or the other factors which might be important.

Results and analysis

Scenario 1: GP costs transferred away from Medicare

Figure 3.2 shows the estimated reduction in government spending if rebates were no longer available for GP consultations. We show the effect of removing benefits for Australians earning more than each of four specified income thresholds.

Figure 3.2 – Scenario 1 results



We make the following observations:

- The rebate amount of the GP item numbers considered is $4.8 billion (nil income threshold scenario)

- The $60,000 threshold assumes government no longer provides rebates to people with annual incomes in excess of this amount, but those on lower incomes continue to receive benefits. We assume children/dependants continue to receive Medicare rebates, even if one member of the household earns more than $60,000 per year. The results for other income levels are prepared similarly.
- We estimate only around 16% of government GP rebates (around $780 million) are paid to individuals earning more than $60,000 per year. This is because:
    - Including children and retirees, only around 20% of the population earn more than $60,000 per year
    - Older people typically visit GPs more often than people of working age.
- Increasing the income threshold further, to $80,000 and $100,000, reduces the transfer of benefits to $430 million and $250 million respectively.

We now qualitatively assess each of these outcomes against our impact criteria:

Table 3.1 – Scenario 1 Impact Assessment

Income threshold	$0	$60,000	$80,000	$100,000
Impact on government financials	Moderate	Low	Low	Very low
Impact on insurer financials	Significant (around 30% extra revenue if mandatory)	Low (around 5% extra revenue if mandatory)	Low (around 2% extra revenue if mandatory)	Low (around 1% extra revenue if mandatory)
Regarded as 'fair'	Unlikely	Possibly	Possibly	Possibly
Potential for efficiencies	Moderate	Moderate	Low/moderate	Low

In summary:

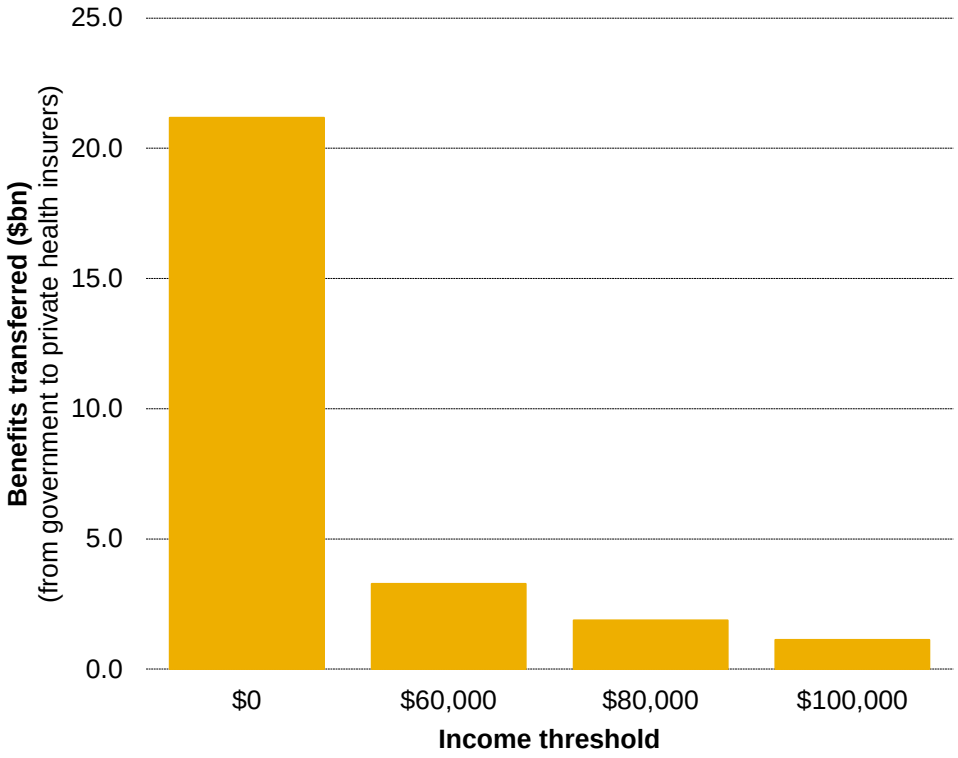
- Impact on government financials: Transferring all costs ($0 threshold) would have a moderate impact on government financials. As the income thresholds increase, the amounts involved become fairly immaterial relative to total government health spending
- Impact on insurer financials: Transferring all GP costs ($0 threshold) would have a material financial impact on insurers. However the other scenarios would not have a material impact, even if people were required to purchase an insurance policy to cover these costs. If insurance was not compulsory we would expect many people on higher incomes to self-insure for GP costs
- Regarded as "fair": Noting the recent public discussion on GP co-payments, completely removing GP rebates is unlikely to be regarded as fair. A proposal is more likely to be regarded as fair if it applies only to people on high incomes

- Potential for efficiencies: Efficiency gains from integrating care would be minimal due to the relatively small dollars transferred, and may even be offset by implementation and increased administration costs.

Scenario 2: All primary care costs transferred away from Medicare

We estimate that, through Medicare, the government contributes around $21 billion per year towards primary care services. Figure 3.3 summarises our estimates of the amount that might be transferred away from the government's contribution were these Medicare benefits removed for all Australians earning higher than each of four specified income thresholds:

Figure 3.3 – Scenario 2 results



We now qualitatively assess each of these outcomes against our success indicators:

Table 3.2 – Scenario 2 Impact Assessment

Income threshold	$0	$60,000	$80,000	$100,000
Impact on government financials	Significant	Low/moderate	Low/moderate	Low/moderate
Impact on insurer financials	Significant (around 120% extra revenue if mandatory)	Moderate (around 20% extra revenue if mandatory)	Low/moderate (around 10% extra revenue if mandatory)	Low (around 5% extra revenue if mandatory)
Regarded as 'fair'	No	Unlikely	Possibly	Possibly
Potential for efficiencies	Significant	Significant	Moderate	Low/moderate

In summary:

- Impact on government financials: Primary care is clearly a significant area of government spending. While the amount of government spending reduces significantly as the income threshold increases, we estimate even people earning more than $100,000 per year receive more than $1 billion of government primary care rebates
- Impact on insurer financials: For each income threshold, the potential impact is greater than scenario 1. The increased amounts involved also mean people are more likely to want to insure
- Regarded as fair: The increased amounts involved also mean people are less likely to regard any changes as fair
- Potential for efficiencies: Transferring the full range of primary care costs to insurers would increase the potential for efficiencies.

Conclusion

Health reform requires financially meaningful changes which both increase efficiency and are regarded as fair. We tried to find reform options that tick all the boxes and, perhaps unsurprisingly, we didn't find the magic bullet.

Across a number of spending areas, government has removed or reduced the level of support provided to those with higher than average incomes. For example, high earners no longer receive health insurance premium rebates, certain family tax credits or the baby bonus. There are suggestions that high earners may lose other benefits, for example, with regard to superannuation. Some of the changes have resulted in fairly small savings for the Federal budget. Set against this background, it appears likely government won't always be the insurer of first resort for primary care benefits.

The most high-profile health reform proposal in recent years was the GP co-payment, and GPs have been the main focus of private health insurers' primary care initiatives. Partnerships with GPs could allow insurers to help members navigate the complex health system and prevent medical emergencies requiring expensive hospital care. However, Scenario 1 indicated that there doesn't seem to be much to gain from simply shifting GP rebates from government to private insurance. The arguments for change become still less compelling if only high earners are impacted by any changes.

GP Medicare rebates are only a small proportion of total government primary health care spending, which we considered in Scenario 2. Even if only a small proportion of the population was required to obtain PHI for all primary care costs, this could have a meaningful impact on the PHI industry. It would also be an effective "pilot scheme" for more significant health reform at a later date.

Bibliography

[1] AIHW, "Health expenditure Australia 2012-13".

[2] Actuaries Institute Green Paper, "Who Will Fund Our Health?," 2014.

[3] The Treasury, "2015 Intergenerational Report (Australia in 2055)".

[4] National Commission of Audit, Phase One report, "Towards Responsible Government," 2014.

[5] Department of Health, "MBS Online".

[6] ATO, [Online]. Available: https://data.gov.au/dataset/taxation-statistics-2011-12/resource/fc2fdc4c-8e8f-49be-b630-071c2f36bcdb.

[7] ABS, "Australian Demographic Statistics," [Online]. Available: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3101.0Jun%202014?OpenDocument#Time.

[8] AIHW, "Australia's Health 2014".

[9] PHIAC, "The Operations of Private Health Insurers Annual Report 2013-14".