

Actuaries Institute Podcast

Title: Private Health and Health Care Financing: Learning from the world

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Interviewer: Vanessa Beenders

Speakers: Andrew Matthews, Francesco Paulucci, Adam Stolz

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Introduction

Vanessa:

Hello and welcome to the Actuaries Institute podcast and this introduction to a new piece of thought leadership about private health. I'm Vanessa Beenders, Practice Excellence Advisor at the Actuaries Institute.

The Institute recently launched a Health Dialogue titled *Private health and health care financing - Learning from the world*. This Dialogue has been written by four authors, three of whom are joining us on the podcast today.

Andrew Matthews is currently Chief Actuary at Medibank Private. He will soon be joining Finity Consulting. Andrew is also Associate Professor at Monash University.

Francesco Paolucci is Professor of Health Economics at the Newcastle Business School as part of the University of Newcastle. He is also with the School of Economics and Management at the University of Bologna.

Adam Stolz, who can join us today on the telephone line, is Deputy Chief Actuary and General Manager Pricing at Medibank Private. He has previously worked with AIA and AXA in both France and the U.S. The fourth author is Josefa Henriquez who unfortunately is unable to join us today.

This paper is what the Actuaries Institute calls a dialogue. Dialogues reflect the opinions of the authors and not necessarily the Institute nor the authors' employers. Dialogues are intended to promote conversation about how a public policy challenge can constructively be moved forward, that's exactly what these four people have done with this piece of work.

Vanessa: So, I'll begin with you, Andrew. What was your objective and motivation in doing this research?

Andrew: Thanks, Vanessa. Our objective was simple. It was to get readers to see a pathway for a future. We're actuaries, so we wanted to look at data analysis and explore possibilities for a better future. The motivation was really around not just being social critics and getting credibility by identifying problems but emphasising looking for possibilities and pathways.

Vanessa: Yes. So being constructive about the solutions here. So, the first part of your paper then is an international comparison, and in what regards then does Australia compare well, internationally?

Andrew: I think when you step back and look at the whole system, Australia compares well both long-term, things like infant mortality have improved enormously and we've all benefited from that and there are a number of studies that put Australia in the top three or top five health systems around the world. So, we compare really well in mortality. Where we don't compare so well is in things like health equity and access to the systems, but a recent study by the Commonwealth fund we quote in our paper puts the top three systems as the Netherlands, the UK and Australia. It's interesting, because the Netherlands is almost all private, the UK is the NHS and almost all public, and Australia is a mixed delivery system. What that says to me is many systems can have good outcomes. No system is perfect.

Vanessa B: So overall though, Australia compares favourably.

Andrew: Correct.

Vanessa B: So, Francesco, turning to you then. On the flip side, from that international comparison, where does Australia not compare so well?

Francesco: I think Andrew really made clear points when discussing both the good aspects and less positive ones. I would say that there are striking design features that pose some questions. One of them is clearly the duality or the public private mix that we currently have, which at times poses questions about arising to a two-tier system. Obviously, that is an equity or an affordability question that we try to address in the paper, and I think by doing that, we also want to concentrate or at least raise some concerns about the growing out of pocket payments. I think these are two critical points.

Vanessa B: Adam, is there anything you want to add to that?

Adam: I think when we look at the paper we see that overall, Australia's system is quite strong at the moment, but the current growth rate of health costs is... Seems to be higher than a lot of other countries and so there may be questions on sustainability of our costs going forward.

Adam: And so, in regard to that, we see that in particular if you adjust the costs of aged care as well as the growth rate, those two things seem to potentially to Australia's health costs outstripping international comparisons in the future. And so in this regard, there is a number of reforms that have been looked at today, for example, in the private health system, we're looking at areas where our health costs are exceeding international benchmarks, and two of these areas are in the areas of procedural costs as well as in low value care. So those among other areas are areas where we potentially improve our international standing, and also improve the sustainability of our health system going forward.

Vanessa: So, you've just raised out of pocket expenses and that is a topic that is of concern I know to many Australians. Your paper does highlight that as a point of interest. Francesco, did you want to say something more about out of pockets?

Francesco: Yes. I think out of pockets exist in every country and obviously the key question is what's the right amount? When we see percentages going around, being 20 or more percent of total healthcare spending, I think there is a serious concern because it's clearly not a pooling mechanism that is in place. It's the opposite of it and the reality of it is that we have out of pocket because there are legal restrictions in Australia for individuals to go and get insurance for this proportion of spending that they may actually need.

Francesco: Obviously out of pocket spending hurts Australia and in particular the ones that are more vulnerable in terms of their ability to pay for care. And clearly one could just simply ask the question why wouldn't, provocatively, sort of remove the barrier for insurance companies to actually cover for general practice and that perhaps could be by itself resolving some of the issues on out of pocket by allowing pooling, which is, as we know, the insurance by itself without any regulation is superior in terms of basically restraints, varying resources, risk pooling now and destroying the risk. So, making the cost of insurance lower than the cost of care in your time of need.

Vanessa: And Adam, did you want to elaborate?

Adam: Yes, I agree with Francesco's points and agree that Australia's out of pockets is higher than international comparisons. The one point I wanted to make clear is that source of out of pockets is across the both the public and the private system in Australia. So, based on our HW research, there's over \$20 billion of out of pockets that individuals need to pay. For example, in terms of pharmaceutical benefits as well as dental benefits. So, in that context, there's been a lot of focus recently on out of pocket medical costs for the private health admissions to hospital, and those medical out of pockets are around \$700-800 million out of that \$20 billion or so pool, and so just wanted to emphasise that the source of out of pockets comes from many different areas.

Adam: And so I think we need to, as a community, work out which are the ones we think are having the greatest detrimental impact on certain segments of the community, and I think any review of the system should look at reducing those and at having a more centralised funding to reduce that impact.

Vanessa: And if I may give a brief referral to another institute paper here, there was obviously the Green Paper on private health insurance done earlier this year, which provides further information on this topic. But moving on now. So, a point I want to draw out then from this work is about the efficiency of spending on healthcare. What did you find when you looked at healthcare expenditure as a proportion of GDP and the so-called outcomes of the different systems around the world that you looked at? Whether that's expressed as life expectancy or a global ranking of performance or some other measure. What did you find there?

Adam: Well I said in the first comment I made was that nearly all developed economies are struggling to manage increased health costs. So, this isn't sort of isolated just to Australia and this is driven by the aging of the population of those developed economies as well as other factors. So, it's important in that context for Australia to look internationally to see if there's areas or innovations which can improve our system. In regards to the question on correlation, we didn't actually find any correlation between the quantum of health spending and health outcomes. So, it really seems to me it's how you spend and use that money which is the most important thing, not necessarily about the quantum of the health costs.

Adam: So, in particular, I mean there's two examples to call out. The first is on the U.S. which does have the highest health costs in the world per capita, but based on the evidence, we show in the paper there's no health outcomes for that higher cost. And also another example is the UK, which has relatively low costs and really good equity across the population in the UK with the NHS single payer system, but again, the health outcomes as rated by the Commonwealth fund study finds that the UK actually has worse than average health outcomes even though it has good efficiency and equity.

Vanessa: Thank you Adam., and that's a great segue then to the second part of the paper, which looks at a selection of countries and how the funding is allocated within their healthcare systems. Francesco, I'll ask this question of you then. Which countries did you look at for the comparison and why did you choose those countries?

Francesco: We could have chosen, of course, more, right? But we have to kind of define, the boundaries focusing on the countries that typically are seen as typology countries or countries representing a particular typology. So we looked at the UK as the NHS pioneer, if you like, and obviously the Netherlands, which more or less at the same time in the early nineties have started quite profound form seeing the direction of introducing a regulated competition model, which is really the primary source of funding and makes it like the, I would say, model for competitive social insurance markets.

Francesco: Germany also represents, and Chile represent a meaningful choice for our comparison because of what has been happening and the fundamental structure of these two systems. Germany has a dual public-private mix, but clearly based on competitive insurance and Chile is actually transforming and Josef and I worked on the reforms of the system, which are now being discussed in parliament as we speak now. So, the reasons were to look at typologies, see and try to as much as we could from these lessons and also to try and see how in a sense, we can implement some of the learnings in our discussions here in Australia.

Vanessa B: And are there any points then that you want to highlight about those different systems?

Francesco: Yeah. Well there are again here, there are many points. I think this is the most intriguing aspect of what we try to think and

develop and probably these are discussion points that we would like also to get feedback from the various stakeholders in the system. I would say that clearly the NHS example as being quite important in its history during the 90s and the early 2000s moving away from quasi markets and quasi competition if you like to kind of base their system on the public procurement basis.

Francesco: This is an option that has been massaged, I would say, and deeply baked even in Australia for a long time. Although as an antagonist to the proposal of having a dual mix, which clearly then, I would say, opened a discussion within the group and basically deciding which other countries we should look at. And I think that the clear point for us to take home is that yeah, we have a very particular public and private mix, but if we don't learn lessons also from those that decided to go the private route, obviously we are missing an important part of the story.

Vanessa B: And so, then based on that international comparison, what do you see as the potential solutions that are worth exploring here in Australia to help address the affordability challenge that gets frequent coverage here in the press for example?

Francesco: I think if we look at these countries and others clearly underpinning the efficiencies in healthcare resources allocation, is an approach towards risk adjusted payments. In some context they're called subsidies, in some others, vouchers, in some others they're called rebates and maybe we have to find a balance in this, but discussion is quite open. If we try to think about these, these are method of payments that can be applied to compensate insurers and also to compensate providers. Obviously when we think about the affordability challenge in a competitive insurance market, what we also need to be conscious about is the interaction with other tools that are used to regulate these markets.

Francesco: So, risk adjusted vouchers are also important to counteract reselection that may well occur in mandatory and voluntary health insurance markets. So, we really think it's the pivotal element and what we're really missing in the current markets and also when we think about reports coming out alluding to a dramatic that spirals and so on, it could well be that they can be resolved if we actually adapt our subsidy scheme or voucher scheme or rebate scheme to a risk adjusted extant approach.

Vanessa: Okay, so you do explore that idea in more detail in the paper and it's quite complicated. So maybe if you can take us through then

what is involved in a risk adjusted subsidy or rebate or voucher or whatever language you want to put on this specific tool.

Francesco: Yes, we call it rebates but I like actually more the term vouchering dissent. Intuitively I think you could see it as a voucher really that could go directly to consumers, for example in their pockets for them to go and shop around for the best policy or insurance product they actually find in the market.

Francesco: Obviously these vouchers are risk adjusted instead of being premium rebated, so calculated on the actual price of the policy, they are adjusted to objective as far as we can find objective risk factors such as age, gender and of course disease or health and obviously there is a wealth of work done initially by the group at Boston University and Harvard subsequently that I've constructed these risk adjustment models that have been using the RG payment systems, even here in Australia for a very long time. Obviously, the structure of the schemes for insurance-based models is slightly different because your objectives are also to ensure affordable access to coverage.

Vanessa: Yeah, so who's paying that rebate subsidy voucher? Whatever you want to call them.

Francesco: Yeah, that's a very good point. It's what the literature calls the sponsor. It could be an employer; it could be unions. Typically, it's governments in Europe and in the U.S. since Obamacare, also government. So basically, if you think of the current model in which the rebates are organised, resources are collected through general taxation or earmarked or by some incorporated contribution they are redistributed on the basis of risk adjusted subsidies, vouchers or rebates.

Vanessa: Okay. And so, I think Andrew, actually you look like you want to add some comments here.

Andrew: Well, I was just going to add, it's important to understand that this is not about the health system or the private health system getting more or less money. It's about achieving good health outcomes with better efficiency, not more funding.

Vanessa: Yeah. So, you're not necessarily talking about changing the size of the pie here. If we want to put it in really simple language, it's about how that is allocated to best effect.

Andrew: Correct. If we want to keep the pie the same, it's about allocating this with more efficiency.

Vanessa: Okay. And so then just this risk adjusted concept. So, I think we're starting to drift maybe into community rating territory here. What do you mean by risk adjusted? How does that take effect? And I think Adam, maybe you could talk to this one please.

Adam: Yes, I'm happy to. So, when we talk about risk-adjusted, this is really about the funding following the patient. So, a really simple example of this is, say that a patient that has some mental health issues and need some treatment, A risk adjusted voucher for that patient and that patient could use that either in the public or the private system. And so, the funding follows the patient where they think that they can get the best care. The current system means that the funding for public and private is quite separate. If the funding doesn't follow the patient, it makes the system work less for the patient or the customer. So that's really the heart of that concept. And I think that this doesn't necessarily mean that we're changing the community rate that we currently have within private health insurance. It's just in terms of, I suppose behind the scenes how the funding and benefits is allocated across the entire system.

Francesco: Yes, I think that's a great response. I would like to just simply add something to clarify that we are not really discussing community rating regulations per se. In fact, we like community rating, we just like community rating as a result of subsidies or vouchers or rebates. So, we like everybody more or less to pay the same risk adjusted subsidy. To do that more efficiently than regulatory restrictions like community rating itself. In fact, in Australia and in other countries, most countries, these regulations have created strong incentives and evidence for selection or like in countries with volunteer health insurance like Australia, what we call premium differentiation by a product differentiation. So, a lot of products are difficult to read for consumers and so on. So, community rating ex-post I think it's a great idea and it's really what we mean when we try to achieve affordability.

Vanessa: So, Andrew, I'll give you the last chance here if you like. Are there any final observations that you'd like to share?

Andrew: I think a final observation that I would share is we started off talking about how good the Australian system is. Let's not forget

there are some people and some marginalised communities that may not say that. So recently in the press we've had a lot of articles about mental health and the need to improve that. We've had remote and rural and our indigenous communities, so there is room for improvement. What our paper is about is exploring what works overseas, looking for pathways that support that better health. It's not to sort of glad wrap it, that our system is good and can't improve, but it's about how we adapt for the future.

Vanessa: And two steps then along the way that you suggest be looked at further then are these risk adjusted rebates, subsidies, vouchers, whatever you call them, and part of what that will achieve then is better integrating the public and the private health systems. Is that a fair statement?

Francesco: Absolutely. Great way of putting it. I think on that note, we can also say that, or that they would be clearly welcome more research I think in this area to understand really how well they could perform.

Vanessa: Which is exactly why this is called a Dialogue publication because we are seeking to stimulate the conversation further. So, this is a space in which there is obviously a lot of further research and analysis that can be done.

Andrew: So that's all we have time for today. Thanks for joining us, Andrew, Francesco and Adam. It's great to hear about this important public policy challenge and how we can think about improving the system.

Vanessa: Listeners, we hope you've enjoyed this discussion. Find out more about the health Dialogue by visiting the thought leadership section of the Actuaries Institute website. See the link in our show notes in the podcast description. As always, please write in with your questions and comments for the show, we love to hear from you. I'm Vanessa Beenders, Bye for now.