

Health insurance: managing risk in the private sector

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Abstract

How does Australia, in both its private and public sectors, provide the health care that Australians want and need at prices they can afford to pay? If this is to be sustainable in the private sector health funds need to be given a capacity to manage their risk exposure. Provided insurers continue to insure sick people, costs will be driven not so much by the age profile of the insured population (though it will have some effect) as by technology and its capacity to supply and create the demands of the aged (not ageing per se). Handling these costs is the real challenge for the future.

It's about time we stopped talking about rating the risks of private health insurance and started talking about managing the risk.

For far too long the emphasis of commentators, and to some extent policy makers, has been on taking steps to adjust health fund profiles and apply "real" insurance principles. The fact is private health insurance is a social product, not an ordinary commercial insurance product - and that's why it is only fair and reasonable for Government's to use the tax system to encourage participation and retention.

Rather than debate whether young people pay more than they should for their health insurance (or, conversely, that older people don't pay enough) the discussion should really be based on how does Australia, in both its private and public sectors, provide the health care that Australians want and need at prices they can afford to pay.

And, if this is to be sustainable in the private sector, the health insurer, as the agent of the contributor, must be given a capacity to manage the risk, not rate it. While the normal insurance principle of "risk rating" might mean younger people would pay less than is the case with community rating, the fact is older people would pay more - much more. Indeed, a risk-rated environment would see older people priced out of the private health insurance system, with all the demand pressures that would impose on the public sector. And how many self-convinced "invincible" young people would buy health insurance if they knew the price would escalate as their own health deteriorated?

At the moment community rating means the private sector picks up about \$1.8 billion in health care costs for the 40 percent of the over 65 population who are privately insured, and who therefore do make a contribution to that cost via premiums. In a risk rating system, Governments would have to pick up that \$1.8 billion, but without the same contribution from the over 65's that currently goes into health insurance. At the end of the day, it would still be the younger person who was paying more than their own actuarial risk exposure might suggest, but through taxes rather than insurance - and the system would lose all the elements of choice and individual contribution that currently take place.

This is not to suggest that initiatives such as Lifetime Health Cover have not been valuable. They have. But it is a fallacy to assume that Lifetime Health Cover was more significant than the 30-percent rebate in rebuilding the insured population. The rebate was an essential precursor to Lifetime Health Cover, for it was the single initiative which allowed a sufficient price reduction (the need for which was confirmed by market research) to restore financial acceptability to the product. Certainly LHC provided a stimulus to ensure people made up

their minds, but I for one do not believe its impact would have been anywhere near as significant at pre-rebate price levels.

Another piece of mythology is the suggestion that LHC would stop premiums rising. It was never expected, nor presented, as doing that. The initial actuarial assessment said no more than that it would slow the rate of growth, which is what it has done. Provided insurers continue to insure sick people (something that is unlikely to happen in a genuine risk-rated environment), costs will be driven not so much by the age profile of the insured population (though it will have some effect) as by technology and its capacity to supply and create the demands of the aged (not ageing per se). Handling these costs is the real challenge for the future.

This problem applies equally in the public sector, of course. The difference is the public sector will almost inevitably deal with that problem by financial caps and rationing. If the private sector is to deal with it adequately, payers will need to be able to apply financial incentives to help them manage their risk exposure. The outcome should be significant improvement in quality and outcomes, provided funds are allowed put the emphasis on appropriateness.

Unfortunately the regulatory environment in which insurers operate today is far from conducive to effective risk management: rather the reverse. While providers, particularly medical practitioners, are able to adjust their charges at any time, insurers cannot. Increasing benefits to match supplier charges increases prices (which can be vetoed by the Federal Government) while holding benefits and prices down transfers the price problem from the pool to the individual patient.

Health delivery has changed in the last two decades. When Medicare was introduced day surgery (which Funds do pay for) was virtually non-existent: today there are about 200 free standing day surgeries in addition to virtually the same number of private hospital beds that existed in 1984!

But day surgery has not achieved all it might: due to the ban on funds paying benefits for services outside “hospital” many procedures that were safely performed in doctor’s rooms (for which the only benefit payable is Medicare’s 85 percent of the schedule fee) are now done in a day surgery (Medicare 75%, Health Fund 25% =100% of Medicare Benefits Schedule) PLUS a facility benefit which may be hundreds of dollars for a 15-minute procedure!

In 1984 hospital-in-the-home was non-existent, nor was the concept of pre-admission and post discharge care, allowing reductions in length of stay without compromising patient safety.

But because health funds are locked inside the hospital walls we have the absurd situation where a health fund can pay for a diabetic’s gangrenous leg to be amputated but cannot pay a benefit to an endocrinologist to make sure the diabetic has proper foot care to avoid gangrene. (It can, of course, pay the podiatrist to cut the diabetic’s nails, but can’t reward a doctor for encouraging the diabetic to get their nails cut!)

Confining hospital and medical insurance activities to “in-hospital” treatment means that insurers are at the end of the line, unable to actively protect their members’ interests, and very constrained in their capacity to control costs. Their only weapons are relatively blunt instruments: prospective contracting about benefit levels and structuring of medical “gap” benefits aimed at a point which, one would hope, would be sufficiently attractive to doctors to reduce their propensity to seek additional co-payments from the patient.

Premiums are vitally affected by two things: the cost of individual episodes and the volume of admissions. Funds have limited power to deal with the former, and virtually no power to deal with the latter.

Regulation severely compromises their capacity to negotiate or offer effective disease management or coordinated care arrangements for their members, and very effectively inhibits any attempt to use market forces to encourage cost and efficiency competition. And the regulatory system is rife with perverse incentives:

- If a Fund wishes to provide home nursing or similar support for a member in an early discharge program they must do so via a hospital if they wish the cost to be debited to reinsurance. But organising early discharge programs is costly in managerial resources. Unless the savings are to be very substantial the cost may be greater than the post reinsurance cost of having the patient stay in hospital.
- Everyone wants the latest technology: but there is no cap on its price, nor is the provider required to advertise the cost. They just expect health funds to pay the bill - and then complain about the price of the premium.

- Prostheses - the marvels of modern technology - are growing in both number and cost. Funds are theoretically able to “negotiate” the price with the supplier BUT under no circumstances can their benefit be less than the price the supplier charges (even if a substitutable device exists at a lower price). This tilts the scales heavily in favour of the supplier, who can simply charge whatever they like knowing the Fund must pay.
- The Government mandated a “handling charge” to hospitals equal to five percent of the price of the prostheses - regardless of whether the hospital actually incurs costs or not. This arrangement expires in June 2002, and will be replaced by a revised reimbursement arrangement.
- Hospital negotiations are compromised by introduction of a so called 2nd tier default benefit for non-contract hospitals which is equal to 85 percent of a health fund’s contract price with similar hospitals. Funds must now disclose the dollar value of this benefit to any hospital that asks, regardless of their current contractual relationship. This severely undermines Fund capacities to hold down costs and encourages hospitals receiving lower benefits to drop out of contract, receive a higher benefit and charge the patient a co-payment! And if all lower benefit facilities drop out of contracts the average price is driven higher.
- Day facilities, have proliferated increasing the prospects of supply-induced demand. Once a facility is licensed by a State Government, the Federal Department virtually automatically declares it eligible for health fund benefits, and funds must pay regardless of whether they believe the facility meets a need or not.
- Funds capacity to deal with medical gaps - a major source of dissatisfaction with the product - is limited to paying more. There are no sanctions on doctors who insist on charging fees above fund benefits, because ultimately they can pursue the patient through the courts for recovery.

Despite this we are making some headway in the most important area of all: improvement in quality and safety.

Insurers’ capacity to promote quality improvement via contracting has been enhanced by one aspect of the 2nd tier default arrangements: if a hospital is to qualify for 2nd tier it will have to meet increasing standards of quality, including:

- Specific infection control policies and procedures;
- Recording, analysing and feeding back information on adverse events;
- Implementation of evidence based clinical pathways;
- Application of continuum of care principles for an episode of care, including proper discharge planning;
- Maintain accurate and comprehensive patient medical records including medication histories, allergies etc.;
- Ensure patients on discharge understand the use and possible adverse reactions of medications;
- Ensure proper qualifications of all staff;
- Provide appropriate information, including the use of interpreter services, to consumers and act on consumer feedback.

One may well ask why such criteria should not apply to all health care facilities.

So what of the future?

Firstly, private health care is far too subject to sovereign risk. Politicians on all sides have to understand that our health system cannot be subject to the crippling policy shifts which lead to massive changes in the level of the insured population. This “yo-yo” effect is not only destabilising, it undermines the capacity for sensible new investment in capital stock. What investor is going to commit funds to new private sector facilities if the environment is likely to change dramatically from one Federal election - or even one Federal budget - to the next and the pool of potential consumers suddenly dries up? Alternately, if they do take the risk and the environment suddenly changes the remaining pool of insured persons would have to pay a premium for under utilisation.

Secondly, while our bed supply is much more balanced today than a few years ago, hospitals are not necessarily located in the right places to meet demand. Insurers are much better placed than Governments to assess whether their membership base is better served by a new facility in one area than another. Funds should be able to

participate in decisions to approve new facilities for benefit purposes. This will further improve the supply-demand situation, and reduce the likelihood of inappropriate supply induced demand driving costs, and therefore premiums, higher. It would also reduce the temptation for entrepreneurs to establish a high (or low) tech facility and then glibly demand health funds pay for every patient they can lure through the door.

Thirdly, artificial regulatory barriers to insurers funding or providing services outside hospital should be removed. The current system provides too many perverse financial incentives for a hospital admission. If a patient can be more appropriately treated outside hospital the decision should be made on their clinical need, not the fact that an admission is more lucrative for providers. Both public and private sectors need to focus on paying for the continuum of care, NOT the artificial divide between in-hospital and out-of-hospital, which simply encourages cost shifting devices without any real concern for patient outcomes.

Fourthly, we should, as a society, begin to question whether hospital treatment is an inevitable part of disease management. I believe the day will come when admission to a hospital is regarded to some extent as a failure of the health care system, not a logical extension of it.

As a result governments and insurers should be able to develop incentive systems which encourage treatment in the lowest cost, most appropriate environment rather than our current system which encourages high volume activity and referral of patients up the diagnostic and treatment line. One of the most disturbing aspects of the so-called corporatisation of medicine is the potential it has to abuse the existing funding mechanisms by using GP practices to capture patients for referral for diagnostic tests and treatment in vertically integrated settings. I would prefer to see a system in which primary care workers were encouraged to avoid such referrals if possible. Treatments and tests should be ordered for the health and welfare of the patient - not the financial welfare of the provider.

Fifthly, health funds should be placed on a much more solid base to negotiate benefit levels with suppliers and providers, whether it be doctors, hospitals or suppliers of technology and be in a position where they can offer, and their members can choose, alternatives. The existing system is weighted too heavily in favor of the provider. Funds cannot be effective purchasers of services for their members under the current regulatory regime. The underwriting of provider income by mandated defaults has to come to an end, and providers seeking the privately insured dollar will have to be prepared to justify it.

Sixthly, any entitlement to health fund benefits must entail adherence to and application of baseline quality criteria such as that already in place for the 2nd tier default (without the mandated payment of the 2nd tier) as certified by an independent accreditation agency. This would ensure that hospitals are seen to be providing quality health care. Not only would this provide both funds and contributors with very real quality assurance, it should also lead to a reduction in avoidable adverse events - which would not only improve patient safety but also avoid unnecessary additional treatment costs - and even, perhaps, a reduction in professional liability premiums.

Finally, and perhaps most importantly, the health care system overall needs to be responsive to the increasing demands of consumers, especially demands for information. We can expect, in both the public and private sectors, more and more demand from consumers for more and better information about performance, costs and outcomes.

Providers have defiantly resisted the provision of this information on the basis that it could be misleading, but the barricades are being broken down. In the UK I can click on a website (Dr Foster) and find out the total price - including the fees consultant surgeon and anaesthetist, prosthesis, and physiotherapy for a hip replacement AND whether the hospital has a laminar flow operating theatre available for the procedure. I can find details of every hospital's staffing levels, waiting times, patient satisfaction levels and areas of expertise. Not only that, I can compare their mortality index based on casemix, adjusted for severity! And I can feel confident the information is accurate and ethical because it is overseen by a committee comprising distinguished clinicians, including the Dean of the Royal Society of Medicine.

In the United States, I can simply buy US News and World Report for a detailed ranking of hospitals, based on a scoreboard which is heavily weighted to clinician assessment for particular procedures. In Pennsylvania I can compare the actual to expected mortality rates of different cardiac surgeons, and in New York I can see a report on which hospitals have the lowest - severity adjusted - mortality rates for angioplasty.

How long before Australian consumers demand this information about health care performance? The real challenge is not how to stop consumers obtaining this information, but how to provide it in a meaningful way within a realistic time frame.

Australia is the envy of the world. We are the only country that has been able to secure a workable mixture of the public and private sectors to meet both the philosophical and very real issues I dealt with at the outset. But there is still need for reform if that mixture is to achieve its potential. To paraphrase Bobby Kennedy: some people look at our health care system as it is and say "Why?"; I look at how it can be and ask "Why not?".