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Walking and chewing gum – policy needs to balance multiple policy objectives, not just consider one

Grattan Institute submission in response to the Options Paper on the growth of private patients in public hospitals

Stephen Duckett

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This submission was written by Stephen Duckett, Director, Health Program. Naveen Tenneti provided research assistance and contributed to the submission.

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Summary

The Department of Health Options Paper on reducing pressure on private health insurance by addressing the growth of private patients in public hospitals is flawed in its conceptualisation of the problem, introduces a range of options which are not feasible, and does not consider all the options for responding to the identified problem.

In this submission we explore some additional reform options and suggest extra considerations for the listed options.

Our main comments and recommendations include:

- The Options Paper does not recognise that private health insurance costs are state government revenues. Failure to consider the impact of its proposals on state government revenues is naïve in the extreme.

- The Options Paper does not recognise the value of choice.

- Alternative options should be considered, such as capping public hospital private patient growth at 6.5 per cent, which is in line with the caps on growth in the current Commonwealth-state funding agreement.

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1 The Options Paper's definition of the problem is flawed

As the Options Paper on private patients in public hospitals states in its first sentence, Australia has a 'mixed public and private health model'.[1] The interactions between the public and private sectors are complex. The Paper addresses one such interaction – private patients in public hospitals.

The Paper moves quickly to suggest that the 'rapid growth in privately insured episodes in public hospitals is a concern for private health insurance costs'. It then suggests five options for 'reform'.

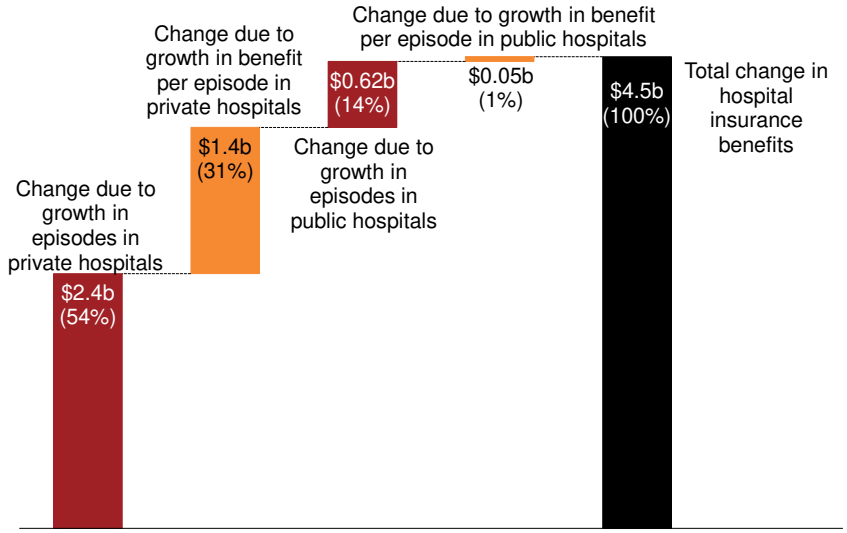
The focus and tenor of the Options Paper is peculiar for five main reasons.

Firstly, the Paper does not address the main reason for growth in private health insurance outlays. As the Paper shows, from 2010-11 to 2015-16 total hospital insurance benefits increased by $4.5 billion (presumably nominal dollars). More than half of the increased cost was due to increased private hospital admissions, with a further 30 per cent due to increased costs for each private hospital admission, the latter growing faster than inflation.

In fact, change in expenditure for private hospital activity accounts for 85 per cent of the increase in benefit outlays.

Yet the Options Paper addresses a much smaller issue, namely the 15 per cent of increased outlays on payments for privately insured patients in public hospitals (see Figure 1).

Figure 1: Growth in 'private in public' is a minor contributor to outlays growth



Sources: Grattan analysis of Department of Health (2017).

[1] Department of Health (2017)

There may well be other policy processes addressing the major problem, but there is little evidence for that in the public domain.

Secondly, every dollar of outlays by private health insurers for costs incurred in public hospitals is a dollar of revenue for state governments. If a 'healthy and stable private health insurance system used by 13.5 million Australians is essential for the stability of Australia's overall health care system', to quote the Options Paper, then ensuring healthy and stable state government finances, used to fund the public hospital system which is available for all Australians, would seem to be at least as essential for the stability of Australia's overall health care system. Yet the Options Paper does not discuss alternative sources of revenue for the states if revenue from private patients were to decline. Mechanisms to reduce private health insurers' costs will reduce state revenue, and consideration needs to be given to how this shortfall will be financed.

Thirdly, in the past policy about private insurance has often been framed as being about supporting patients' right to choose their own doctor. But the Options Paper appears to devalue choice: in one option it effectively proposes to eliminate insurance benefits for emergency admissions to a public hospital, but presumably keep them for emergency admissions to private hospitals.

The Paper also introduces a new concept in health insurance policy, *meaningful* choice of doctor. One option would remove the requirement on health insurers to pay benefits for episodes *where there is no meaningful choice of doctor or doctor involvement* (emphasis added).

This is a welcome development, but the consideration in the Options Paper is incomplete. As we have argued in our submission to a current Senate Inquiry, patients often do not have adequate information to make an effective choice of doctor.[2] There is little information to help patients assess the relative quality of different health professionals. Further, patients have no ways of checking whether a higher specialist cost correlates with better outcomes.

The Options Paper should have explored the meaning of 'meaningful choice', and the full ramifications of introducing this concept.

Fourthly, the Paper claims that, with the exception of identifying savings within the health-service-provider chain (principally in prosthesis purchasing), 'opportunities to identify savings through the internal operation of health insurers is (sic) limited'. The only evidence adduced for this claim is that 'health insurers (return) around 90 cents in the premium dollar back to consumers as benefits'.

However, between 2010/11 and 2015/16, health insurance management and other expenses have increased by 36 per cent, while the number of people insured and the number of policies have increased by 13 per cent and 14 per cent respectively. This growth in the number of insured people and policies potentially generated greater economies of scale for insurers.

The higher rate of expenses growth may reflect increasing complexity of patient disease profile requiring increased staffing to manage claims and internal business. But it may also reflect

[2] Duckett, *et al.* (2017).

unwarranted increases in internal management expenses. The Options Paper does not explore the reasons for this discrepancy, or how insured patients' disease profiles have changed.

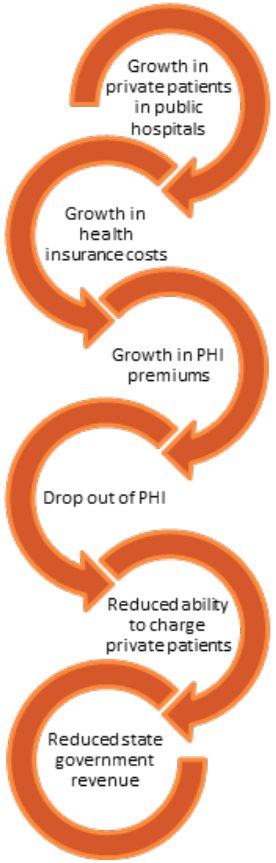
Finally, the Paper makes no effort to assess the broader impact of its proposed options. Although one can infer from the Paper that the additional private patients treated in public hospitals would otherwise be treated as public patients in public hospitals, there is no quantitative evidence to support this assertion. If there were to be a reduction in the number of private patients in public hospitals, some of these patients may end up being treated in private hospitals, and this effect would probably be larger if the policy changes led to a reduction in public hospital activity because of the reduced revenue flowing to the states.

Patients in private hospitals cost insurers significantly more than private patients in public hospitals. So, depending on the nature of the shift in patient flows, private insurers could end up not getting the expected net cost reduction from the implemented policies.

The naiveté of states

In a perfectly functioning market, market signals provide feedback loops to buyers and sellers. States, for example, should normally have considered a vicious cycle where faster growth in private patients in public hospitals, which in the short term may have increased revenue, would in the long run lead to revenue declines (see Figure 2).

Figure 2: Faster growth in private patients in public hospitals will lead in the long run to declines in revenue



Source: Grattan analysis.

Either the states didn't consider those effects or they discounted them.

There are several reasons why the states may have failed to consider those effects on private health insurance:

- The impact of each state on premiums would be small, and even collectively, the combined state impact was estimated in the Options Paper to cause premiums to be only 2.5 per cent higher than they might otherwise be.
- Commonwealth health insurance policies make drop-outs from insurance less likely than reductions in levels of benefits. Downgraded packages may still provide adequate opportunities for states to achieve their revenue targets.
- States may have discounted the importance of future problems.[3]

[3] A common trait of decision makers, see Angner (2016).

2 Evaluating the options presented

The Options Paper presents five options. In the table below we evaluate the five options against two criteria: impact on patient choice, and feasibility. On the following page, we assess the impact each option would have on an important third criterion, state revenue.

Table 1: Evaluation of options presented

	Impact on patient choice	Feasibility*
1. Limit private health insurance benefits to the medical costs of private treatment in public hospital, with no benefits paid to the hospital	Potentially positive, because patients may face reduced deductibles.	High.
2. Prevent public hospitals from waiving any excess payable under the patient's policy	Significantly negative, because this change would increase the effective cost of electing to be a private patient.	Not feasible. The Commonwealth has no power to implement this change, and the states unlikely to do so.
3. Remove the requirement for health insurers to pay benefits for treatment in public hospitals for emergency admissions	Negative, because this change would remove choice for an important class of admissions.	Moderate. This change would be open to gaming, because the definition of emergency admission could be manipulated.
4. Remove the requirement on health insurers to pay benefits for episodes where there is no meaningful choice of doctor or doctor involvement	Limited, because this change would only apply where there is no effective choice at the moment.	Moderate. This change requires definition of areas of no meaningful choice.
5. Make changes to the National Health Reform Agreement's National Efficient Price determination and funding model	None.	Moderate. This change would require the Independent Hospital Pricing Authority to collect better data on costs, including the incremental costs of single-room accommodation.

** The impact on state revenue is not considered in this criterion*

Source: Grattan analysis.

Of the five options advanced the first, limiting private health insurance benefits to the medical costs of private treatment in public hospital, with no benefits paid to the hospital, appears to be the most beneficial in terms of the two criteria considered. The fifth option, involving technical changes to the calculation of the National Efficient Price, may also be worth considering.

Impact on state revenue

All five options impact adversely on state revenues, an issue not considered in the Options Paper. The extent of the impact of most of the options is difficult to estimate because, except for option 1, each involves a partial reduction in the number of private patients in public hospitals or, for option 5, the revenue received for each patient.

To the extent states and public hospitals replace patients previously classified as private patients with public patients, some of the revenue lost to the state would be offset by increased Commonwealth revenue. But the overall impact on state revenue would still be negative. In the absence of alternative revenue sources (discussed below), a reduction in revenue from private insurance would have a severe adverse impact on funds available to the states for state services, including public hospital care. A reduction in public hospital funding would impact adversely on access to health care in Australia. It is most surprising that the Options Paper does not explicitly consider the impact on state revenue.

If the Commonwealth were to implement a unilateral reduction in state revenue for health care, this would represent a major breach of trust between the Commonwealth and states. The ink is barely dry on the last financial agreement between the Commonwealth and the states for health care, and that agreement was the Commonwealth's third hospital funding policy in as many years.[4] This perpetual tinkering with public hospital funding is redolent of the Fraser government's health policy gyrations.

An alternative way for states to recoup lost revenue might be to levy a special income tax on private health insurers, to ensure state revenue is maintained. This would probably reduce the cost of raising private revenue and thus may be a worthwhile initiative on efficiency grounds. A recent precedent is the South Australian bank levy.[5] A more distant precedent is Victoria's Hospital Benefits (Levy) Act 1982, which imposed a levy on private health insurers to pay for outpatient care.[6]

States should immediately explore the potential to impose a tax on private health insurers to mitigate any loss in revenue from unilateral Commonwealth action.

[4] Counting the changes announced in the 2014 Commonwealth budget. These were not implemented.
[5] Grudnoff (2017); McIntyre (2017)
[6] The Act was repealed after Medicare was introduced. The Commonwealth tried to overturn the legislation with its Health Legislation Amendment Bill (No.2) 1982, but the relevant clauses were defeated in the Senate. A subsequent bill on the same topic, Health Legislation Amendment Bill (No.3) 1982, also failed to pass the Senate.

3 The options presented are incomplete

The Option Paper does not propose a full set of possible options to address the problem, even in the inadequate way it has been framed in the paper.

An alternative option: cap growth directly

If the problem is that the growth in private activity in public hospitals is too high, then a policy to cap that growth is more direct, simpler and equally effective.

The current Commonwealth-state funding agreement caps growth payments from the Commonwealth to the states at 6.5 per cent. This cap should also be applied to public hospital private patient growth; that is, any private patient growth in any state above 6.5 per cent should not attract Commonwealth growth funding. A stronger policy would be to cap Commonwealth growth payments for private patients at the same level as public patient growth in the state.

A complementary approach: force a greater focus on public hospitals

Recent Australian Institute of Health and Welfare statistics show that in 2015-16, the waiting times for private patients in public hospitals was significantly less than for public patients.[7] The average waiting time for public patients was 42 days, but for private patients who used their private health insurance to pay for their admission, the average waiting time was only 20 days. Other measures of waiting time show a similar pattern.

This may indicate that privately insured patients are getting priority access to public hospitals. If so, this is a breach of the national funding agreements, which require that patients be prioritised for admission on the basis of clinical need. Further analysis of the data is required to identify if this pattern is occurring in all states. For those states where there is a materially shorter waiting time for privately-insured patients compared to public patients, the Commonwealth and the state should jointly audit hospitals which show this pattern.

A fundamental principle of Medicare is that patients are to be treated on the basis of need – public patients should not be relegated to the bottom of an admission hierarchy. Where there is evidence of prioritising privately-insured patients, the Commonwealth should impose a severe penalty on the state, perhaps by excluding hospital activity in those hospitals where inappropriate prioritisation has occurred from counting toward recorded activity of the state for any quarter in which this has occurred.

Some of the increase in private patient admissions to public hospitals may be the result of preferential access. This problem of potential preferential access should be addressed, regardless of the impact on private insurers' outlays.

[7] Australian Institute of Health and Welfare (2017)

Addressing the major problem

As we showed in section 1, the major factors influencing private insurers' outlays are growth in admissions to private hospitals and growth in the cost per patient admitted to private hospitals. These private hospital factors account for 85 per cent of the growth in benefit outlays. Yet the Options Paper focuses on the minor element of the problem – the 15 per cent of growth in outlays attributable to private patients in public hospitals.

If the problem to be addressed is increases in private insurer outlays – from whatever source – then there are other places to look.

Low value care

A 2015 Grattan Institute report, *Questionable care: avoiding ineffective treatment*,[8] proposed policies to address provision of treatments of low or no value. Yet provision of questionable care still abounds. Stronger action needs to be taken. Private health insurers should be given more autonomy about how they provide benefits – and whether they pay benefits at all for – for low value care.

Rapidly growing specialties

There are puzzling differences between patterns of care between public and private hospitals. For example, between 2010-11 and 2015-16, admissions to public hospitals for rehabilitation care increased by 19 per cent, but admissions to private hospitals for rehabilitation care increased by 65 per cent. The number of rehabilitation bed days in public hospitals increased by 8 per cent over this period, but in private hospitals the increase was 37 per cent.

If the increase in private hospital rehabilitation activity has led to an improvement in outcomes for patients, say in terms of improved functioning, then the increased admissions and associated costs may be cost-effective. But there is no published evidence to show such benefits.[9]

Rehabilitation care is one area where changed funding arrangements, for example to allow payments related to improved patient outcomes, should be explored. Excessive government regulation constrains private insurers' flexibility to deal with these issues. This should be addressed as part of any strategy to help insurers to control increases in outlays.

[8] Duckett, *et al.* (2015)

[9] Naylor, *et al.* (2017)

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