AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | ama@ama.com.au
W | www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

AMA submission to the Department of Health's Consultation Paper on Risk Equalisation

Via email
PHIconsultation@health.gov.au

The AMA has highlighted on many occasions that Australia's health policy levers are not set and forget. Private health in Australia is complex and interlinked – the AMA's *Prescription for Private Health Insurance* acknowledged this by looking at numerous levers that all work collectively to underpin just the issue of private health insurance (PHI). The AMA does not believe it is possible to look at any one aspect of this complex system in isolation. To do so risks serious unintended consequences.

The AMA has serious concerns about the direction of this work. The consultation paper does not have patients and the broader value they derive from the private health system at its core. The focus seems much more about 'preserving incentives for insurers to control costs' or 'incentivising insurers to operate efficiently' to improve affordability. The real value proposition and the reason people choose PHI is lost in this approach.

The proposed shift to prospective risk equalisation will likely help insurers minimise costs, but it will achieve this by creating a system which may reduce patient choice and the clinical autonomy of doctors. As such the AMA does not support a move to prospective risk equalisation, and especially as we do not believe there are appropriate regulatory safeguards in place.

The AMA has called for, and welcomes, meaningful research and review which aims to make our private health system better able to provide sustainable quality health care into the future. The AMA has called out the lack of mechanisms to ensure that the policy settings underpinning the private sector remain fit-for-purpose. We believe that the mechanisms overseeing the impact of broader health system reforms on the private sector are inadequate.

Australia's private health policy and regulatory framework is incomplete. There are gaps in knowledge, in evidence, and in regulation, all of which ultimately impact the patient through unexpected out-of-pocket costs, reduced clinical outcomes and the development of a system that is difficult (and in some cases near impossible) to navigate.[1]

[1] https://www.ama.com.au/form/discussion-paper-a-whole-of-system-approach-to-reforming-private-healthcare

It is difficult to see implementation of wholesale change to the private health system being adequately managed and guided in the absence of a fit for purpose policy and regulatory authority – indeed this consultation document itself acknowledges the need for such a regulator beyond the capacities of any of the current regulatory bodies:

A regulator: Identifying a 'regulator' to take responsibility of setting the risk adjustment parameters based on experience data. The regulator would require significant lead time to develop and implement the new capability required. (p27)

The AMA has supported the current work in process by the Australian Government, we have championed the need to understand better how the policy levers are currently working. Now is the time to take these individual reviews and analyses done by the Department of Health and develop a cohesive plan. The current approach is disjointed and will not achieve meaningful reform. The AMA is prepared to sit down with the whole the sector and develop a workable plan for a sustainable and thriving private health sector into the future.

Patient and clinician centrality

The AMA has advocated changes to the private health system in Australia including PHI. However, these changes must have at their very core the ability to improve the value proposition for patients. Value cannot be determined solely by the cost to Australians of their PHI premiums. People take out insurance for the following reasons:

- To gain better, quicker access to health care;
- To have a choice of doctor and choice of hospital;
- Increased peace of mind regarding costs associated with medical treatment; and
- A better range of treatment options.[2]

Nowhere is this clearer than the unconsulted change in the stated objective for risk equalisation. In the 2018 Risk Equalisation Working Group report to the Private Health Ministerial Advisory Committee (PHMAC) the objective was described as:

"The objective of risk equalisation is to support community rating by minimising incentives for insurers to discriminate against consumers based on risk, in a way that:

a) Does not put well managed insurers at prudential risk; and
b) Maintains a competitive private health insurance model with incentives for insurers to compete".[3]

[2] https://chf.org.au/sites/default/files/what_australias_health_panel_said_abour_the_private_healthcare_system.pdf
[3] https://www.health.gov.au/sites/default/files/documents/2021/12/foi-request-2712-release-documents-agendas-and-attached-documents-meetings-of-phmac-subcommittees-and-working-groups-between-september-2016-december-2018-foi-2712-report-risk-equalisation-wg-report-to-the-phmac.pdf

The AMA believes this is a far cry from the objective contained in this consultation paper. Without consultation or discussion with the sector it appears the stated goal for risk equalisation is now to:

"Improve value for money by providing insurers with incentives for efficiency, while mitigating risk selection and ensuring appropriate compensation to insurers who cover people with high expected claim costs" (p6).

A focus on efficiency without balance could see:

- Increased pressure on contracts with hospitals reducing diversity and choice (especially in outer metropolitan and rural areas);
- The development of lower cost options for patient care that do not deliver better clinical outcomes;
- Increased pressure on medical practitioners to enter into contracts with PHIs that include targets set to meet the insurers fiscal objectives which can limit clinical autonomy and undermine patient outcomes; and
- PHI run care programs that are not linked to the patients' medical practitioner.

The AMA does not support a move to prospective risk equalisation without adequate safeguards for clinical independence or a fit for purpose regulator ensuring that the patient is central to the management of the private health system.

1. The validity of the study's findings and how they relate to:

i. current and future outcomes for policyholder; and

ii. current and future performance of Australia's private healthcare system.

The AMA has some questions about the work undertaken in this study.

<u>The assessment criteria are inadequate</u>

The AMA cannot support the finding in the report that:

Finding 3: We have demonstrated that alternative models test better than the current model, using actual Australian insurer data and a comprehensive set of criteria.

We do not believe that a comprehensive set of criteria were used. The criteria for the study were:

- Incentives for efficiency
- Statistical variation in spending
- Incentives for risk selection
- Protect insurers against large losses
- Risk equalisation system set-up and maintenance costs
- Platform for future improvement and adaptability. (p4)

The AMA provided early feedback that we thought the focus of such criteria was narrow, one-sided, weighted for insurers and failed to adequately consider clinical outcomes and the consumer perspectives, especially choice. The AMA has concerns that the strong focus on improving the economic position of insurers to reduce premiums is likely to contribute to an uneven playing field for the rest of the sector.

The AMA believes that a strong private health system needs diversity and balance to produce quality outcomes and provide choice of health pathways for patients.

What constitutes 'efficiency'

The focus on reduction of costs to insurers does not take into account the potential impacts to other parts of the private health sector. On page 11 of the document one of the examples of opportunities for insurers to operate more efficiently is outlined as:

> *Contracting more efficiently: Analysis of Australian PHI data shows differences in average claim costs between insurers, even after data is adjusted (to the extent possible) for other factors which might explain differences such as member age and location. If funds with above average costs are able to achieve average cost levels, we estimate a 6% reduction in claim costs.*

The AMA questions the real outcome of a such a reduction in claim costs. The AMA's annual PHI report card demonstrates that many insurers pay considerably less towards the work carried out by doctors for the same procedure. Of the limited number of items (21) that our report card looked at last year more than a third had a greater than 25% variation in the amount paid for the same MBS item:

Percentage variation	0-10%	11-20%	>25%
Number	6	7	8

The AMA does not support a race to the lowest common denominator for the payment of doctors,[4] especially as PHI rebates are based on the MBS benefit rate which has failed to keep up with the health inflation or increases in average weekly earnings or the consumer price index for over a decade.[5]

The AMA agrees that increasing efficiencies can be obtained through innovation of quality evidence--based care, but it can also be obtained by substituting less effective and therefore cheaper care, or by underpaying for services and thereby undermining our whole private health system. Paying above an average rate is not inefficient when it buys better standards of care or achieves better clinical outcomes for patients.

[4] https://www.ama.com.au/ama-rounds/18-november-2022/articles/poor-medicare-indexation-saves-federal-government-billions
[5] https://feeslist.ama.com.au/resources-ama-gaps-poster

The emphasis throughout the consultation document on reducing costs, so that premiums can be lowered without a framework that guarantees evidence-based quality care, is fraught. The substantial change to risk equalisation outlined in the document must be first supported by quality information and evidence gathering. It is not possible to evaluate changes when we cannot measure their outcomes.
Unlike a normal competitive market, insurers are unable to charge more for the provision of higher quality services. They rely on overall reputation for quality spread across their membership. When insurers reduce the quality of care, it is very difficult for patients to 'take their business elsewhere', as alternative insurers will not attempt to attract a person at risk of high claims. This was this original purpose of the dual pronged approach to RE to place on equal footing the imperative to lower costs while treat patients with above average claims (even allowing for age) the same.

PHIs contend they want to support innovative care, both in and out of the traditional hospital setting. In spite of announcing a move to out of hospital rehabilitation and mental health in the 2020-21 Commonwealth Budget,[6] to date the Government has not been able to develop a framework that ensures the development of evidence based, quality care options that clinicians choose for their patients, not insurers. Moving to prospective risk equalisation in the absence of a framework and that supports and guarantees the quality of innovative care does not make sense.

The only ability we have at present is to measure the costs involved with some private health services. There are no mechanisms in place to measure clinical output – so it is not possible to ensure that lowering cost delivers the same let alone better health outcomes.

2. The merits of the Study's recommendations and how they relate to: (i) possible outcomes for policyholders; and (ii) the future performance of Australia's private healthcare system.

The AMA understands that purchasing PHI is a significant financial commitment for many consumers and achieving value for money is extremely important especially in current times with growing increases in cost of living. However, the real point of PHI is that, ideally, it should offer Australians greater choice in their doctors, access to evidence based treatment at a location that suits the patient and delivers shorter waiting times for services.

Reduction of choice

Recent AMA submissions and documents have highlighted the significant reduction in choice for consumers over the last decade. PHI firms have moved from primarily not-for-profit organisations to the current situation, where almost 70 per cent of the insured population are now covered by for-profit funds.[7] This has been accompanied by an shift from funds acting as passive payers to 'active funders' – extracting sizable profits from the sector for shareholders, administration costs and executive remuneration.

[6] https://www.health.gov.au/resources/publications/budget-2020-21-private-health-insurance-expanding-home-and-community-based-mental-health-and-rehabilitation-care
[7] https://www.ama.com.au/articles/ama-private-health-insurance-report-card-2021

With the market power shifting in favour of the private health insurers, they are increasingly influencing who can provide treatments to their members and where it can be provided. The AMA believes that health insurers (often being driven to make a profit for their shareholders) should not determine or influence the provision of treatment for a patient. Health insurers should not interfere with the clinical judgement of medical practitioners (this includes interfering in the medical advice about which provider of other medical and ancillary services a medical practitioner requests, as often they can contribute particular expertise in a clinical area). The AMA believes that moving to prospective risk equalisation (especially if accompanied by downgrading or removing second tier default benefits) in the absence of an effective regulator that can hold health insurers accountable is likely to exacerbate this trend.

Lowering individuals' clinical outcomes

Changing the risk equalisation settings from retrospective to prospective is based on average health outcomes as costs are paid prospectively based on population (or sub-population) averages. This creates a system that weights towards average outcomes that are best for the insurer versus ensuring clinicians can optimise individual outcomes. A prospective system based on rich health status data risks incentivising insurers to use those data to drive clinical care choices that preserve their prospective payments.

There is a strong likelihood that over time, insurers will utilise any external data they can gather (or buy) that indicates their insured customer base could achieve a lower-than-expected claims cost. This 'adverse selection' problem will pit insurers against one another in a data arms race. The outcomes of such a race can be financially beneficial and drive efficiencies through effective clinical programs. A 'successful' data driven program is one that lowers cost. Any way to achieve that is satisfactory from the insurer's perspective.

Sadly, this may include putting exclusionary criteria on programs that only allow low-risk members to claim or exclude more expensive treatment options that may be more clinically appropriate or desirable for a patient. This data driven selection bias will become predominant throughout the insurers business model. That is the most effective way to drive down costs. This will be effective at lowering premiums but at the expense of patients in higher dependency or higher risk categories. The insurers will not see any negative from driving away higher-cost patients as such a move to another provider will further lower costs for the insurer over time.

Incentives in RE will be in place for insurers to offer 'sweetheart deals' to doctors willing to work within a purpose designed program that reduces patient choice or changes recovery program guidelines to lower cost potentially at the expense of patient outcomes. It is also possible for alternative programs to offer better clinical outcomes through clever design. Unfortunately, there are only incentives to lower cost and no appropriate regulatory framework in place to ensure that adverse selection and program design do not simply lower clinical outcomes to achieve this.

Reducing the ability to complain about your insurer

The AMA has real concerns that the proposed changes would impact strongly on the ability of patients to complain about the standard of care provided by their insurer. Insurers will have no incentive to retain members they see as potentially costing them significant benefit payouts when they complain to the insurer or to the ombudsman. Whilst the system of community rating is not being questioned in these reforms, insurers can still exert negative influences on select customers through restricting access to programs or, where they are the providers of health services (which is also increasing in Australia's private health sector), opting for a later date to provide services. While the AMA is sure that insurers will deny that they would ever do this, we are also sure that a portion will.

3. The arrangements or mechanisms that should accompany a process to develop a detailed proposal and the major implementation issues and considerations (including transition timing) that should be considered in developing a detailed proposal.

There are two main issues with the current consultation process on PHI reforms being undertaken the Department of Health:

- The lack of coordination across the different reviews and analyses of for each of the PHI levers being investigated;
- The short time allowance and ad hoc approach to running meetings or webinars.

The lack of coordination across the different reviews and analyses of for each of the PHI levers being investigated

The AMA has highlighted on many occasions that Australia's health policy levers are not set and forget. Private health in Australia is complex and interlinked – the AMA's prescription acknowledges this by looking at numerous levers that all work collectively to underpin just the issue of PHI. The AMA does not believe it is possible to look at any one aspect of this complex system in isolation.

Issues that are raised in response to discussion for one study that cover other areas are not reported to the other reviews nor are the interdependencies or synergies explored. This risks serious unintentional consequences occurring if changes are made to the single policy lever under question.

The short time allowance and unorchestrated approach to running meetings or webinars.

The consultation across the different reviews including this one has often offered one or more webinars or workshops. The number of participants can exceed 100, and the invitation list varies so that sometimes key participants are left off. Even in a 2- or 3-hour webinar, with more than 100 participants there is little opportunity for real discourse.

The smaller workshops that have been organised have given rise to the start of a discussion across the sector, but instead of providing the ability for peak organisations to take new ideas and solutions back to their constituents and re-engage in productive discussion which could move the sector forward, there are no follow up meetings.

The AMA understands that the plan for these reforms is that there will be high level decisions taken to Government to be made in the May 2023 budget context. Following that there will be further opportunity to refine the proposed way forward and work on implementation issues. But in doing this Government has lost the ability to engage with the sector to look at how they might approach these issues and what real reform that can be agreed by the whole sector would look like.

This is especially true of the work that has been done on risk equalisation. There has been token input asked of members of the sector. For this consultation on risk equalisation our submission reflects the AMA's observations and concerns. Ideally, we would have worked through our thoughts with other members of the sector to help understand the impact across the sector and collectively develop ideas for reform.

The AMA calls for the government to bring together the sector to engage in meaningful consultation of reforms. There have been criticisms of the previous PHMAC process, yet it still delivered substantial reforms for the system that are benefiting patients today.

Something like this approach is needed again – a mechanism where the sector can consider the evidence generated in each of these reviews and studies and discuss and negotiate all aspects of reform, rather than being continually constrained as to what is in scope or not in scope, what there is or isn't time to discuss. Organisations need to be able to test ideas generated by other areas of the sector with our own constituents to have a chance of developing a platform of reforms that work across private health sector. Only in doing this will we stand a chance of generating meaningful reforms that will not just improve insurers bottom lines but have a much stronger chance of improving the health outcomes of our patients.

4. What are other considerations associated with the proposed changes that the Department (and other stakeholders) should be aware of?

There isn't a framework to support innovative care

One of the central tenets of this consultation paper is the ability of insurers to innovate and be rewarded for that innovation. Risk equalisation is not the only factor that supports meaningful innovation. The AMA contends that there are several other key factors that need to be in place including better data collection, increasing the evidence base supporting care, more appropriate funding mechanisms to support new models especially as they are being developed, the ability evaluate and accredit care alternatives that take place out of the hospital sector and a stronger mechanism to protect patients' rights and their voice in a reformed sector.

In June 2022 the AMA held a summit to discuss issues facing the private health sector. At this summit we proposed the establishment of a Private Health System Authority.

Whilst there was not agreement on all aspects of this work, across the sector there were areas of agreement. The top five of these included:

- increasing collaboration through the development of an ongoing mechanism that supports working together as a sector,
- improving the value proposition of private health and PHI for consumers,
- increasing access and utilisation of data to drive understanding and reform,
- building a better evidence base across the work of the sector; and
- developing and implementing better and more innovative models of care.

Changing the risk equalisation framework in isolation of the rest of the body of work that is truly needed to develop will not support the sector to nurture and develop innovative models of care.

The AMA believes the following are needed to achieve this:

- A better evidence base for the programs being implemented by PHIs,
- Ongoing evaluation of these 'innovative programs' many of which will be new or at least untested in Australia,
- Accreditation framework for innovative programs to ensure they are delivered by appropriate and qualified professionals, and
- An independent regulatory mechanism to ensure that all players abide by the rules, but also to evaluate the settings involved and calibrate these appropriately.

Development of an independent regulator

The AMA agrees with the contention from Catholic Health Australia that:

The private health sector faces significant macro challenges beyond the short-term crises that COVID has engendered, which are an existential threat to the viability of the sector. ….. It is time to turn our minds to the macro reforms that are required to ensure the sustainability of the private health sector. [*https://www.cha.org.au/wp-content/uploads/2022/10/Default-Benefits_CHA-submission.pdf*](https://www.cha.org.au/wp-content/uploads/2022/10/Default-Benefits_CHA-submission.pdf)

The AMA has stated previously that we support reform – it was our prescription that highlighted many of the issues that government by these various reviews agree need consideration.

However, we firmly believe that to achieve quality system reform there needs to be an independent authority established. This authority would fill in gaps in the regulatory framework (such as ones identified in this consultation document). It would also oversee the sector highlighting issues to government. It would also have the capacity, objectivity, and expertise to ensure that the system evolves as government policy intends, ensuring that robust mechanisms are in place which balance the interest of all sector stakeholders in the delivery of patient-centric, clinician led care. Importantly, an independent authority is needed to create a platform for all the players in the sector to come together and agree on the necessary once-in-a-generation reforms which are required to secure the future viability of private healthcare in Australia, and build a better system.

Conclusion

The AMA strongly believes that changes to our model of risk equalisation risks removing both the patient and their clinician as the central points in deciding what services can and should be offered in a patient's health pathway. Prospective risk equalisation risks incentivising insurers to increase pressure on hospitals, on doctors and on patients to make cheaper but not necessarily the most clinically advantageous choices.

This situation will be exacerbated by the lack of an effective, fit-for-purpose regulator for the sector. We need this regulator so that when insurers put undue pressure on their customers, when they try and substitute for inferior care, or when they put quotas on hospitals and medical practitioners as part of the opaque commercial in confidence contracts they negotiate, we have a body that provides balance, ensures quality standards are enforced, and listens to the voice of the patient when they come up against their insurer.

5 DECEMBER 2022

Contact

Tracey Cross
Senior Policy Advisor
Australian Medical Association