Members Health Fund Alliance

Submission to the Draft recommendations from the Primary Health Reform Steering Group on the Australian Government's Primary Health Care 10 Year Plan

27 July 2021

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Putting members' health before profit

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Introduction

Members Health is the peak body for an alliance of 26 health funds that are not-for-profit or part of a member-owned group. They all share the common ethic of putting their members' health before profit. Our funds represent the interests of more than 3.9 million Australians.

Collectively, our funds are growing at more than twice the rate of the rest of the industry, they return more premiums back to members as benefits, offer fewer policies with exclusions or restrictions, and excel in customer service and trust.

Fundamental to our funds' continued success is their shared commitment to improving members' health and wellbeing through timely access to quality health care services in appropriate health care settings. Our funds have a deep seated respect and appreciation for the many components of Australia's world-class health care system – primary care being a crucial element of that mix.

However, we also recognize that not all systems are perfect. We note the findings of the Steering Group with regards to weaknesses affecting Australia's primary health care system: its structure, funding, data and information sharing, workforce issues and general disconnectedness to the rest of the system.

Australia's rapidly aging population is driving up utilisation and cost in the healthcare system. By 2057, it is projected there will be 8.8 million people aged over 65 in Australia (22 per cent of the population, up from 15 per cent in 2017).

Meanwhile, the rate potentially preventable hospitalisations (PPHs) continues to rise, reaching 748,000 separations in 2017–18 and accounting for almost 7 per cent of all public and private hospital admissions.

Put simply, more people are presenting to their GPs and medical practitioners and being hospitalized for conditions at unprecedented levels. The consequences of this volume-based system are stark, with States across the country struggling to keep up with demand for hospital based services.

Members Health commends the Steering Group for its overarching vision for Australia's health system and its aspirational list of recommendations aimed at remedying the weaknesses and challenges it faces.

We support the move towards a proactive wellbeing system focused primarily on preventative health rather than an "illness system" focused on responsive treatment; moving away from a volume-based system to a value-based system where patient needs are placed solely at the centre of the healthcare journey; and tackling the siloed, disjointed nature of Australia's healthcare system to make way for a more coordinated, integrated and multidisciplinary ecosystem of health services (public and private) driven by innovative funding mechanisms and information sharing across settings and professions and with patients and their carers.

Again, thank you for inviting Members Health to participate in this important consultation. We have sought to respond to a number of specific recommendations outlined in the Discussion Paper.

We look forward to discussing the future of Australia's primary care system, and overcoming the challenges it faces, in the near future.

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Feedback on key recommendations

Members Health agrees that in order to strengthen primary health care over the next decade, reduce preventable hospitalizations and to ensure the sustainability of Australia's health care system as a whole, a broader and more collaborative approach to care management must be adopted by clinicians, medical leaders and policymakers.

To achieve this objective, innovation and collaboration between all components of the health system should not only be encouraged, but mandated.

Therefore, in support of the recommendations set down by the Steering Group, and overarching our feedback, is the need for the draft recommendations and 10-year plan to include in-principle acknowledgement that the private health system be better integrated with the primary health care system.

The recommendations, as currently described, largely refer to integration of public health services, providers and systems while insufficiently recognizing the function of private health services, providers and systems and the issues and requirements to integrate private health with primary health.

More specifically, we suggest:

- Better integration of private health insurers' health care management programs as complementary offerings or options for patients – upon GP recommendation and referral; and,
- Adoption of more flexible funding models to allow private health insurance to support allied health care services in the primary care setting;
- Better information and data sharing (including outcome measures), as well as transparency between components (private and public; primary and secondary) of the healthcare system;
- Leveraging existing e-health platforms to empower health consumers with timely, more specific and relevant information for consumers to make better health decisions (e.g., helping patients to improve their understanding of the potential outcomes and costs associated with different health care options).

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Integration and Funding

Members Health welcomes the Steering Group's recommendation for more integrated health care system, which places high-value care – from the primary care setting and beyond – at the forefront of the patient journey.

In particular, we note the objective of this key recommendation is to make primary care "a lynchpin for continuity of care across all stages of life", with a commitment to quality, access and efficiency through a flexible system of delivering care and preventive services via various funding sources, services and programs.

However, we suggest that if the Steering Group is truly intent on achieving a more cohesive and collaborative health ecosystem, private health insurers (and the private health system more broadly) should be included as a key stakeholder to this recommendation's success.

From the outset, it is important to state clearly that Members Health and its constituent health funds do not support 'US-style managed care'. Members Health supports Medicare and it continuing to cover out-of-hospital medical practitioner services. And while our funds are firm believers in the value and sovereignty of the patient-clinician relationship, we also advocate for consumers to be empowered to make informed choices about what care they receive, how, when and where they receive it.

The evidence and experiences of insurer-funded Broader Health Cover (BHC) programs, such as Chronic Disease Management Programs (CDMPs) (as defined in the Private Health Insurance Act and related legislative instruments), indicates that success can only be achieved if (among other factors) GPs integrate them with their own care management pathways.

Insurers invest a lot to support the development of BHC programs, in order to keep their members healthy and out of hospital. We believe, if it is in the interest of the patient and receives the GPs' full clinical support, such insurer-funded programs can and should play a greater, complementary role in coordinated care.

Many of the recommendations of the primary health care 10-year plan allude to this concept – e.g., the health care home as the hub for patients with chronic diseases and management of the services they require. Building better patient care pathways and identifying and eradicating treatment gaps across GPs, medical specialists, other healthcare professionals or insurers needs better public-private integration.

Members Health believes strongly that insurers and General Practitioners should be supported by Government to explore coordinated approaches to better leverage the existing BHC programs and services supported and funded by insurers.

Greater collaboration, integration and data sharing between primary healthcare and hospital care can only have a positive impact on the patient journey, particularly for those with chronic health conditions.

Broader Health Cover: Lessons learned in integration

In 2007, the Broader Health Cover measures took PHI out of the hospital and allowed either cover or direct provision of health maintenance, prevention and chronic disease management services, helping manage benefit outlays and mitigate the risk of avoidable acute hospital treatment.

Much like the objectives set out in the Recommendation 1, Chronic Disease Management Programs (CDMPs) were initially hailed as potentially enabling GPs and other clinicians to plan and coordinate the care of patients with chronic or terminal medical conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and other care providers.

The success of CDMPs, however, has left much to be considered. Following an initial spike in usage, service and program volumes have fallen despite the burden of chronic disease growing.

We believe the following contributing factors resulted in generally poorer CDMP engagement over the past 14 years, and provide sound guidance on how primary care and private insurers could better improve collaborations over the coming decade to jointly improve integrated patient care pathways and achieve Recommendation 1.

Insurer related factors

When BHC legislation was introduced, there was a great deal of enthusiasm and promotion from insurers to fund a variety of CDMPs and hospital-substitution services as (i) it added to the existing value proposition of PHI; and (ii) it was believed that these services would significantly lower benefit outlays and improve patient outcomes.

Health insurers have evolved their strategies for such programs to target more high clinical risk policyholders based on claims data. This process is generally more resource intensive, generates lower volumes of participation in aggregate and because promotion is from an insurer, generally, results in relatively low activation with targeted policyholders/patients.

Clinician related factors:

GPs play among the most trusted, central coordinating roles in an individual's healthcare journey. However, most remain unaware of CDMPs (or the detail of CDMPs) and the insurance status of their patients.

Not knowing how CDMPs work or the evidence base regarding their clinical benefit; it is only logical that clinicians have largely abstained from recommending such programs to patients for fear of adding complexity or an unknown entity to care management.

Compounding this issue is a communications deficit between health funds and GPs. CDMPs are generally funded and delivered as an optional bolt-on that is distinct from and parallel to other primary health care services that a patient may engage with.

With very few – if any – opportunity for health funds and GPs to share information or data about such programs, clinical performance or patient history, CDMPs and insurer-led wellbeing programs are consequently not well integrated with other primary or community health services.

Patient related factors

Given insurer- and clinician-side factors, it is likely that the majority of privately insured patients who present in the primary care setting with chronic diseases remain unaware of programs offered by their insurer.

From an insurer's perspective: widespread promotion is no longer common, while patients/policyholders tend to respond poorly, or simply do not retain general program information unless it specifically concerns the patient's own circumstances at relevant points in time.

From a clinician's perspective: Patients respond much more readily to their GP's advice and recommendations. Clinicians have a close relationship with their patients, and are well placed to link a health-related event or condition to a broader program.

But without sufficient information sharing between insurers and the primary care setting, there is little opportunity or incentive for clinicians to explore such management programs with privately insured patients.

Funding Reform

Members Health welcomes Recommendation 3, which aims for new and flexible funding models that support best practice in primary and integrated health care to help move the system from volume to value.

Australia's world-leading health care system is characterised by its unique balance of public and private funding and services. The private system alleviates immense pressure on the public hospital system by providing millions of individuals and families fast access to the highest quality health care and surgery when and where they need it.

From day one of a policyholder's membership, health funds are keenly focused on ensuring their members stay healthy and out of hospital. Whether that be through broader health cover programs, as described above, or through important access and benefits for preventative health care services in the allied health sector – Dentists, Optometrists, Pharmacists, Physiotherapists and Psychologists, just to name a few –a vital element of that patient journey.

However, as rightly pointed out by the Steering Group, Australia's health system has evolved towards one focused largely on illness treatment and volume rather than value.

Consequently, low-value health care remains a consistent issue in both of Australia's public and private health care systems. Addressing "waste" or low-value care across the system is, we believe, best served at the very centre of the patient journey – in the primary care setting. To do so, GPs should have the flexibility of funding resources to examine a patient's healthcare management pathway against the following very basic criteria:

> ***Is it the right care?*** *High-value care does not necessarily equate to "cheapest" care. It is considerate of patient outcomes and experiences relative to direct (and indirect) costs.*
>
> ***Is it the right time?*** *The right treatment may be provisioned to a patient but if it is provisioned too early or too late, the outcomes may be poorer than would otherwise be if the timing was more appropriate. Meanwhile, delays in accessing the right care may result in poorer clinical outcomes such as complications, and higher opportunity costs such as time required off work.*
>
> ***Is it the right setting?*** *This refers to cost inefficiency resulting from use of more expensive resources when less costly and equally effective resources would suffice. Examples are the use of overnight inpatient hospitals for simple same-day surgery, when a day surgery facility (or non-hospital setting) would suffice.*

Spotlight on low-value care

Potentially Preventable Hospitalisations	2014-15	2015-16	2016-17	2017-18	2018-19
Public Hospitals: Total preventable hospitalisations	493,347	523,616	553,921	581,840	581,067
Percentage of all public hospital separations	*8.2%*	*8.3%*	*8.4%*	*8.6%*	*8.4%*
Private Hospitals: Total preventative hospitalisations	140,953	154,754	161,401	165,902	163,778
Percentage of all private hospital separations	*3.4%*	*3.6 %*	*3.6%*	*3.7%*	*3.5%*
Average acute private hospital benefit per episode	$2,817	$2,877	$2,929	$2,968	$3,035
Estimated total benefits for private hospital PPH	*$397,056,175*	*$445,233,429*	*$472,801,999*	*$492,405,723*	*$497,144,789*
Total private health insurance policies	6,444,616	6,531,555	6,596,069	6,632,237	6,408,437
Estimated savings per policy	$61.61	$68.17	$71.68	$74.24	$77.58

Potentially preventable hospitalisations (PPH) are admissions to hospital that could potentially have been avoided through preventive health care services, or appropriate disease management (such as management of chronic conditions) in community settings (primary or allied health).

The AIHW reports that across Australia, 748,000 (1 in 15 or 6.6%) hospital admissions were classified as potentially preventable in 2017–18 – or around 2,800 per 100,000 people.

'Nationally, the rate of potentially preventable hospitalisations in 2017–18 was around 2,800 per 100,000 people.

Based on the average acute private hospital benefit per episode (excluding medical and prosthesis benefits) of $3,035[1], this wastage represented $497 million in potentially preventable costs to health fund members in 2018-19 alone. That translated to a $77 cost premium per health insurance policy – a figure that is consistently increasing year on year.

Such levels of low-value care represent a high and unnecessary cost to Governments and health funds alike, contributing to inflated health care costs and subsequent taxes, and upwards pressure on premiums.

We note that recommendation point 3.2.4 calls for reforms to PHI funding to allow delivery of contemporary and evidence based primary care by allied health professionals and nurses. Recommendation 7 urges an expanded delivery of comprehensive preventive care. And finally, related to this is recommendation 11, which reiterates support for an expanded role of the allied health workforce in a well-integrated and coordinated primary health care system underpinned by continuity of care and innovative funding.

We note that all these recommendations reflect in part the advice of the Productivity Commission only a few months ago, who provided compelling support for a more inter-connected health care system, with health insurers playing a more central, complimentary role in the preventative health care space and chronic disease prevention and management.

> *Private health insurers have a limited role in preventive care. However, there may be scope to reconsider the extent of their involvement. Currently, regulation allows private health insurers to fund only a limited range of interventions to improve the management of chronic conditions. Allowing an expansion in the role of private health insurers in preventive care may allow more people to access interventions that would assist them in managing their health.*[1]

The Commission suggested that in order to improve integrated health care, changes to health care funding arrangements are needed – including addressing the rules that limit the role of private health insurers in preventative care. Members Health supports that sentiment.

Without more detail about the implementation of such funding reforms over the coming decade, we remain committed to working with the Government and the healthcare community to develop innovative funding models that empower GPs and patients, and move our system to one focused more on value and preventative care, rather than illness and volume, and is more involving of private health funds.

Importance of Data

Members Health commends the Steering Group on its comprehensive focus on data throughout the full range of recommendations.

The power of data in driving innovation and collaboration across all industries cannot be overstated. We wholeheartedly agree that in order to achieve greater collaboration, best practice and *a culture of innovation* across all components of a truly integrated health care system, all reforms proposed under this 10-year plan need to support data collection, sharing and analysis, reporting and accountability.

However, across Australia's health system as it currently stands, there remains an imbalance: some components of the system enjoy an abundance of data and others are starved of any regular or insightful resources.

This imbalance inherently hinders any ambition of creating a single, integrated and coordinated health care system driven by individual patient needs, value and continuity of care across settings.

Members Health and its sister organisation, the Australian Health Services Alliance, actively promote transparent practices across the full range of health services that insurers deal with.

There are currently no examples of effective, collaborative data sharing and output transparency in the private sector that crosses the funder/provider/clinician divides. Some initiatives have come close in the past to generating true data sharing (e.g., AROC for rehab, PPHDRAS for mental health) but they regressed to data ultimately being siloed.

True data sharing, we believe, should be a two-way street. Both (or multiple) parties to a collaboration should be exchanging data and working together on the analysis and interpretation of said pooled data.

Within the correct policy frameworks, under the right regulation and with the correct mix of stakeholders, we believe true data sharing can:

- Equip clinicians with more information than ever about a patient's individual circumstances (e.g., a patient's interactions with private health services), their insurance status, available programs and pathways under both the public and private system; and,

[1] Productivity Commission, March 2021, *Innovations in Care for Chronic Health Conditions*: https://www.pc.gov.au/research/completed/chronic-care-innovations

- Improve patients' health care literacy, awareness of preventative health measures, understanding about treatment options in both the public and private systems; and knowledge of program and specialist fees and services;
- Strengthen the Government's existing digital health platforms, such as My Health Record or the Medical Cost Finder website, and inform health care policy so that it reflects the contemporary wellbeing status of all Australians.

What data needs sharing?

The following summarises potential areas of data sharing that Members Health believes will benefit the primary care and the private systems' collaboration:

- Identification of treatment pathways that do work and do not work in primary care (i.e. outcomes and success rates for existing coordinated care and chronic disease management programs) alongside GP-led research and commentary.
- The establishment of chronic disease registries. Such disease registries are vital to achieving long term savings in the health system through the improvement of community health. Properly developed, these registries would be key resources for research, data and evaluating management practices. Registries would also serve as an information source for researchers, health professionals and health partners as they develop preventative and management models for chronic conditions.
- Greater and more timely detail on referrals to specialists (e.g., primary clinical reason/s for a referral) such that insurers could be more responsive in enabling more timely access to potential required health services and proactively resolve access issues before they arise (e.g., provide more certainty and information regarding eligibility for cover)
- Information on GP-prescribed pharmaceuticals and/or medical devices to enable funds to assist GPs with improving performance on patient activation and prescribed treatment compliance.
- Patient reported outcome measures (PROMs) and Patient reported experience measures (PREMs) captured as part of hospital-based instances of care.
- More 'near real-time' and more detailed information on admitted episodes of hospital care and utilisation of allied health services to add to GPs' awareness of and access to detailed information regarding their patients' utilisation of private health services.
- More detailed and patient-specific information of potentially applicable additional options of insurer-funded clinical services and programs (such as CDMPs or hospital-substitution service providers).

Given that service providers are the core drivers of health inflation and insurance premium increases, and are central to patient care and treatment, we support transparency measures concerning performance and pricing data for medical costs. Such work supports efforts to reduce or eliminate gap payments and to ensure that consumers are fully aware any out of pocket costs prior to engaging with a medical specialist. Attempts to address this issue are being made through the Government's Medical Costs Finder website, and has the potential to achieve greater transparency, improved patient literacy and empower patients and clinicians alike with accurate pricing and performance information.

We encourage the primary care sector to support the population of data on the Medical Costs Finder website, and more broadly, transparent pricing for specialist practitioners, as they form a large part of GPs' referrals and treatment pathways.

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How data drives PHI

Members Health supports efforts to ensure that public and private health services effectively and efficiently complement each other. The private health system reduces pressure on the already overstretched public hospital system by providing fast and efficient access to high quality care at a much lower cost to Government.

In addition to a publically conducted annual premium setting process, the full gamut of operations of private health insurers are made publically available through quarterly and annual APRA reports as well as the annual '*State of the health funds report*' published by the Commonwealth Ombudsman. This report details the financial and operational performance of each health insurer, including their Management Expense.

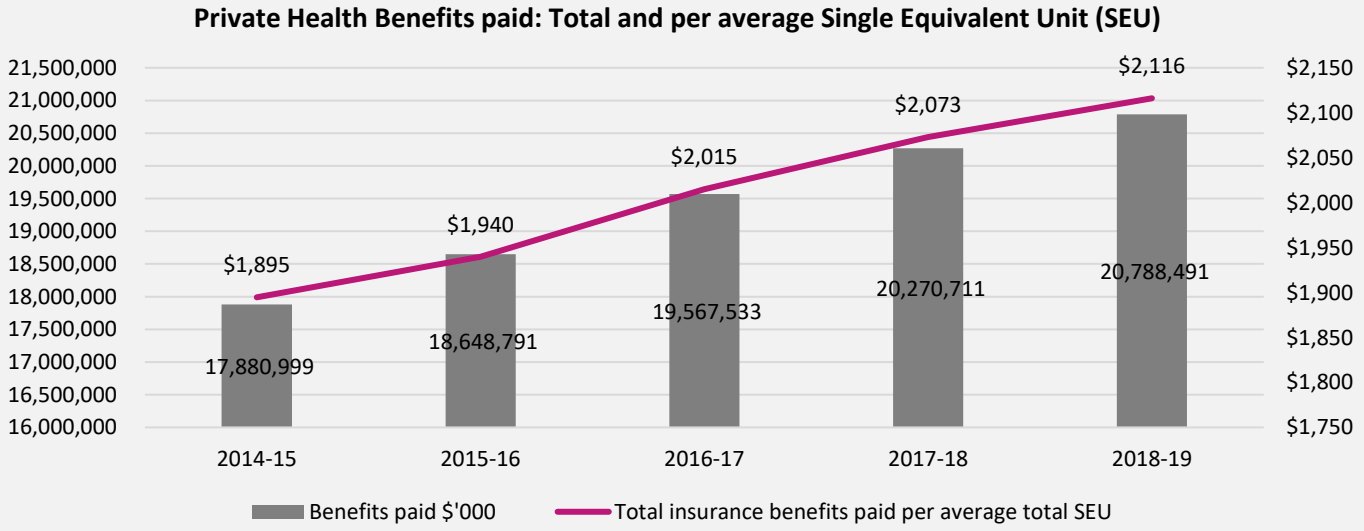
The result of having such transparency imposed on the private health insurance industry is – above all – accountability. Health funds' operations and products are constantly debated, compared and scrutinized in the public arena. And this is due to the availability of the data.

Consumers have a many Government and non-government resources to help them choose the right health fund for them based on premium or price, coverage, inclusions or exclusions, additional wellbeing programs, geographical area, industry or community segment.

As a result, the private health insurance industry receives vastly fewer ombudsman complaints as a share of the market compared to general insurance, telecommunications or energy. Their consumers are informed, empowered with choice and – based on recent growth figures – eager to join and seize control of their health care decisions.

Unfortunately the oversight and very high transparency and accountability standards applied to private health insurers do not extend to health service providers, rendering insurers as *passive payers* of services. Operational data around the performance and pricing of hospitals, medical practitioners and medical device manufacturers are not readily available. Therefore consumers are unable to make informed and empowered choices around their care.

Alongside rising demand across the entire health care system, benefits in private health insurance had been steadily increasing until the onset of the Covid-19 global pandemic, with little to no additional scrutiny on how these dollars are being spent or the value of the care being provided.



Private health insurers have no involvement in a patient doctor relationship and are unable to control prices set by medical practitioners. Further, under the rules of the Medical Benefits Scheme (MBS), insures are required to pay 15% of the cost of the set Government price. As such, if medical specialists chose to charge more than the set Government price a gap is created.

Empower consumers with enhanced e-health literacy and resourcing

Members Health notes the Steering Group's raft of recommendations dedicated to empowering individuals, families, carers and communities manage their wellness and health within a more digitized and efficient system.

Members Health is a long supporter of the Government's MyHealth record and other initiatives encouraging consumers to engage directly with their health care choices.

If properly leveraged, e-health has a big future in Australian healthcare in terms of increasing quality of care and outcomes, while reducing costs. Responsible information sharing that includes PHI insurers, through a reliable and consumer-friendly e-health network, has a real value to consumers from the primary care setting and beyond.

My Health Record has the potential to:

- Empower patients to participate in their electronic health record, take a keener interest in their health and management of their health.
- Enhances patient health-literacy.
- Effectively share data across practitioners to avoid costly re-testing.
- Collect and reports data in such a way that is interoperable, facilitating its use and value across a range of platforms.

Members Health believes that insurers can contribute positively to the success of the My Health record and that their involvement will improve health outcomes across the population – the over-arching goal of a national e-health strategy.

Where consent is given by the patient, private health insurers should be allowed access to their My Health Record. This will allow insurers to add health service utilisation information specific to the patient to their health record (including any related clinical metadata that may be informative to other health practitioners utilising the health record). This will also improve insurers' capacity to propose effective early interventions with their funded Broader Health Cover (BHC) services and to support the care paths of patients using these programs.

It is important to acknowledge that the interests of patients and private health insurers do align. The Community Rating principle underpinning private health insurance in Australia means that insurers cannot discriminate on the basis of risk factors or illnesses and insurers cannot raise the premiums of high risk or chronically-ill patients. Better managing the health of patients and reducing risk factors is therefore highly important to the insurer, to avoid unnecessary and costly hospital admissions.

Greater access to information allows insurers, in collaboration with medical practitioners, to better understand the appropriateness and effectiveness of their services and care management programs. Improving the capacity of insurers to measure the performance of their BHC services has the potential to improve utilization, driving increased innovation as the benefits of early intervention and preventative care plans are quantified.

As a simple starting point, Members Health notes that individuals' private health insurance status is not included on their My Health Record.

For GPs, this could be a very simple but useful fact to include on a patient's digital health profile. Knowing whether a patient is insured, the level of cover and with which fund, could at least direct the clinician and the patient to consider insurer-led health care management or wellbeing programs or services, additional allied health care services.

Alongside other useful resources – the Medical Costs Finder Website, privatehealth.gov.au – GPs and patients would be able to make the simple yet important connection between future treatment and potential cost.