

**Health Insurance Conference, July 2009**

**Rohan Mead, CEO, Australian Unity**

*Private insurance in a reforming agenda, or*

*“We need a health system with muscle”*

A few weeks ago, during a conversation between one of Australian Unity’s members and one of our employees, it became clear that the member’s heart condition symptoms had become so serious it was likely she would soon end up in an emergency department with heart failure. The employee, a registered nurse providing support via the telephone, advised her instead to immediately go to her GP to discuss immediate changes to her treatment regime that would act as a preventative measure.

This conversation was no accident. The member was registered under our Healthy Heart program, in which we offer free telephonic counselling to members who have congestive heart failure; helping them to reduce their risk factors; monitor their health indicators and understand when to seek primary care intervention rather than emergency care.

In the past few years, there’s been quite a shift in the nature of health insurance funds. Once, health funds were primarily transaction-based bill-payers. Now, funds such as Australian Unity aim to be partners in our

members' lives, supporting them to get and stay healthy. We continue to develop more and more programs – based on scientifically rigorous outcomes assessments – to hopefully make a real difference in our members' lives.

There are financial imperatives, also, for us taking such an approach. As a funder of health, we experience the realities of the rising cost of health care. For example, our health fund experienced a 16 percent compound annual growth rate in diabetes benefits paid from 2001 to 2006, and is recording similarly steep (and above inflation) compound annual growth rates for other chronic diseases, including coronary artery disease and congestive cardiac failure. The growth rates are driven in part by an increasing number of members afflicted with these diseases, but also by rising costs per member of the treatments.

So it benefits us to keep our members out of hospital. This also benefits the membership as a whole as we are a mutual company, owned by our members. The more we can do to encourage and support our members to stay healthy, the better off we all are.

In that sense, we are not unlike the position the Government finds itself in as it grapples to deal with the rising tide of health costs. We are both funders of

health. We both recognise that funding health will become increasingly challenging in the decades ahead.

The National Health and Hospitals Reform Commission, which released its final report in June, says health as a proportion of GDP is expected to grow to 12.4% by 2032. At Australian Unity, we've done some analysis that suggests an even more worrying figure. Using the Treasury's Intergenerational 2 report, published in 2007, we commissioned Port Jackson Partners to consider what Australia's total health bill might be in 2047. The IGR had only given data about the expected costs to the federal government over this time period.

That analysis concluded that by 2047 total health expenditure is likely to grow to more than 20% of GDP, or some \$600 billion, across all system "payers".

When we looked more at these projections, we saw that individuals, at that time, will be contributing directly to health funding – this is on top of their taxes – about the same amount as Canberra. This will equate to about six percent of GDP, or around \$154 billion. Currently, individuals pay the equivalent of about two percent of GDP on health, on top of their taxes.

Interestingly, these rising costs are not only driven by the ageing population, though of course that is one contributing factor. The biggest cause of the

increase is non-demographic, primarily technological and procedural advances. These changes are leading to a rise of real expenditure per person. There was a 44% real expenditure increase per person between 1996 and 2006, for example<sup>1</sup>.

Whether we like it or not, health expenditure is going to grow dramatically. In fact, to get to the point where we pay 22% of GDP on health, we're going to allocate an extra 3% of GDP every decade. To put that in perspective, Australia currently spends about 3.5% of GDP on defence each year. Behind numbers such as these are some truly significant shifts in activity across the economy, together with substantial reconfiguration challenges. This means potentially less money being spent on other parts of the economy; and less money to national savings.

These extrapolations might not play out exactly. There might be events or interventions that affect the result or the trajectory in either positive or negative ways. But there's no doubt that ordinary Australians will be expected to pay more and more for their own health needs as Australia's health challenges develop.

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<sup>1</sup> AIHW, Health Expenditure in Australia 2005-06. Port Jackson Partners' analysis.

Until the last year or so we've looked at this projected future from the perspective of a 15 year unbroken rise in prosperity at a rate of growth itself unprecedented.

That era, for the globe, has ended. We are now a world of high government debt, budget deficits and difficult employment conditions. Add to that the growing but still unknown pressure on growth rates, or additional reconfiguration challenges, from carbon taxes and other implications of climate change.

Without careful reform to maintain effectiveness, health spending is likely to crowd out these other very real agendas significantly. We have a situation where the savings and wealth creation have slowed, but these demographic destiny issues – the cost side of the equation – are still there and growing.

These cost pressures have been there for a long time. But they've been hidden behind the fact that the health sector is largely an unsurveyed economy, driven by government activity and individual owner-operators (clinicians): it has therefore been a less examined piece of the GDP puzzle.

So I say it is time for us to take a system-wide view, not just of health dollars and whose budgets they settle in, but of the outcomes these dollars produce.

What we need, in my opinion, is an independent health commission, divorced from either a national or state set of political imperatives. The commission must be citizen-focused. It should be responsible for requiring the generation and maintenance of system-wide information and data-collection and for using the data for citizen and patient interests. What are infection rates and revision rates in hospitals across the country? What are the outcomes of chronic disease management and prevention programs? What are the aligned interests between funding, procurement, and outcomes at an individual as well as a system level?

In their report, the National Health and Hospitals Reform Commission proposed a new Australian Health Promotion and Prevention Agency. I believe this idea should be further expanded to include all measures of health, particularly comparative data – accessible to the public – that indicate the effectiveness of particular treatments at particular hospitals. I've spoken about this at length in other fora, and so I won't go into too much more detail now, but I was disappointed to see that the Commission's report seems to suggest that comparative data; data that compares the outcomes between one hospital and another; one clinician and another, be made available to the hospitals and clinicians. It doesn't seem to recommend that that same data be available to consumers, other funders and policymakers.

Imagine you or someone close to you is in need of a heart operation. Your GP tells you that Surgeon X at Hospital Y is available and ready to operate. How would you like to jump on a website and discover the actual performance record of the actual operation you'll be having at that precise hospital and from that specific surgeon – all adjusted for risk and international standards? You can do that in the UK, but not in Australia. You can look up a website and select your hospital and your surgeon and discover exactly how many times they've performed your operation and what their mortality rate is, risk-adjusted and compared to European standards.

In Australia, on the other hand, we do know that there is a difference between the results of one hospital from another – in the case of Victorian public hospitals The Alfred, the Austin, The Royal Melbourne, St Vincent's, Geelong and Monash Medical Centre – all sizeable and respected institutions.

We know that their outcomes are different. The Australasian Society of Cardiac and Thoracic Surgeons collects the data and publishes it<sup>2</sup>. The result is a difference (though we are told not a statistically significant difference) between the mortality rates of Hospital B and Hospital F. The difference is between a 3% mortality one month after surgery and a point-something %

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<sup>2</sup> Australasian Society of Cardiac and Thoracic Surgeons, Victorian Cardiac Surgery Database Project. Annual report 2005-06 (latest available)

mortality rate. But we're not told which hospital is hospital B and which is hospital F. If you were going to have a heart operation, would you like to know?

I liken it to the idea that the car companies conduct their crash tests, and then refuse to give the information to consumers, other than to enticingly say that "car X" is safer than "car Y".

These are the kinds of conversations we need to have at a public level to improve health literacy, and to reduce adverse events. The Commission, in its report, quoted again the landmark 1994 Quality of Australian Health Care Study, which concluded that the health system in Australia causes the deaths of 13 jumbo jets, each carrying 350 people, every year. The Commission notes that \$1 billion a year would be saved if we could reduce these adverse events by half. My point is that we don't manage what we don't measure, and these reductions won't happen until we have transparent comparative data available to the public and to policymakers. The providers are conflicted in this issue.

It is important to get away from the idea that the "cost" of healthcare is an issue between federal and state governments. Who pays, who shifts the costs,

who subsidises whom? These are all sideshow arguments that ignore one fundamental: the Australian community pays. People pay.

It is this failure to connect people in the community with the cost of healthcare that perpetrates one of the great myths of Australia's health system: that we are in a "better" position than the rest of the world with our "free, universal healthcare". In fact, healthcare, as everyone in this room knows, is not universal and it is definitely not free.

There are currently some 10 million employed people – individual taxpayers – in Australia<sup>3</sup>, according to the Australian Bureau of Statistics. If we distribute among them the health dollars spent in 2006-07 by the federal and state governments ... \$65 billion<sup>4</sup> ... that equates to \$6034 for every taxpayer. That's quite a leap from the 1.5% Medicare levy, which, on an assumed \$60,000 p.a. median income<sup>5</sup> contributes a mere \$900 – or around 14% – to the funding pool.

These are crude calculations, of course, to make a point. The point is this: Australians pay about *seven times* more than most of them *think* they pay for healthcare through their income taxes.

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<sup>3</sup> ABS Labour Force Statistics, June 2009

<sup>4</sup> AIHW Health Expenditure Australia 2006-07

<sup>5</sup> ABS Household Income and Income Distribution, Australia, 2005-06

Hypothetically then, a person earning just over \$40,000 per annum would need to have all the income tax that Canberra collected from that individual to be distributed to pay their proportionate contribution to the total Government health bill. (The corollary, of course, is that on this analysis, the taxes required to fund all other government services including welfare, defence, education and infrastructure have to be found from other sources.)

Further, this \$6034 doesn't count the amount individuals contribute privately, on top of their taxes, to health care. That's another \$22.5 billion, counting private health insurance<sup>6</sup>.

The National Health and Hospitals Reform Commission report came up with a very interesting proposal, which I believe is worth further investigation, which it calls Medicare Select. It suggested that each Australian citizen register with a "health and hospitals fund" (which can be government operated or privately operated). The fund would receive money from the federal government according to the risk profile of its membership and would be responsible for paying all that person's health costs, up to a "universal" level. Individuals could choose to buy extra benefits through private health insurance funds.

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<sup>6</sup> AIHW Health Expenditure Australia 2006-07

Interestingly, the Commission suggests that this proposal could include the notion of transparency of health costs. It suggests Medicare Select could be financed from consolidated revenue, or, “to aid the community’s understanding of the cost of the universal entitlement to health care, it could be financed through a publicly identified share of consolidated revenue, or from a dedicated levy.”

As I’ve already indicated, that dedicated levy would be in the order of seven times higher than the current Medicare levy. And that’s just on today’s health costs – this will only increase. The bravest federal government is unlikely to raise taxes by that much (and I am certainly not suggesting that they do!), but there could be a case for re-labelling the current tax system so that people are more aware of exactly how much tax it takes to fund universal care.

There are a number of reasons for the Medicare Select concept to receive further consideration. Firstly, it does something that I would submit is vitally important. It consolidates the funding attention in the one place. The NHHRC says this is important because it allows for strategic purchasing decisions, and would also help to reduce costs as providers compete for contracts with plans. I support this view.

There is another potential advantage, and it goes back to the story I told at the beginning of this. It allows funders to get a holistic view of a member's health picture, in order to continue to provide better preventative health services.

The ability for us to have a telephone conversation with a member about their medical condition and make suggestions is a crucial reform that has already occurred within the health system. A few years ago we were prevented from doing this in the way that we are doing now. But reforms to health insurance legislation in 2007 opened up our ability to provide out of hospital and chronic disease management programs.

Australian Unity typically has long-term relationships with our members. These relationships often last for 40 or 50 years (10,000 of our health fund members have been with us for more than 50 years). We believe we are in an ideal place to provide chronic disease management support. When our members consult with us, it is often when they are facing major health issues – such as when they are planning to have a baby or having just had a child, about to have surgery, or because they have been diagnosed with a serious illness. Increasingly, consultations on diet, lifestyle and exercise form part of these discussions as members review how they might improve or protect their health.

To expand our ability to fund all of the members' health services, from the GP consultation through to major surgery, would only enhance our ability to design, promote and fund programs that aim to prevent poor health.

The other interesting element of the proposal is that all Australians, not just those currently in private health insurance, would have the benefits of such a system. Even if they only joined a health and hospitals fund to get the publicly-funded component (the "free" element), they would still be part of a fund that could and would be taking a strategic view of the health population of their members.

There are many questions, also, with this proposal. It is not clear, for example, how to identify which benefits would be funded by the taxpayer, and which would need to be topped up by the member if they wanted greater levels of benefit. How would the current system of co-payments, for example with PBS and GP visits, translate into this system?

But the underlying principle is taking us, I believe, in the right direction. This is closer to a citizen-centred approach, and closer to creating a system with muscle.

At Australian Unity, we believe our future is bound up with developments in this space. We have to do our bit to support our members to stay healthy.

And that is why we have established a new business, Remedy Healthcare, that provides chronic disease management programs for our members. These evidence-based programs support members like the one I mentioned in my opening remarks, with a view to keeping them out of hospital for such problems as congestive heart failure and osteoporosis. We have an integrated approach offering telephone support and in-home rehabilitation if required.

We will soon be adding programs for type-2 diabetes and chronic obstructive airways disease (COPD). Combined with our innovative member benefits, including quit smoking benefits and weight-loss benefits, this demonstrates to our members that we are serious about keeping their health costs down by helping them get and stay healthy.

We're doing this with an unashamed focus on results. It is not about funding gym memberships. It is about knowing for sure that our programs are providing the best possible outcomes, objectively measured. If we can prevent hospitalisations, while at the same time reducing hospital acquired infections and adverse events, we end up with a better quality healthcare system, healthier and happier patients, and a better use of precious funding resources.

If we can use the information gained as sophisticated purchasers of health services (which is what health funds are and can be) to drive better health outcomes and a more efficient and effective use of resources, then, and perhaps only then, can we be in a position to be able to afford an economy dominated by the health sector.

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