Exploring Global Health Care Cost Drivers: Australia and Singapore

Sponsored by the International Actuarial Association Health Section (IAAHS) and the Academy's Health Practice International Committee (HPIC)

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Presenters

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Exploring Global Health Care Cost Drivers: Australia and Singapore

All nations face difficult challenges in providing health care to their people

Exploring Global Health Care Cost Drivers: Australia and Singapore

A series of webcasts that highlight the health care models of various countries in 2015

- February 18 (Israel & Netherlands)
- May 13 (South Africa & US)
- **September 2/3 (Australia & Singapore)**
- November (Canada & Chile)

We are holding a conversation that will explore the following:

- General characteristics
- Financing system
- Cost drivers
- Methods of coping with the cost drivers
- Measurement metrics
- Insights, successes, hurdles
- Future trends

Exploring Global Healthcare Cost Drivers Singapore

Alvin Fu , FIA, FSAS

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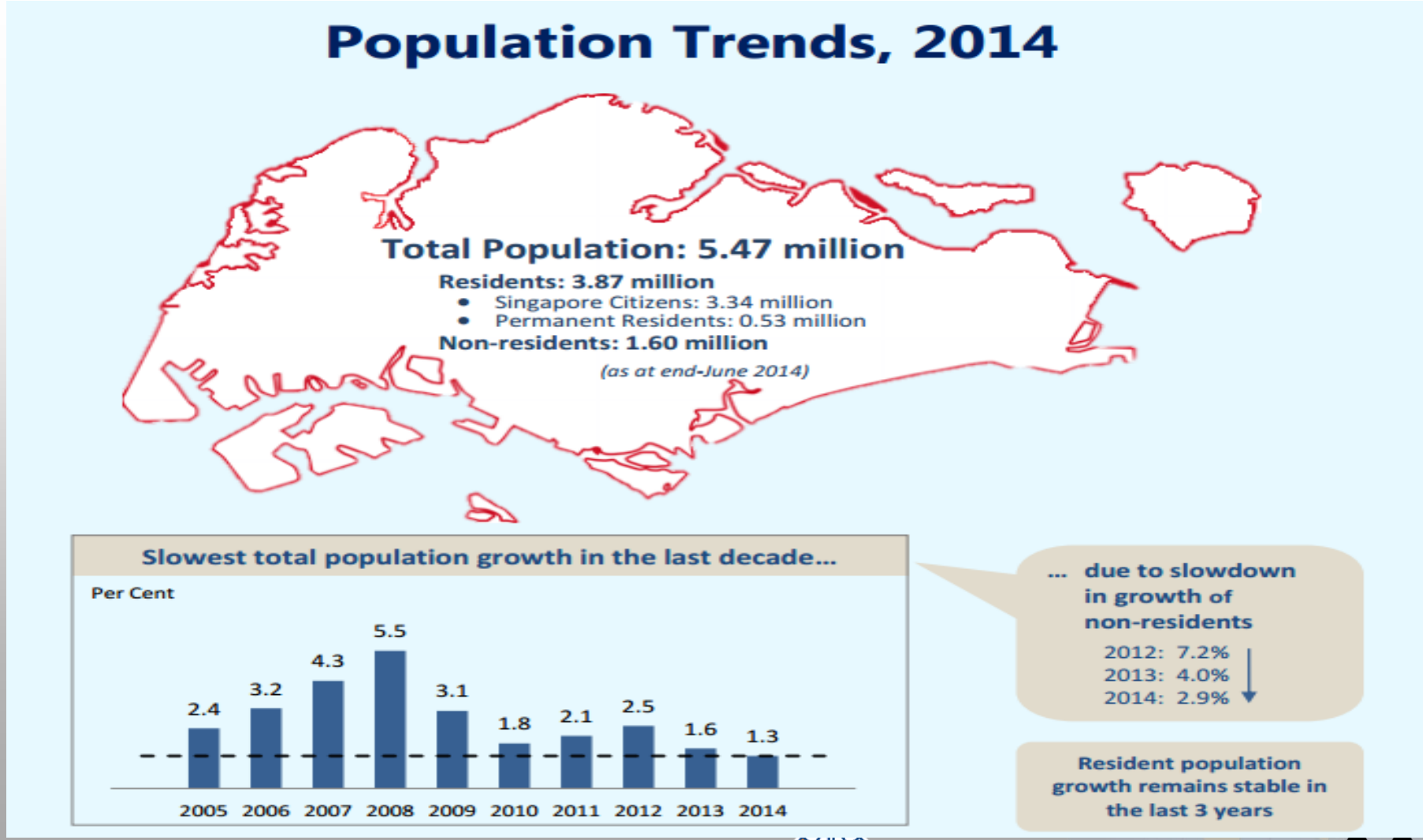
- My sincere appreciation to Chi Cheng Hock in providing peer review as well as Lim Tien Yung, Wong Soon Leong and Lin Fang Cheng in supporting the compilation of statistics.

Agenda

- Introduction to Singapore
- Healthcare Financing System
- Healthcare Outcomes
- Healthcare Challenges
- Role of Actuaries

Introduction

A Slowing Singapore Population



Source: https://www.singstat.gov.sg/docs/default-source/default-document-library/statistics/visualising_data/population-trends2014.pdf

Introduction

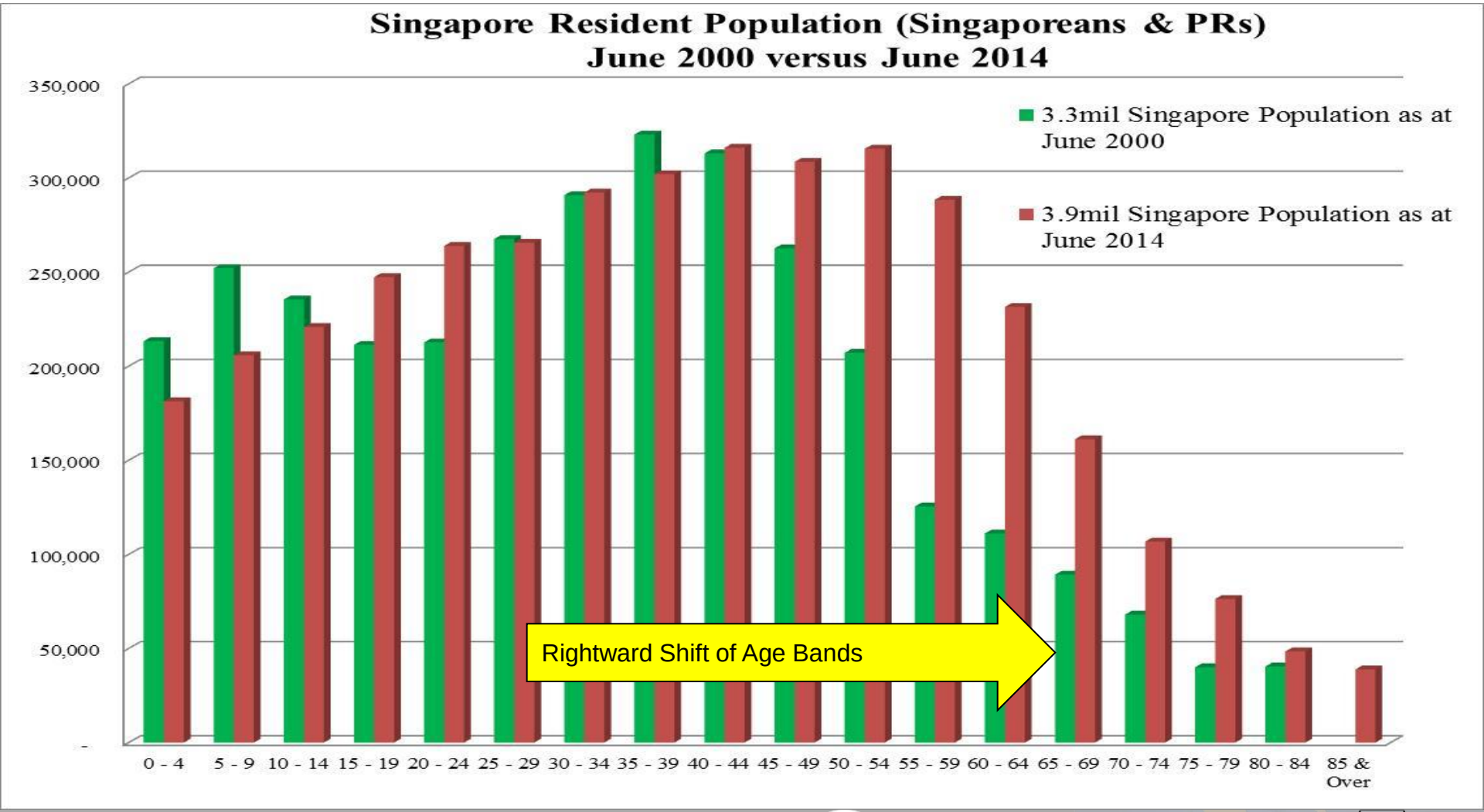
An Aging Singapore Population

Year	Elderly Citizen	Citizens in working-age band of 20-64 years of age
1970		 13.5
2000		 8.4
2011		 6.3
2015		 4.8
2020		 3.6
2025		 2.6
2030		 2.1

Source: Singaporeans only, excluding Permanent Residents
http://population.sg/key-challenges/
https://www.singstat.gov.sg/docs/default-source/default-document-library/statistics/visualising_data/population-trends2014.pdf

Introduction

An Aging Singapore Population



Source:Singstats.gov.sg

Note: June 2000 figures for 85 & over is unavailable.

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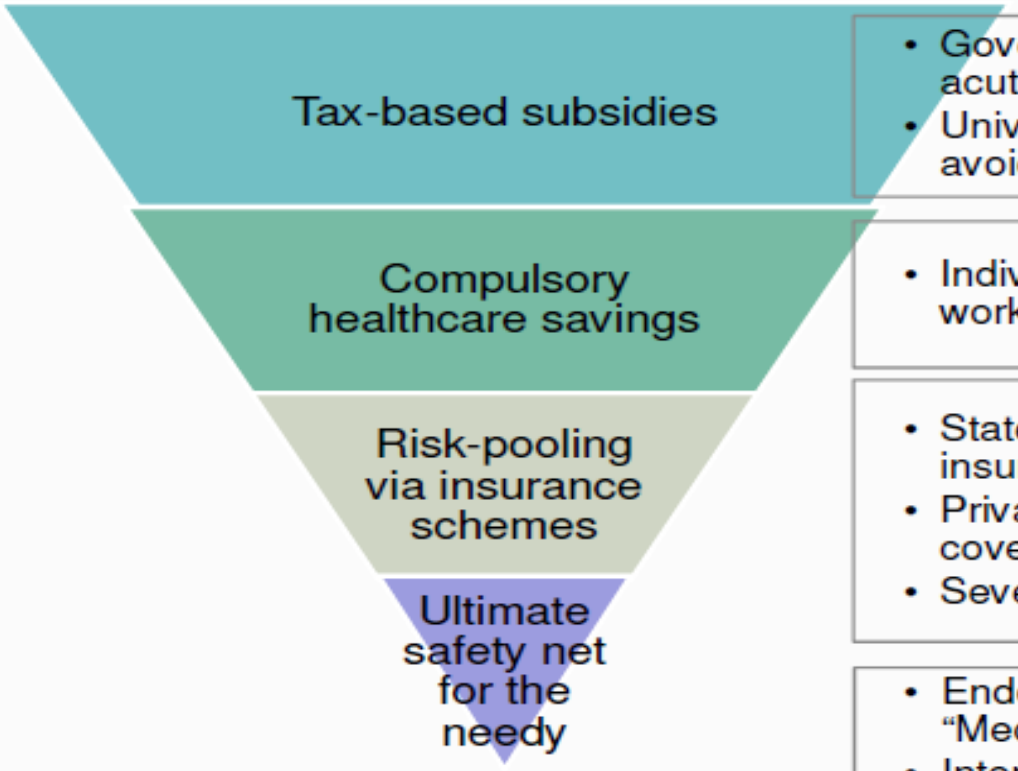
Singapore Financing System

Overview of Singapore Multiple Layers of Healthcare Financing

Universal coverage through multiple layers of protection



- Government subsidies across primary, acute, rehabilitative and nursing settings
- Universal access, but no 100% subsidy to avoid over-consumption

- Individual medical savings accounts for all workers – "Medisave"

- State-run, low-cost catastrophic health insurance scheme – "MediShield"
- Private health insurance for additional coverage – "Integrated Shield plans"
- Severe disability insurance – ElderShield

- Endowment fund set up by government – "Medifund"
- Interest income generated goes towards assisting the most needy

Source: Ministry of Health, Public-Private Partnership by Anthony Tan

Healthcare Financing System

Underlying Philosophy

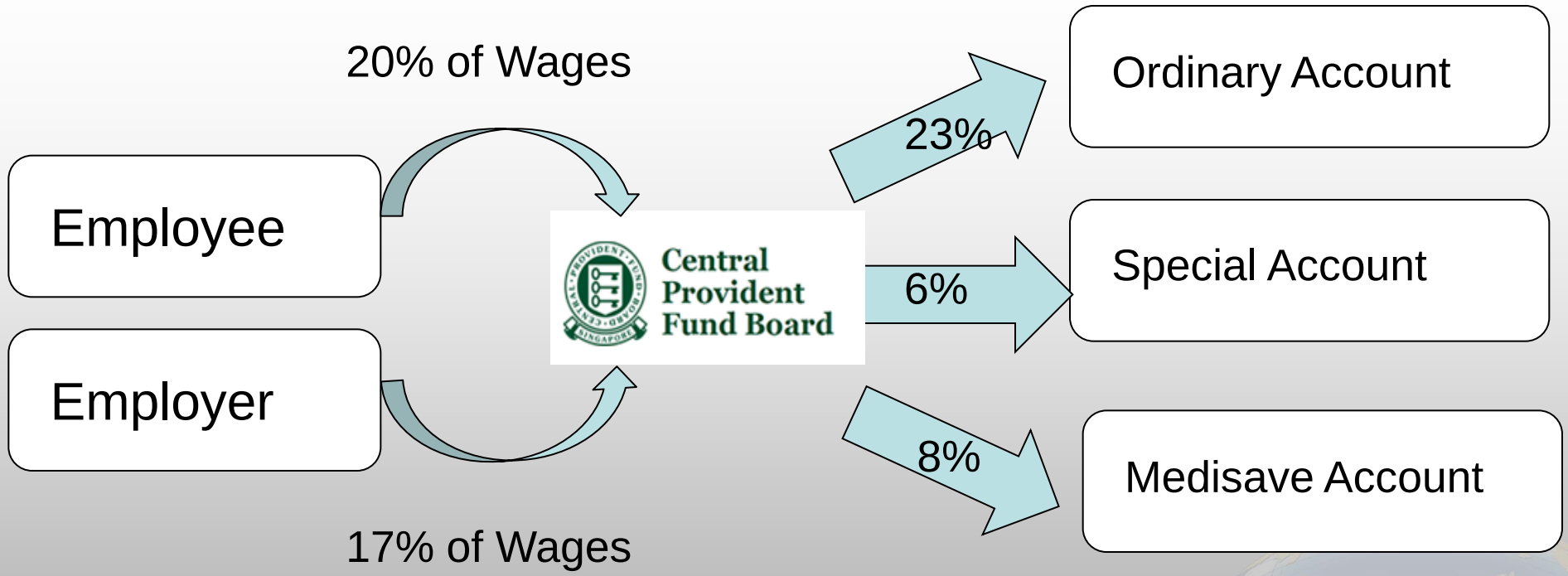
- Reports to the Minister for Health and other ministers of state.
- Manages Public Healthcare delivery
- Licenses and regulates hospitals, nursing homes, clinics, doctors, dentist.
- Provides subsidies to hospitals and individuals.
- Regulates Private Integrated Shield plans jointly with the Monetary Authority of Singapore.

Source:

https://www.moh.gov.sg/content/moh_web/home/about-us.html

Healthcare Financing System

Central Provident Fund – Example Based on Person Aged 35



Source:
Contribution rates and split into various accounts vary by Age
www.cpf.gov.sg

Healthcare Financing System

Quick View of Public Healthcare

Source:
http://brightsparks.com.sg/profile/mohh/abouthealthcare.php

Healthcare Financing System

Medisave, MediShield, MediFund

Healthcare delivered to Individuals

Taxation

- Individuals
- Employers
- MINISTRY OF HEALTH SINGAPORE

ParkwayHealth

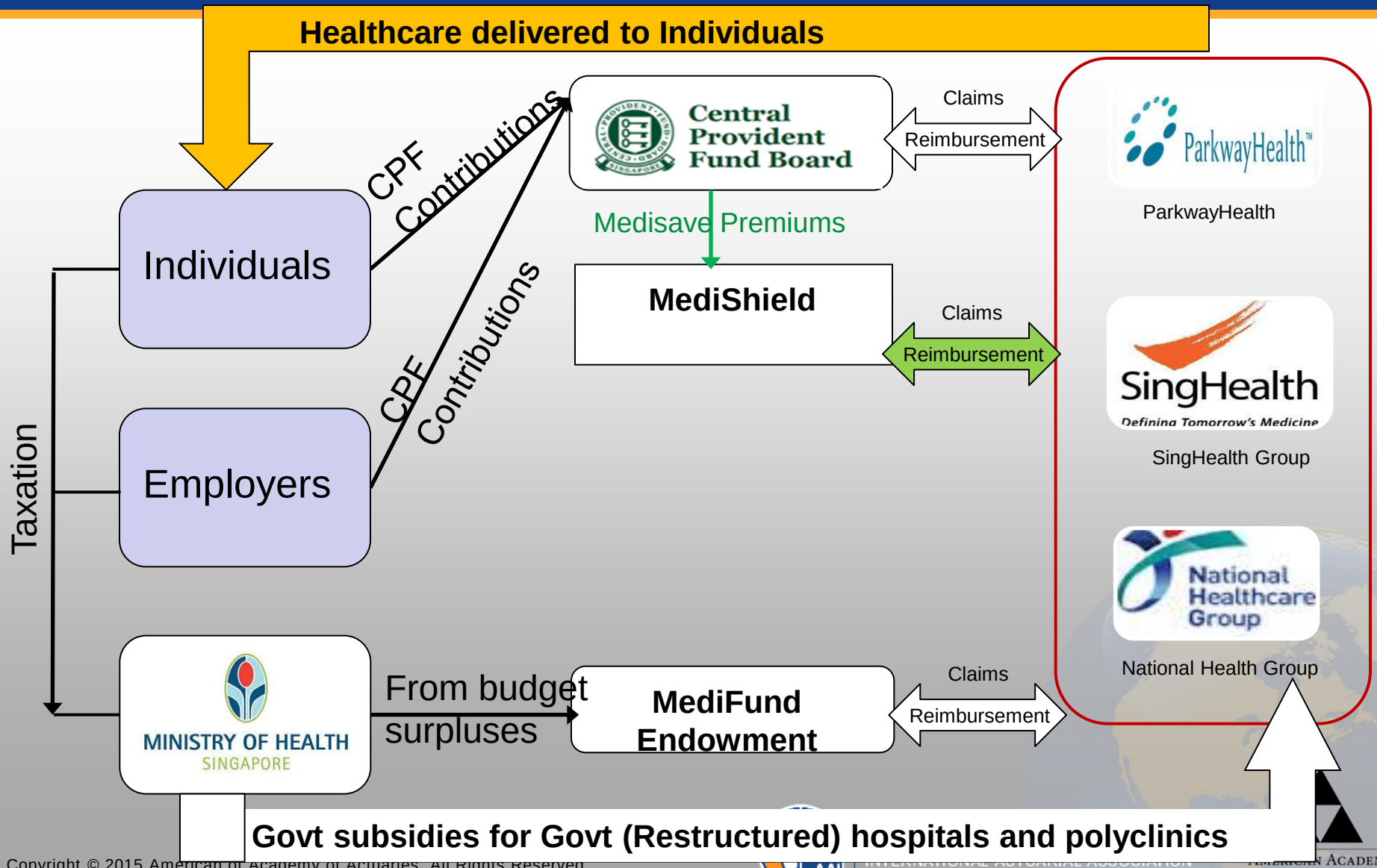
SingHealth Group

National Health Group

Govt subsidies for Govt (Restructured) hospitals and polyclinics

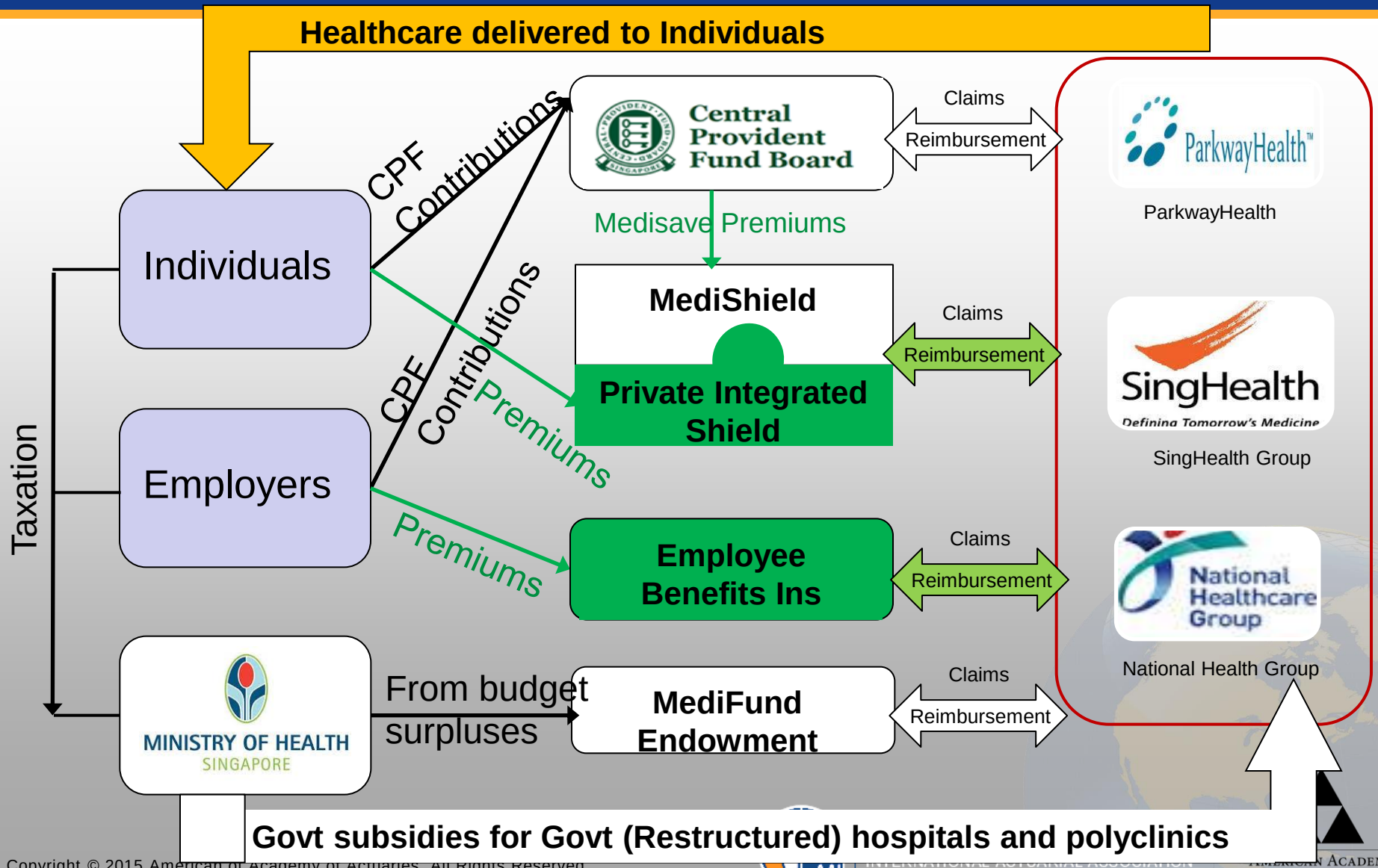
Healthcare Financing System

Medisave, MediShield, MediFund



Healthcare Financing System

Medisave, MediShield, MediFund



Healthcare Financing System

MediShield Life and Private Integrated Shield Plan

- About 93% of Singaporeans and PRs are covered under MediShield or Integrated Shield Plans.
- With effect from 1 Nov 2015, MediShield will be enhanced to MediShield Life to provide:
  - Better protection and higher payouts, so that patients pay less Medisave/cash for large hospital bills
  - Universal Coverage
    - Protection For All Singapore Citizens and Permanent Residents, including the very old and those who have pre-existing illnesses
    - Protection For Life
- No one will be left without coverage due to inability to afford premiums. Government will provide significant subsidies to lower to middle income, elderly and those who cannot afford.

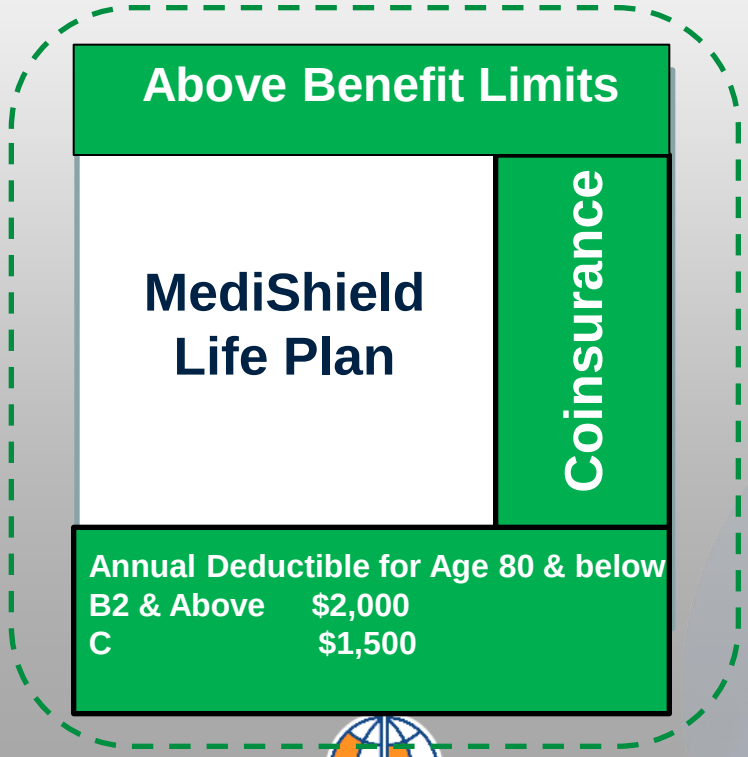
Source: https://www.moh.gov.sg/content/moh_web/medishield-life/about-medishield-life/what-is-medishield-life.html

Healthcare Financing System

MediShield Life and Private Integrated Shield Plan

- MediShield Life is meant for B2 (6 Beds) /C (>10 Beds) class wards in Govt/Restructured hospital coverage.
- MediShield Life does not provide first dollar coverage.
- Private Integrated Shield plans is provided by Insurers to cover the green gaps and provide a higher coverage. This is the "market mechanism" used to create competition.

Claimable Amount	Coinsurance
$0-$3k	10%
$3k-$5k	10%
$5k-$10k	5%
>$10k	3%
Outpatient Treatment	10%



62% of Singaporeans & PRs have an Integrated Shield Plan

Agenda

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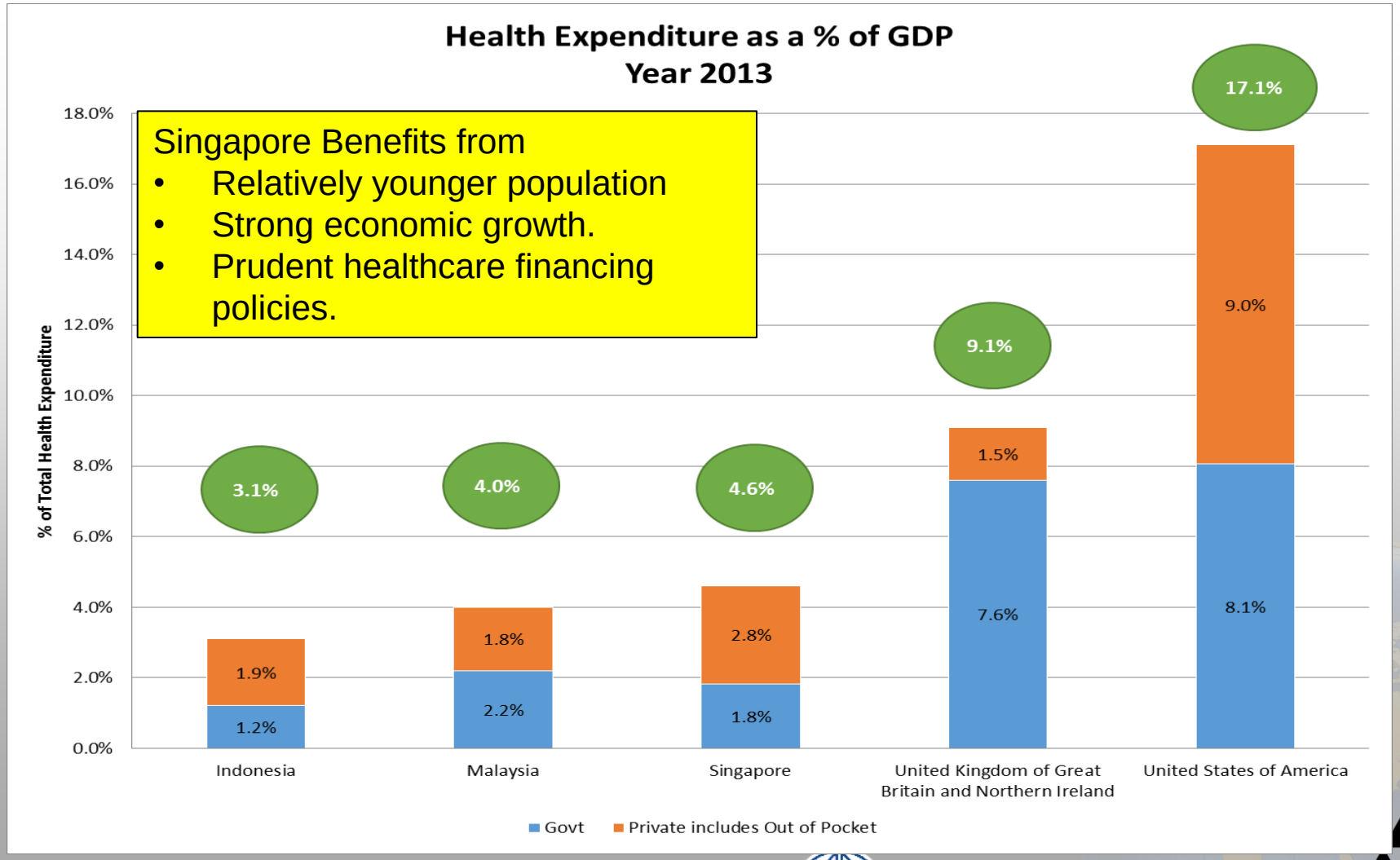
- Healthcare Outcomes
- Healthcare Challenges
- Role of Actuaries

Singapore Healthcare Outcomes

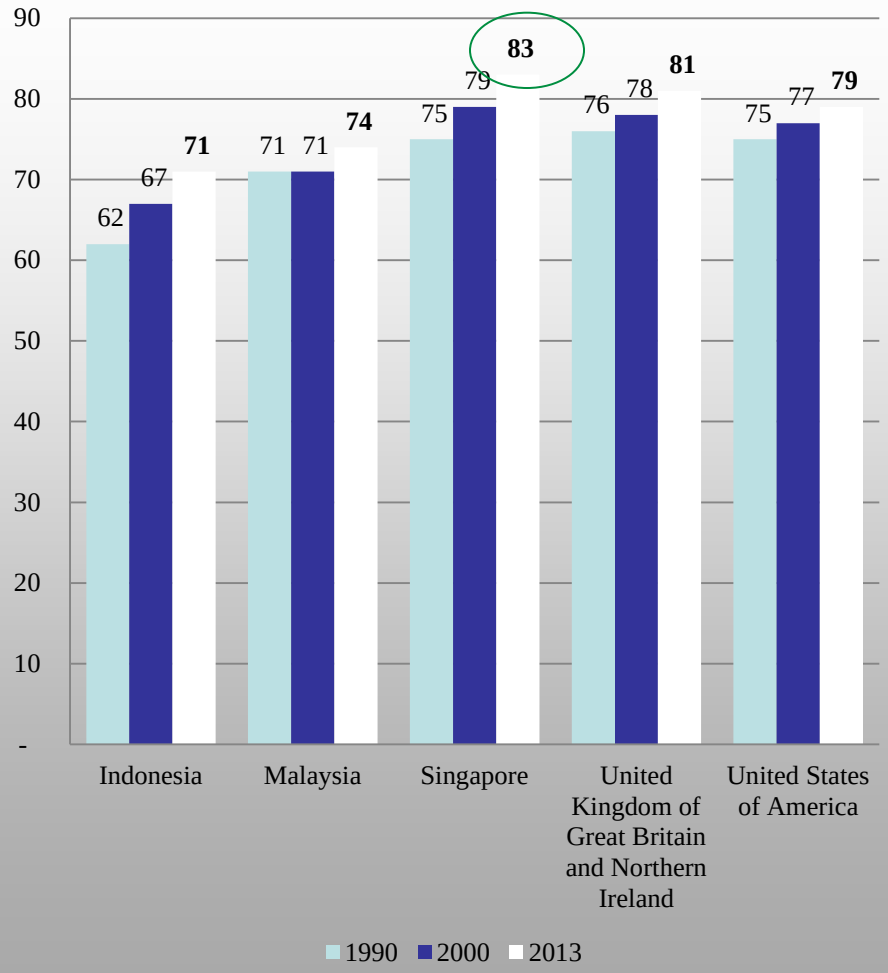
Moderate Health Expenditure, High Life Expectancy, Low Mortality, Moderate Medical Inflation

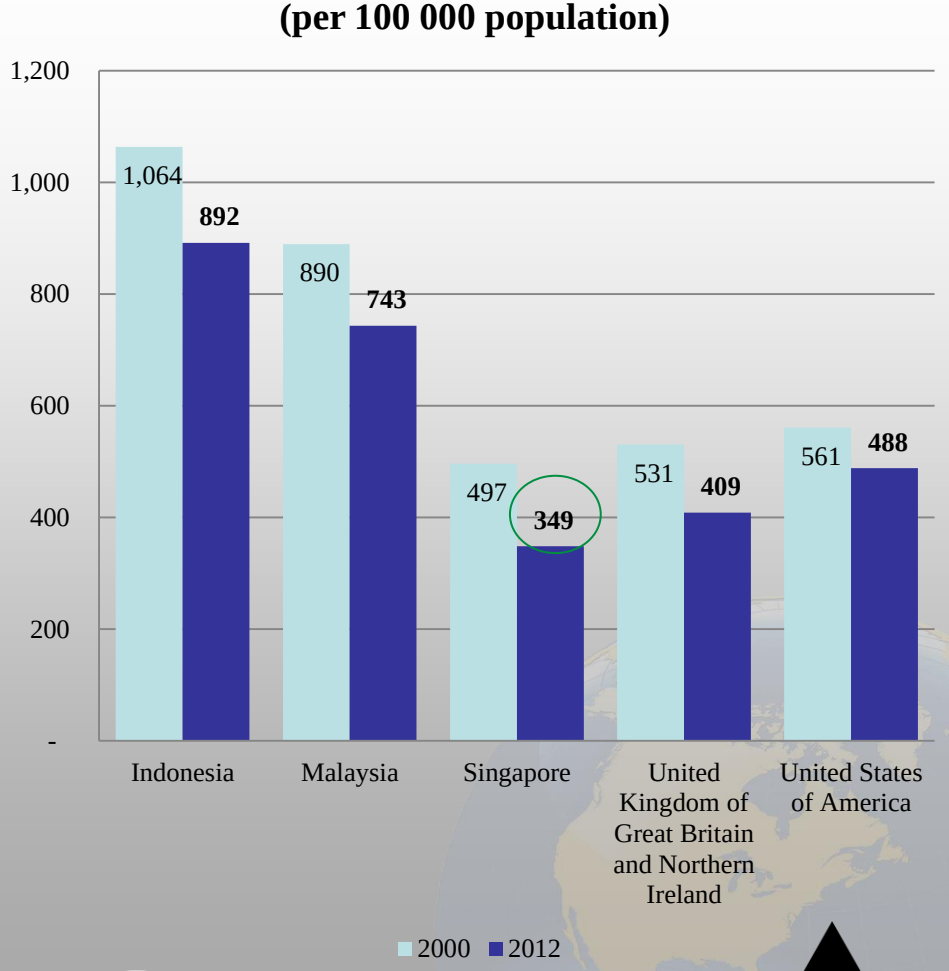


Source: World Health Statistics 2015

Singapore Healthcare Outcomes

Moderate Health Expenditure, High Life Expectancy, Low Mortality, Moderate Medical Inflation





Source: World Health Statistics 2015

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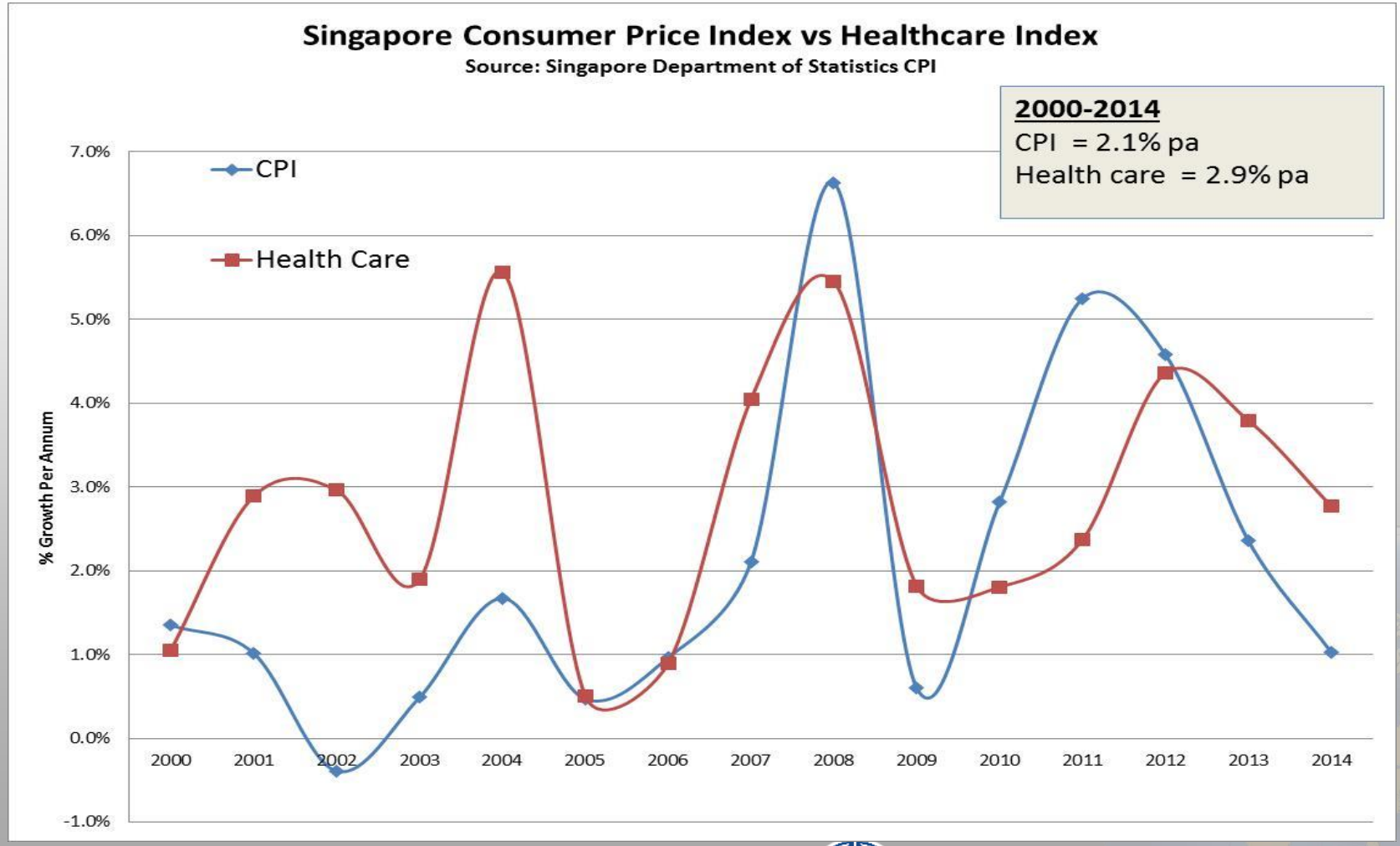
Singapore Healthcare Outcomes

Moderate Health Expenditure, High Life Expectancy, Low Mortality, Moderate Medical Inflation



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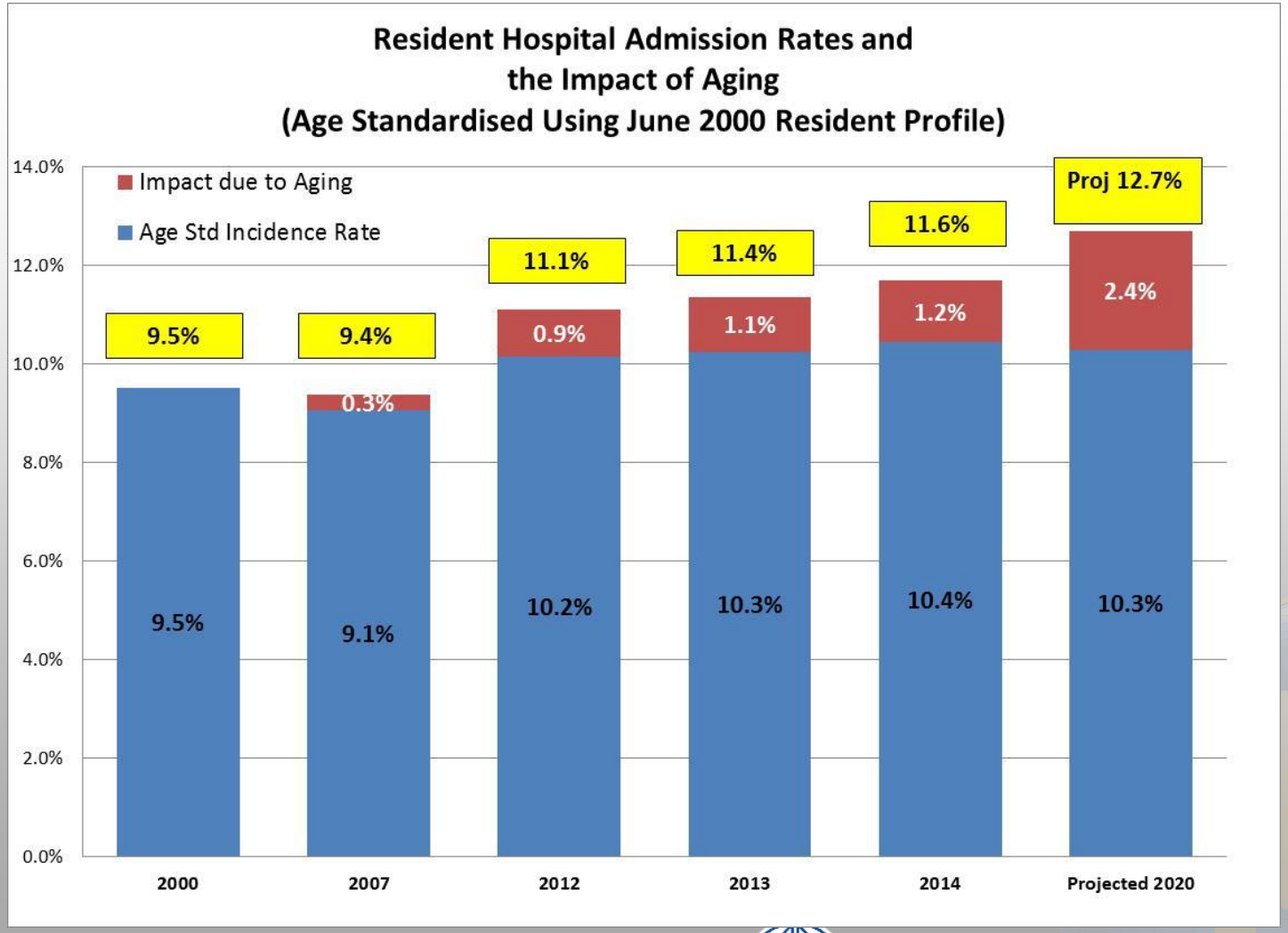
Healthcare Challenges

Demand Side Factors	Supply Side Factors
• Impact of Aging Population	• Rising Medical Price Inflation
• Increase in Chronic Conditions	• Near full capacity at government hospitals.
• Competing uses for MediSave	• Limited doctors and medical workers
• Insureds' desire to maximize insurance coverage	• Doctors desire to maximize insurance payouts.

Healthcare Challenges

Impact of Aging on Hospital Admissions



Source: MOH Hospital Admission Rates 2000,2007,2012-2014

Healthcare Challenges

Prevalence of Chronic Conditions

	1992	1998	2004	2010
Prevalence among adults aged 18 to 69 years[1] (%)				
• Hypertension[2]	22.2	27.3	24.9	23.5
• Diabetes	8.6	9.0	8.2	11.3
• High Total Cholesterol	19.4	25.4	18.7	17.4
• Obesity	5.1	6.0	6.9	10.8
• Daily Smoking	18.3	15.2	12.6	14.3

Definitions:

Hypertension: ≥ 140/90 mmHg

Diabetes: 2-hour plasma glucose during an oral glucose tolerance test ≥ 11.1 mmol/l

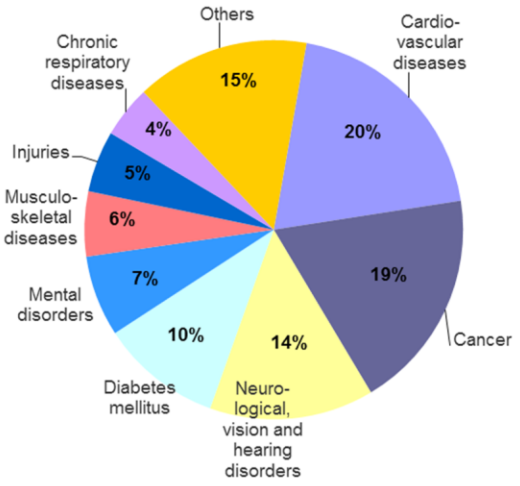
High Total Cholesterol: Total cholesterol ≥ 6.2 mmol/l

Obesity: BMI ≥ 30kg/m^2

Daily Smoking: Smokes cigarettes at least once a day

- Health Promotion Board
- Chronic Disease Management Programs
- Shift from Acute to Community hospitals.
- Subsidies at outpatient setting for elderly and lower income. (CHAS)

Distribution of Disability-Adjusted Life Years by Broad Cause Group 2010[1,4]



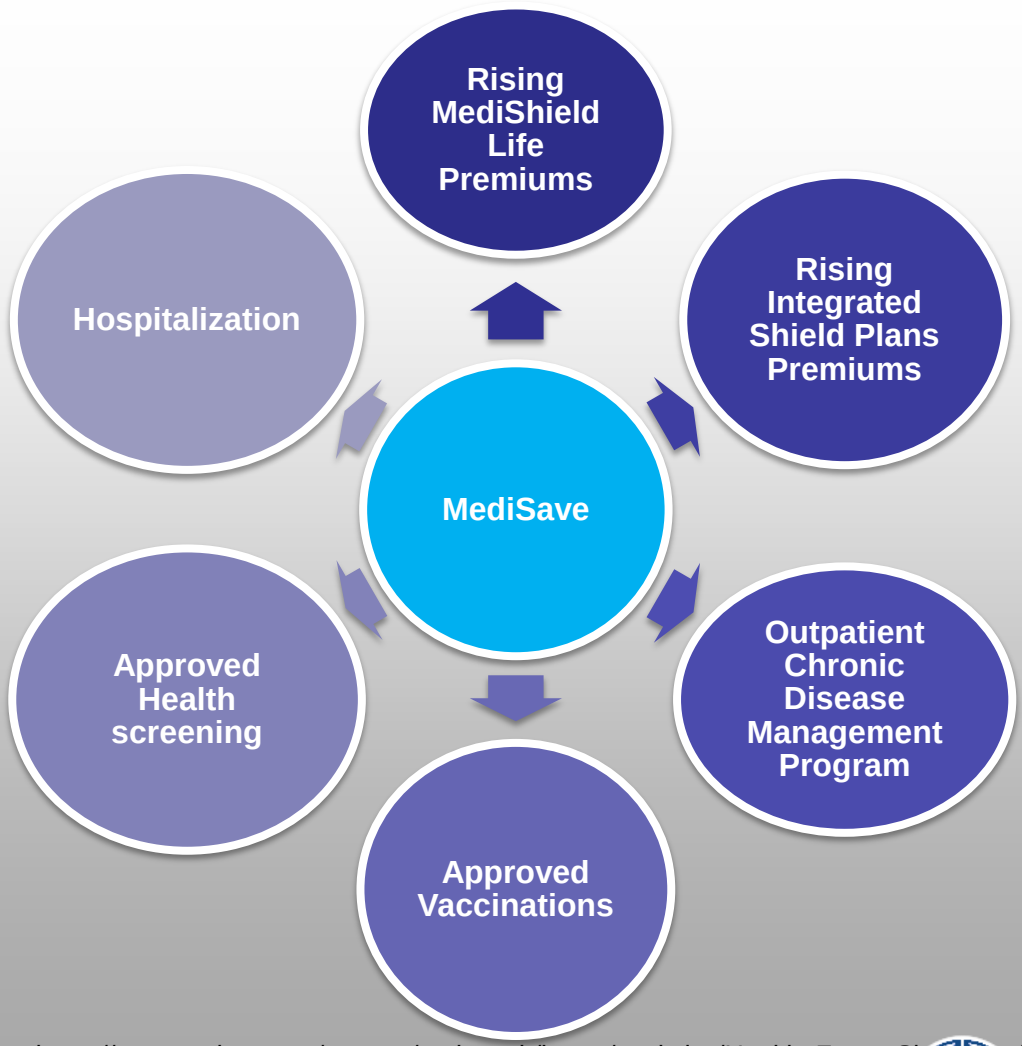
Total of 399,675 life years lost due to mortality and ill-health in 2010

Notes:
1 - Singapore Residents
2 - Among adults aged 30 to 69 years
3 - ASR: Age-standardised rate per 100,000 per year. ASR derived by the direct method using the 'World Population'
4 - Source: Estimates from the Singapore Burden of Disease Study 2010

Source: https://www.moh.gov.sg/content/moh_web/home/statistics/Health_Facts_Singapore/Disease_Burden.html

Healthcare Challenges

Competing Use of Medisave



MediSave is capped at $49,800 from 1 Jan 2016, increased annually for medical inflation.

Is Medisave enough? See <http://www.actuaries.org.sg/?q=node/10166>

Source: https://www.moh.gov.sg/content/moh_web/home/statistics/Health_Facts_Singapore/Disease_Burden.html

Healthcare Challenges

Competing Use of Medisave – Rising Insurance Premiums

Age Next Birthday	Current Annual MediShield Premiums ($)	Annual MediShield Life Premiums Before Subsidy ($)[3]
1 – 20	50	130
21 – 30	66	195
31 – 40	105	310
41 – 50	220	435
51 – 60	345	630
61 – 65	455	755
66 – 70	540	815
71 – 73	560	885
74 – 75	646	975
76 – 78	775	1,130
79 – 80	865	1,175
81 – 83	1,123	1,250
84 – 85	1,150	1,430
86 – 88	1,190	1,500
89 – 90	1,190	1,500
>90[4]	1,190	1,530

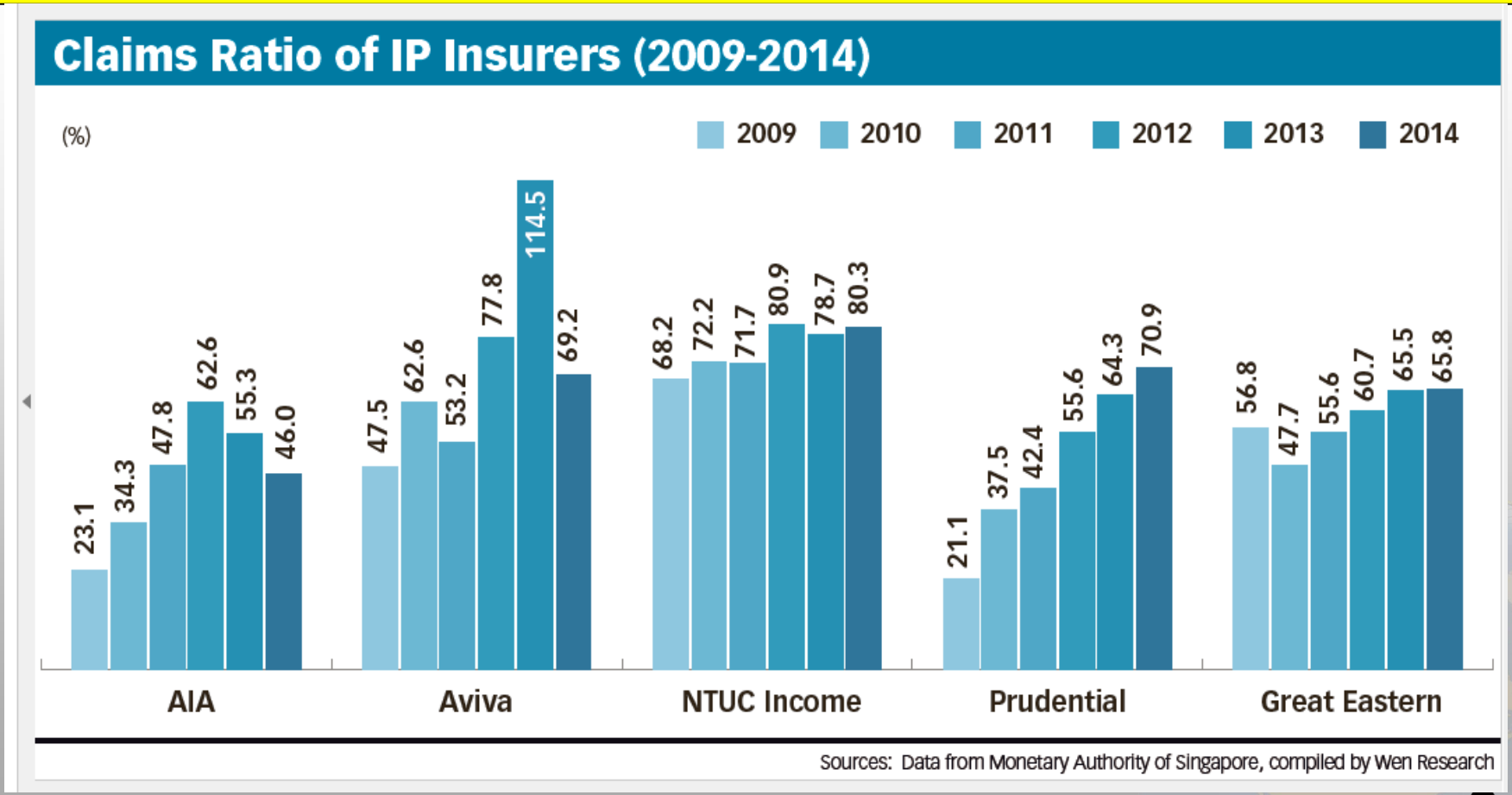
MediShield Life Premiums from 2015 will increase significantly

Source: https://www.moh.gov.sg/content/dam/moh_web/MediShieldLife/Others/Downloads/MediShield%20Life_Online%20Preview_Jul2015.pdf

Healthcare Challenges

Competing Use of Medisave – Rising Insurance Premiums

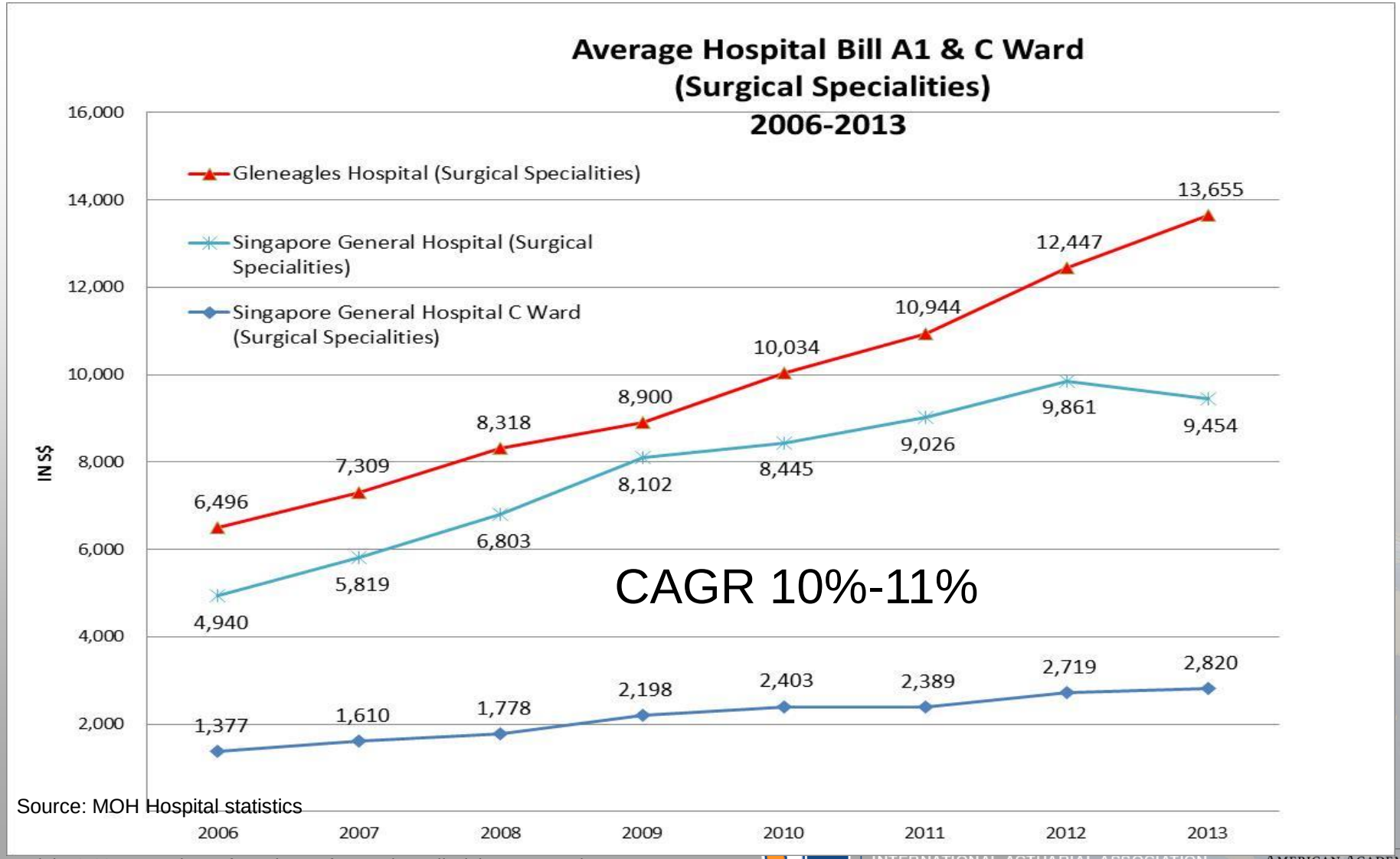
There will be pressure in the medium term to raise premiums on integrated shield plans as well. Insurers working more diligently on claims and medical management.



Source: http://www.businesstimes.com.sg/opinion/rising-health-insurance-claims-threaten-all

Healthcare Challenges

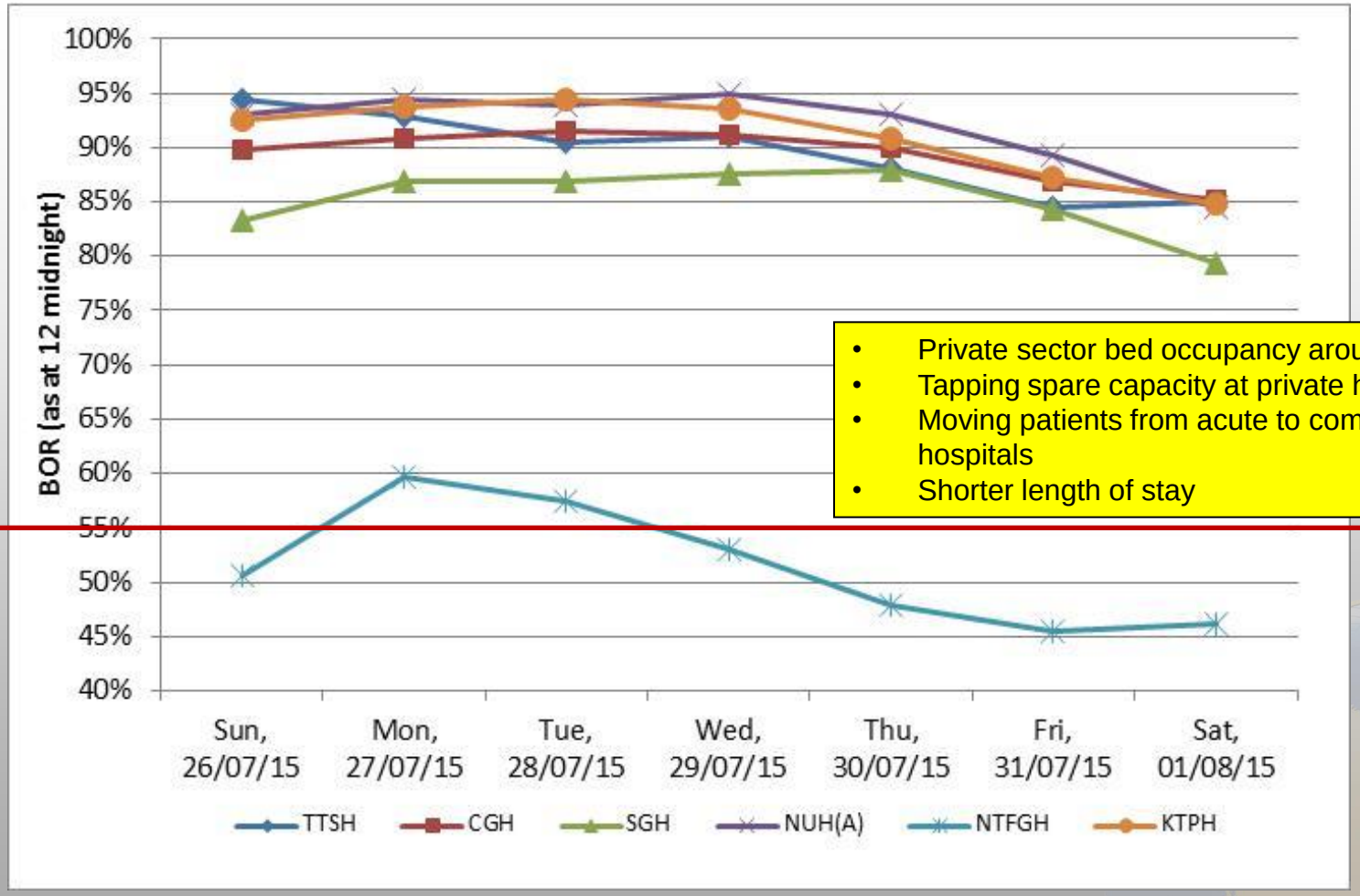
Rising Average Cost at Private and Government Hospitals



Source: MOH Hospital statistics

Healthcare Challenges

85% to 95% Govt Hospital Bed Occupancy



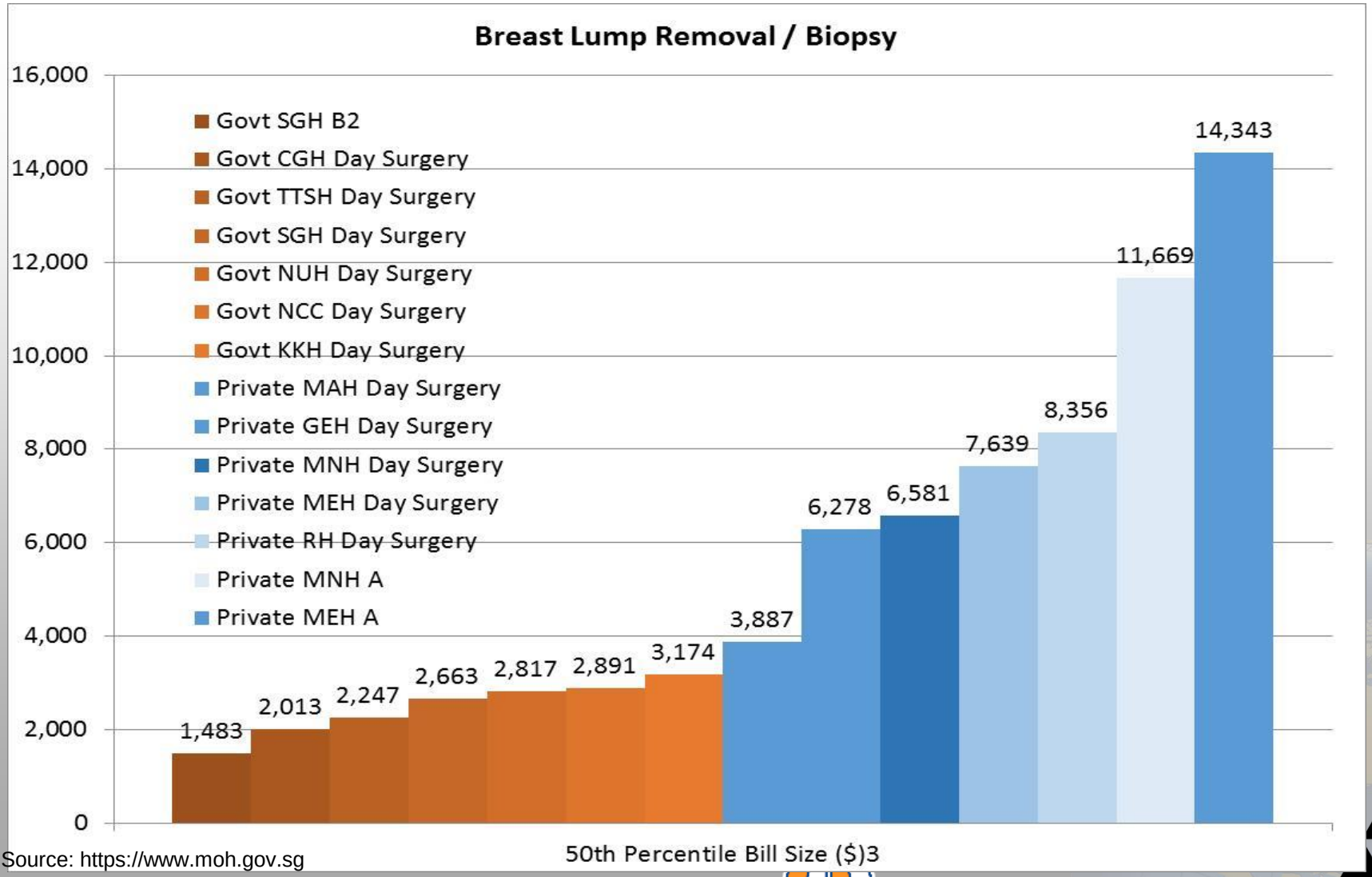
- Private sector bed occupancy around 55%[1].
- Tapping spare capacity at private hospitals
- Moving patients from acute to community hospitals
- Shorter length of stay

Source: https://www.moh.gov.sg/content/moh_web/home/statistics/healthcare_institutionstatistics/Beds_Occupancy_Rate_BOR.html

1 MOH 2012 Committee of Supply Speech Healthcare 2020

Healthcare Challenges

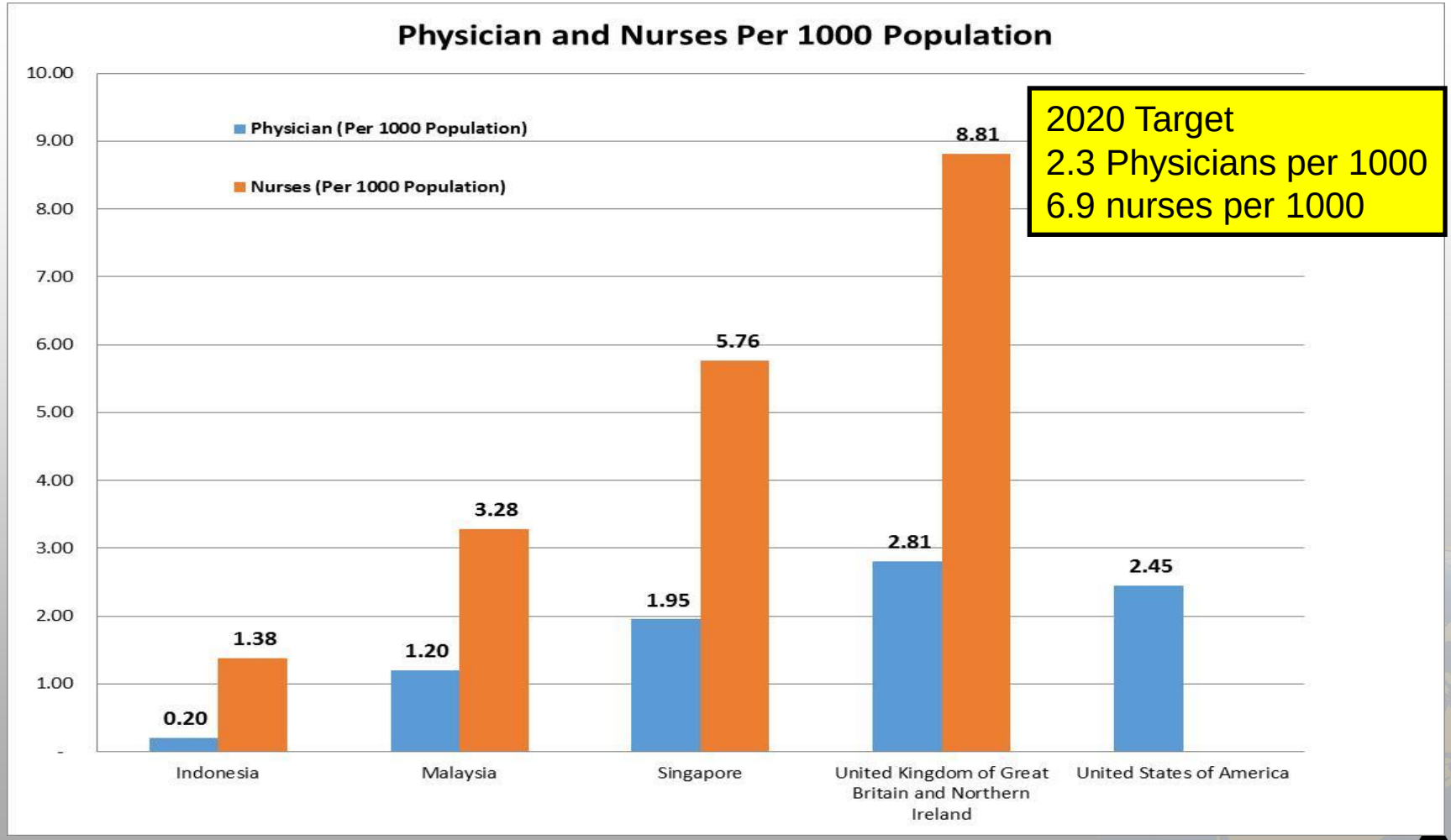
Variation in Healthcare Cost between Private & Govt Hospitals



Source: https://www.moh.gov.sg

Healthcare Challenges

Limited Supply of Medical Professionals.



Source: WHO Report 2015, Data 2007-2013

Healthcare Challenges

Integrated Health Cluster –Outpatient, Acute & Chronic Hospitals

Source: http://www.juronghealth.com.sg/Our_Hospitals_Facilities/Ng_Teng_Fong_General_Hospital.aspx

Agenda

- Introduction to Singapore
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- Healthcare Challenges
- Role of Actuaries

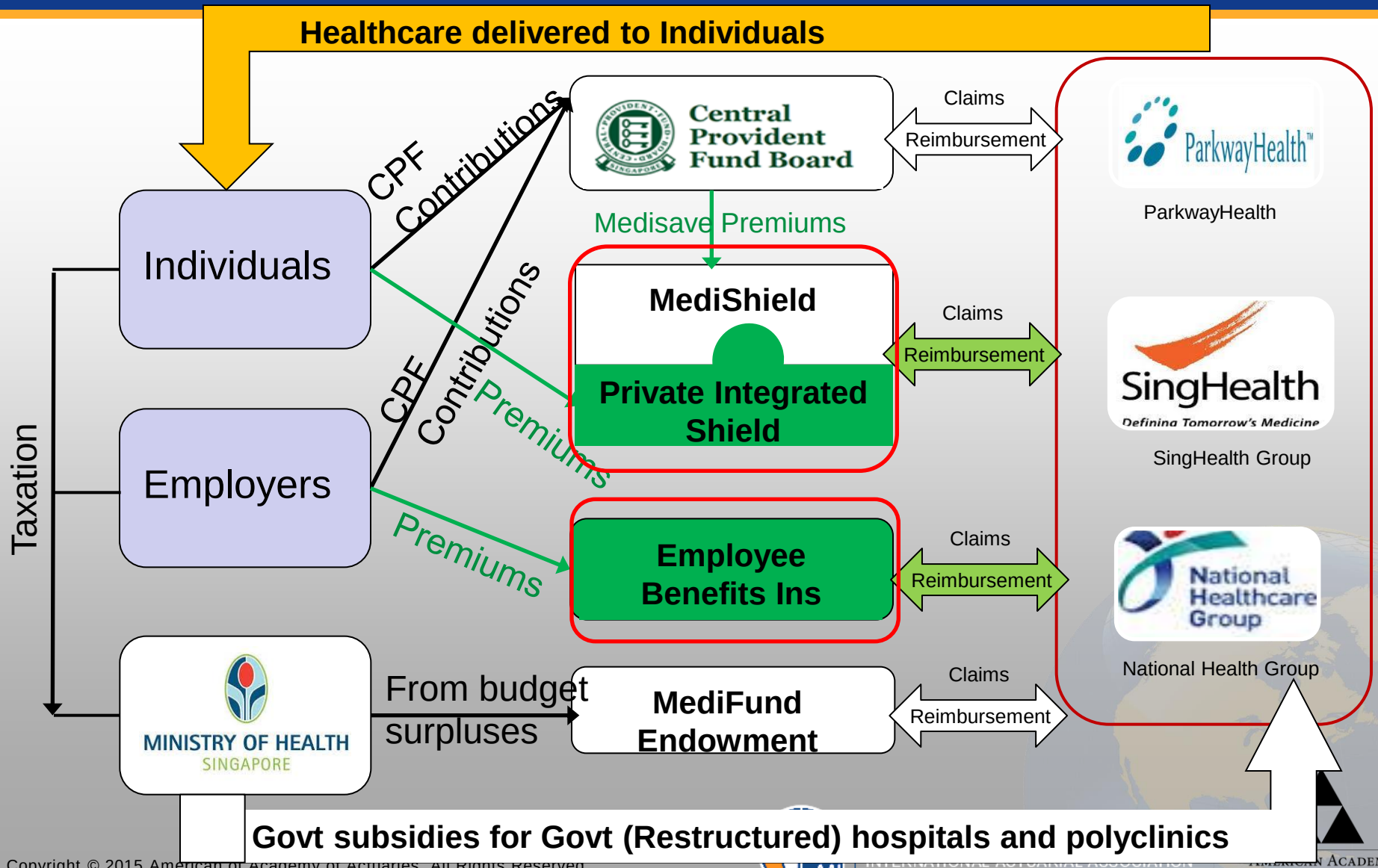
Role of Actuaries

- Under Insurance Act Accident and Health policies are classified between Short Term and Long Term.

	Insurer may Unilaterally terminate policy	Insurer may not unilaterally terminate policy
Term > than 5 years	**Long Term A&H**	**Long Term A&H**
Term <= 5years	**Short Term A&H**	**Long Term A&H**

- Long Term A&H policies can only be written by a life insurer. It requires Appointed Actuary certification and MAS approval.
- Short Term A&H policies can be written by both life and general insurers.
- Annual Stress Testing and Reserving to be approved by the Appointed Actuary / or Certifying Actuary.
- Potential for growth in actuaries doing medical management, data analytics and policy making roles.

Role of Actuaries



The End

Thank You

Exploring Global Health Care Cost Drivers Australia

Stuart Rodger, FIA, FIAA, FSAS

Candice Ming, FIA

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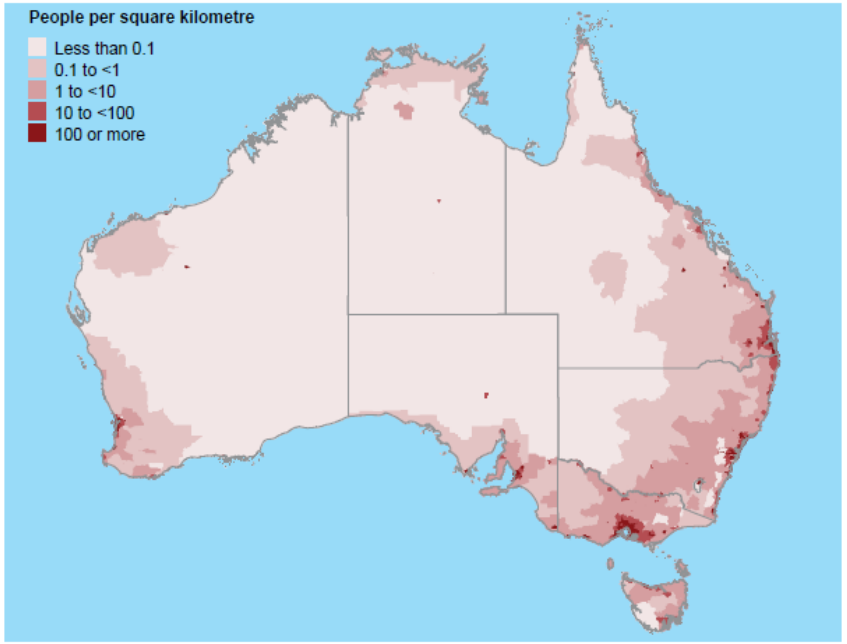
Agenda

- Health Care in Australia
- Health Care Costs
- Drivers of Health Care Costs and Responses
- Role of the Actuary

Australia – a snapshot of the demographics



Note: figure shows population density by Statistical Area Level 2 based on the ASGS (see Box 1.1).
Sources: AIHW analysis of ABS 2010a, 2013m.

Population density, 30 June 2012

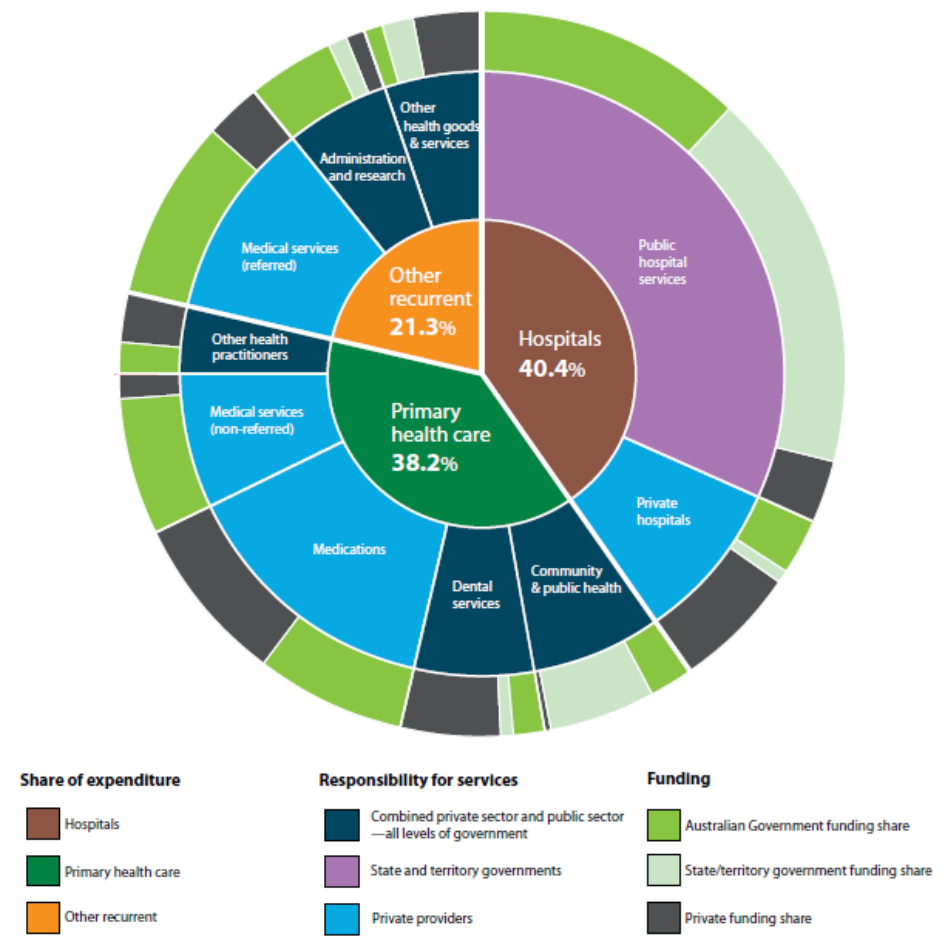
- 23 million people at June 2013
- Around 27% of the population in 2011 were born overseas
- 3% were Indigenous Australians
- Our birth rate is 1.9 births per woman, less than the replacement rate of 2.1
- An estimated 162,700 people were added through natural increase in the year to June 2013 and 244,400 people were added through migration in the same period
- Population growth has not been consistent across all age groups

Source: Australia's Health 2014, Australian Institute of Health and Welfare (2014)

Australia operates a mixed Public and Private healthcare system

- Key features:
  - A mixture of public and private sector health service providers and a range of funding and regulatory mechanisms
  - National health insurance with universal coverage and free access to public hospitals
    - No charge for treatment as a public patient in a public hospital by a doctor appointed by the hospital
    - Subsidisation for primary care medical services (Medicare) and for a high proportion of prescription medicines (Pharmaceutical Benefits Scheme)
  - Private health insurance complementary to National health
    - Can cover private and public hospital charges and a portion of medical fees for inpatient services. It can also cover allied health/paramedical services and some aids and appliances.

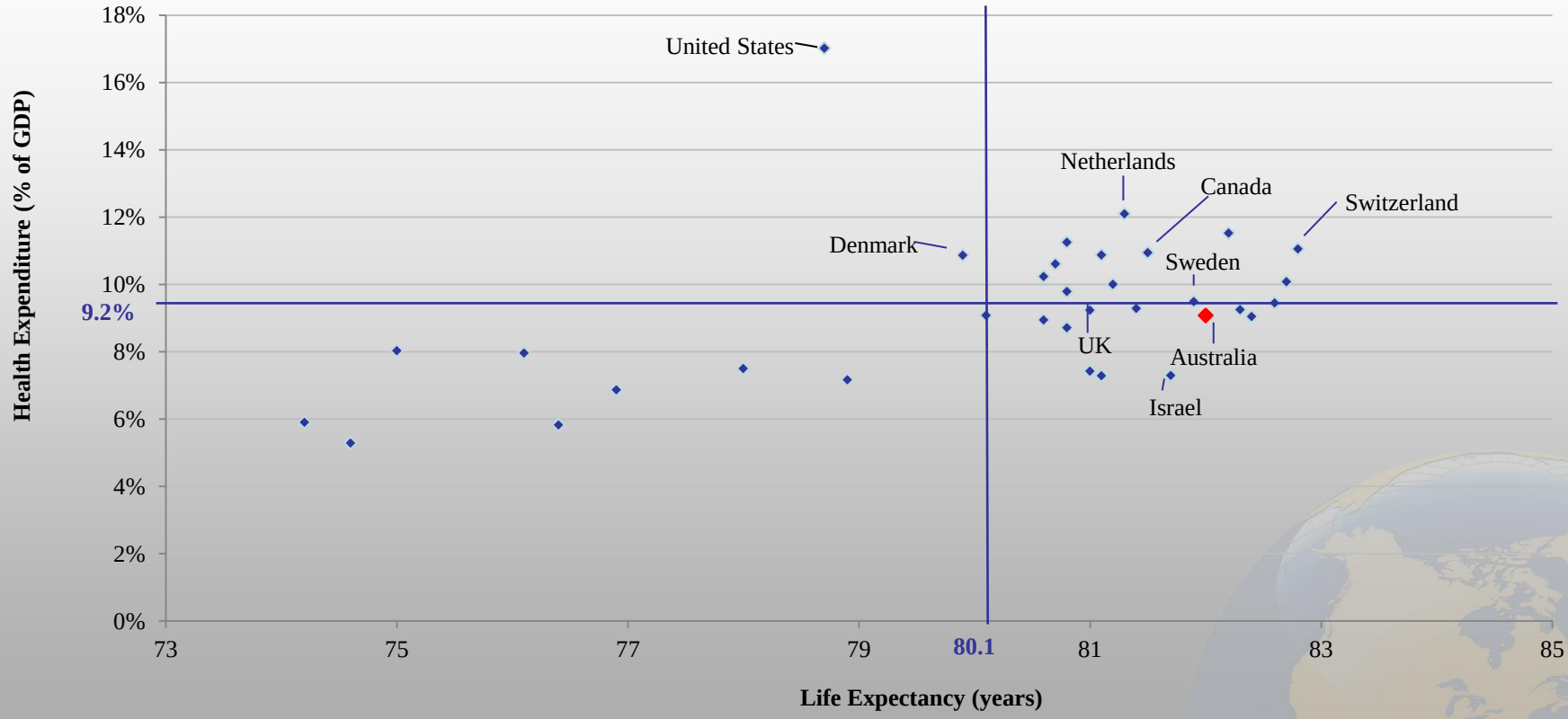
The balance of Public/Private varies across the "Provider" and "Funder" roles



Source: Australia's Health 2014, Australian Institute of Health and Welfare (2014)

Internationally, where do we stand?

Health Expenditure and Life expectancy (OECD countries 2011)



Source: OECD (2015), Health spending (indicator) 2011. Accessed on 02 July 2015; OECD (2015), Life expectancy at birth (indicator) 2011, Accessed on 02 July 2015.

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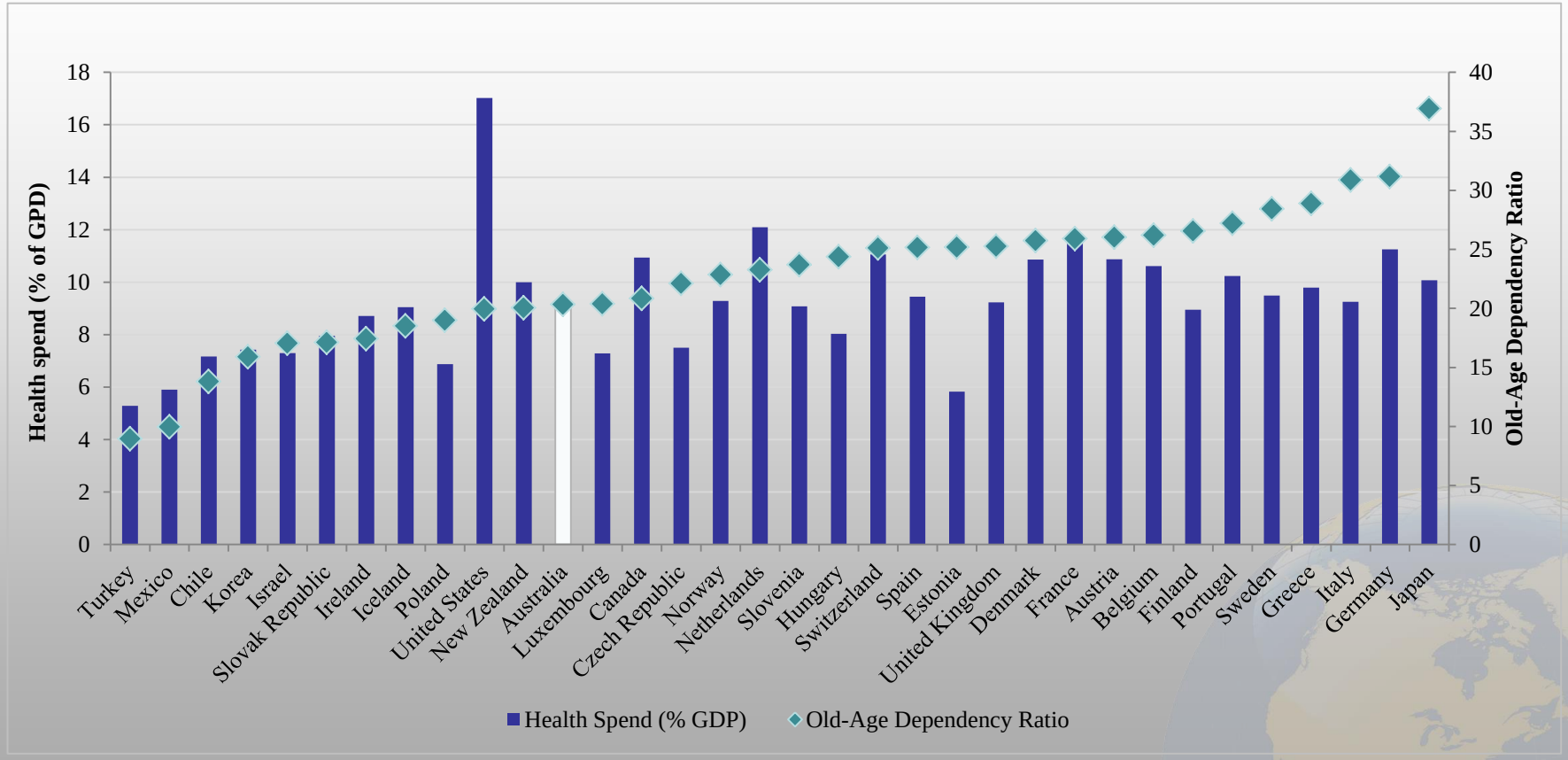
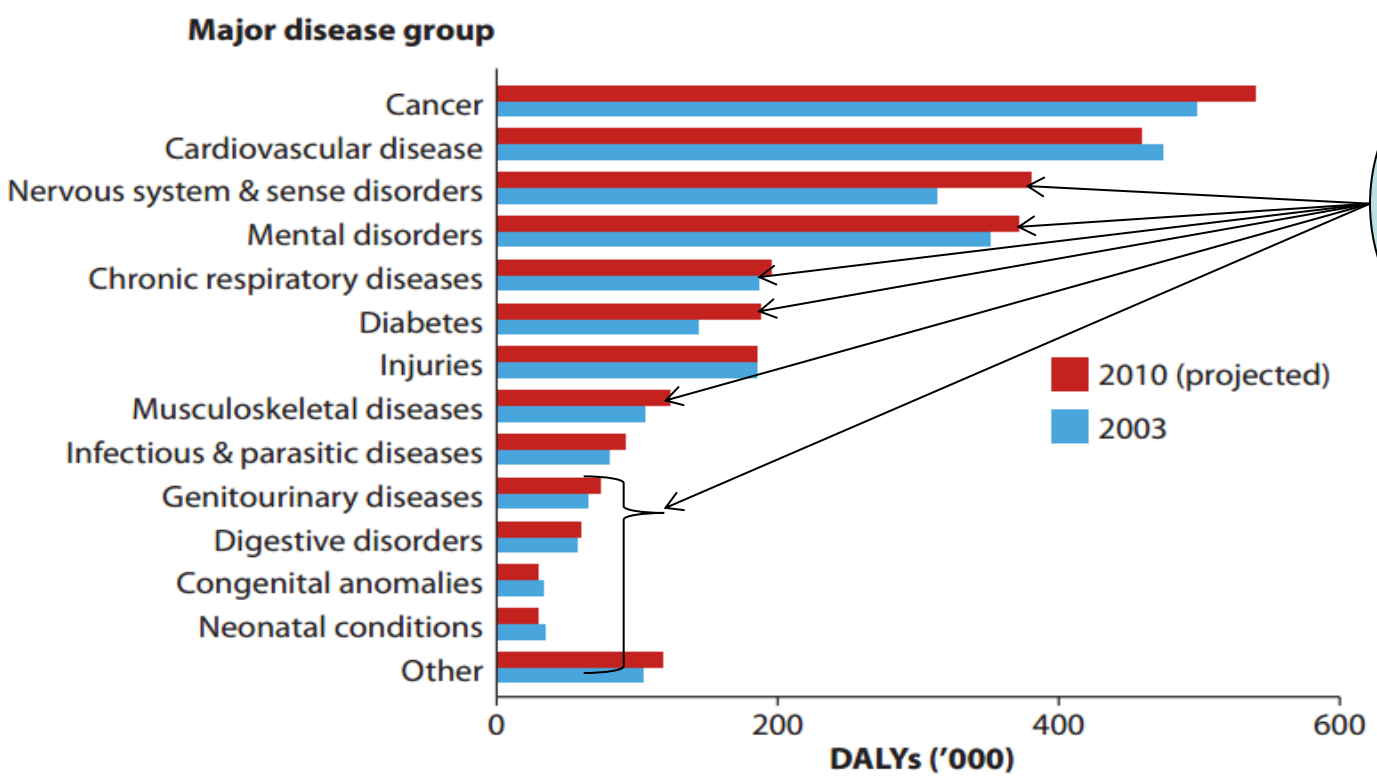
Australia is one of the "younger" countries but some others of similar "age" spend less



Source: OECD (2015) and OECD Economic Policy Paper No 3 (2012)

Four of the top six diseases are chronic



Majority of the contribution is years lost through disability

Source: AIHW Burden of Disease Database.

Figure 3.3: Estimated and projected total burden (DALYs) of major disease groups, 2003 and 2010

Source: Australia's Health 2012, Australian Institute of Health and Welfare (2012)

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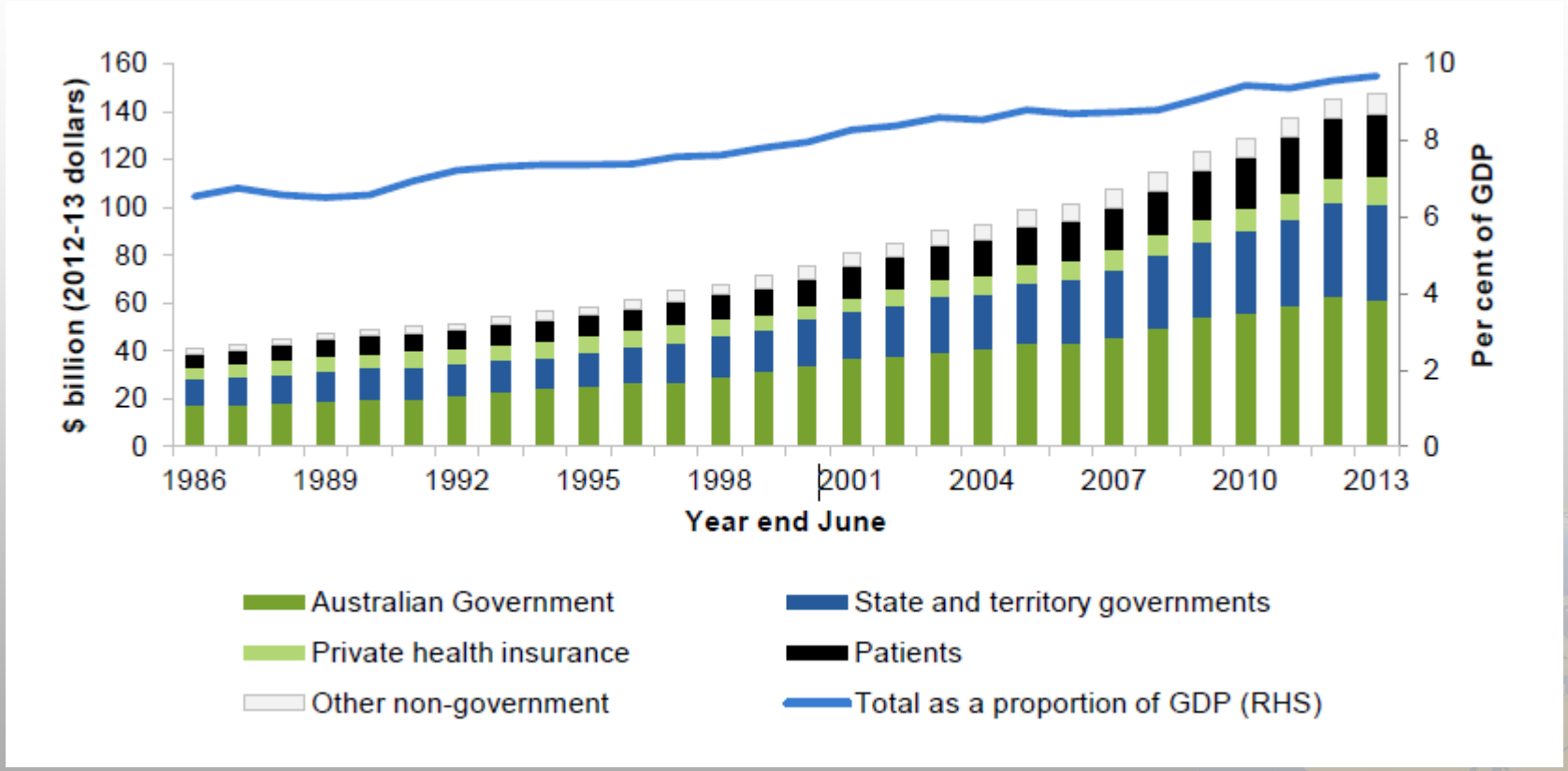
Health expenditure is rising as a %GDP, with all payers sharing the increase



Source: Efficiency in Health, Productivity Commission (2015)

While growth in health expenditure varies by year, by 5-year periods it is close to 5%

Table 2.8: Total and recurrent health expenditure, constant prices[a] and annual growth rates, 2002–03 to 2012–13

	Total health expenditure		Recurrent expenditure	
Year	($ million)	Annual growth (%)	($ million)	Annual growth (%)
2002–03	90,042	. .	85,307	. .
2003–04	92,960	3.2	88,735	4.0
2004–05	98,921	6.4	93,988	5.9
2005–06	101,478	2.6	96,269	2.4
2006–07	107,513	5.9	101,634	5.6
2007–08	114,596	6.6	108,905	7.2
2008–09	123,103	7.4	116,679	7.1
2009–10	128,308	4.2	122,475	5.0
2010–11	136,874	6.7	129,372	5.6
2011–12	145,175	6.1	136,361	5.4
2012–13	147,384	1.5	138,777	1.8
	Average annual growth rate (%)			
2002–03 to 2007–08	. .	4.9	. .	5.0
2007–08 to 2012–13	. .	5.2	. .	5.0
2002–03 to 2012–13	. .	5.1	. .	5.0

(a) Constant price health expenditure for 2002–03 to 2012–13 is expressed in terms of 2012–13 prices. Refer to Appendix C for further details.

Source: AIHW health expenditure database.

Source: Health expenditure Australia 2012-13, Australian Institute of Health and Welfare (2014)

Annual real growth in health expenditure per person averages around 3½%

Table 2.13: Annual growth in recurrent health expenditure per person[(a)], constant prices[(b)], all sources of funding for each state and territory[(c)], 2002–03 to 2012–13 (per cent)

Period	NSW	Vic	Qld	WA	SA	Tas	NT	Australia[(d)]
2002–03 to 2003–04	5.3	–0.6	1.1	5.1	5.1	–0.3	7.5	2.9
2003–04 to 2004–05	6.0	3.6	3.7	4.6	6.5	3.2	3.8	4.8
2004–05 to 2005–06	–0.8	1.6	4.4	–0.5	1.0	3.8	5.4	1.1
2005–06 to 2006–07	3.4	3.2	6.2	4.7	2.3	4.5	3.1	4.0
2006–07 to 2007–08	4.2	4.1	5.9	6.1	8.0	10.4	8.3	5.2
2007–08 to 2008–09	4.8	5.2	5.5	3.3	5.0	4.4	5.5	4.8
2008–09 to 2009–10	3.1	4.9	3.8	–0.6	3.2	0.8	–3.2	3.1
2009–10 to 2010–11	3.1	4.8	2.9	6.3	4.3	7.7	11.4	4.2
2010–11 to 2011–12	3.7	2.9	5.0	1.9	4.4	3.1	13.4	3.8
2011–12 to 2012–13	1.0	0.1	0.1	–0.3	–1.9	–1.2	–6.3	—
Average annual growth rate (%)								
2002–03 to 2007–08	3.6	2.3	4.2	4.0	4.5	4.3	5.6	3.6
2007–08 to 2012–13	3.1	3.6	3.4	2.1	3.0	2.9	3.9	3.2
2002–03 to 2012–13	3.4	3.0	3.8	3.0	3.8	3.6	4.7	3.4

(a) Based on annual estimated resident population. Refer to Appendix D for further details.

(b) Constant price health expenditure for 2002–03 to 2012–13 is expressed in terms of 2012–13 prices. Refer to Appendix C for further details.

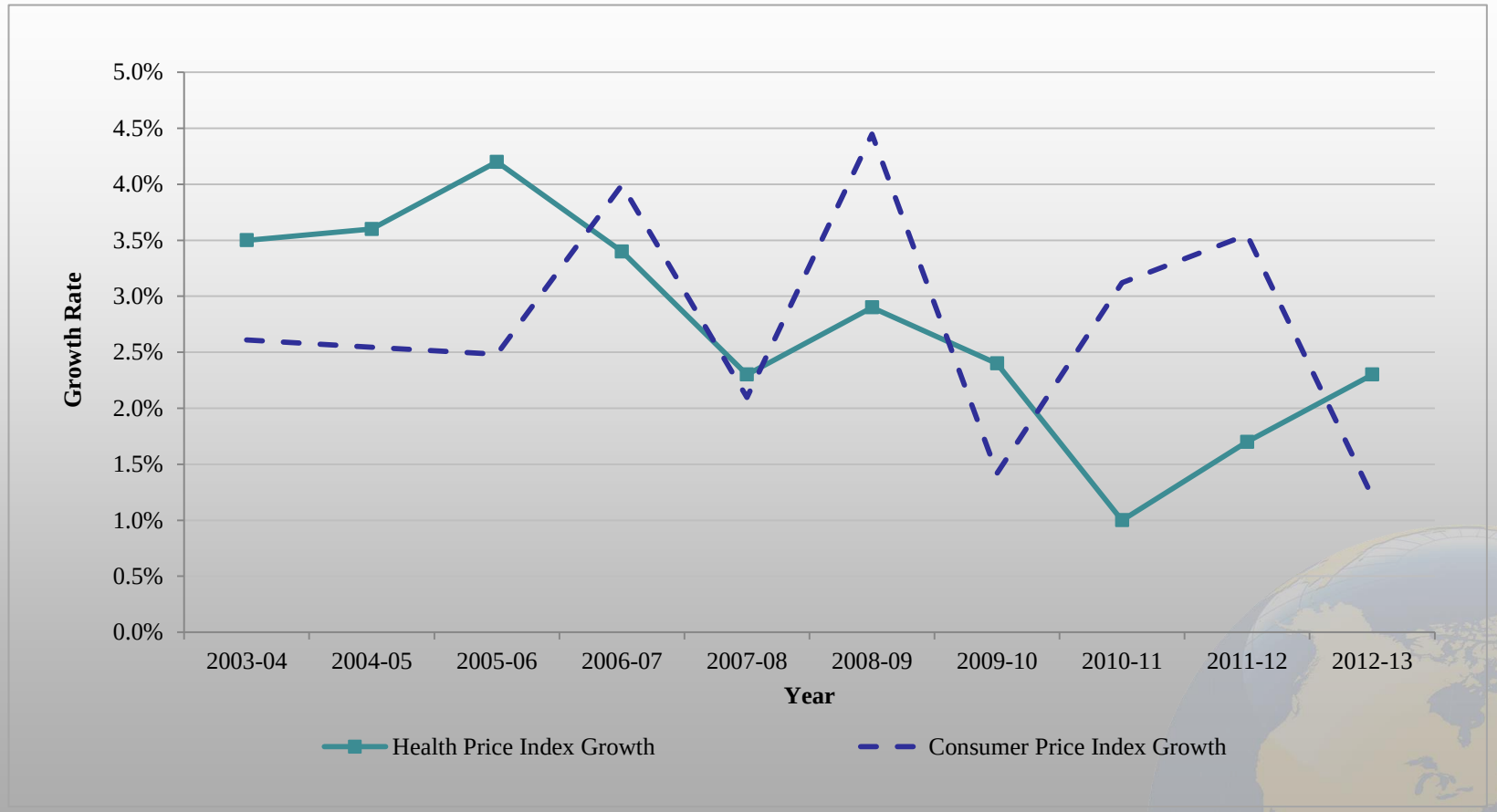
(c) ACT per person figures are not calculated as the ACT expenditure estimates include substantial expenditures for NSW residents. Thus the ACT population is not the appropriate denominator.

(d) Australian average includes ACT.

Source: Table 2.12.

Source: Health expenditure Australia 2012-13, Australian Institute of Health and Welfare (2014)

Health price inflation is reasonably well controlled



Multiple Sources: AIHW (2014), ABS (2015)

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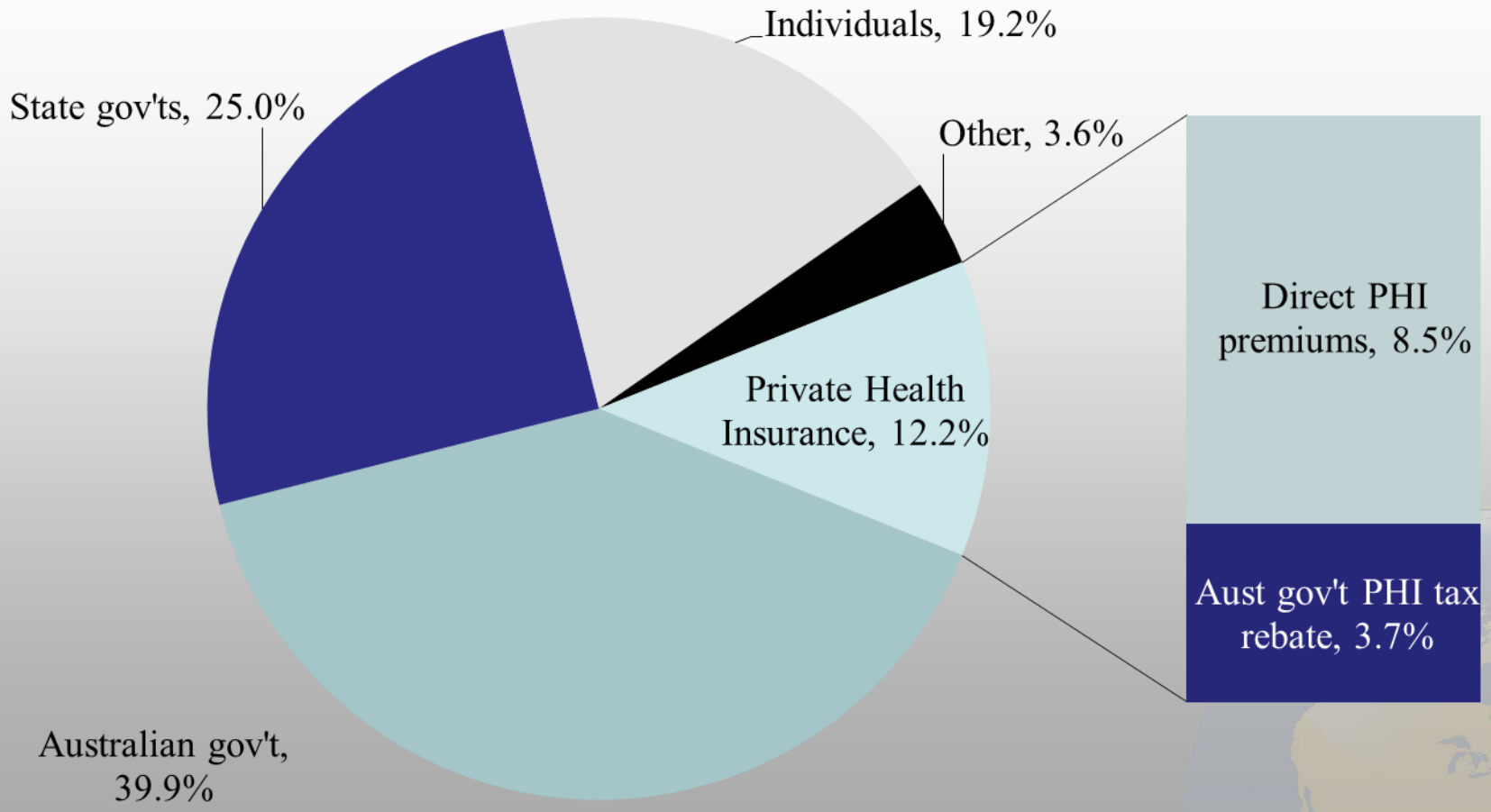
Population ageing alone contributes 20% of health care cost growth

Period	Estimated Cost Growth Standardised by Age and Gender*	Reported Annual Growth in Recurrent Health Expenditure with Constant Prices Per Person**
2009-2010	0.6%	3.1%
2010-2011	0.8%	4.2%
2011-2012	0.7%	3.8%
2012-2013	0.5%	
2013-2014	0.7%	
5 Year Average	**0.6%**	**3.2%**

*AIHW (2014) and ABS Australian Demographic Statistics (2010, 2011, 2012, 2013, 2014)
** AIHW Health Expenditure 2012-13 (2014)

Multiple sources: Australian Institute of Health and Welfare, Australian Bureau of Statistics

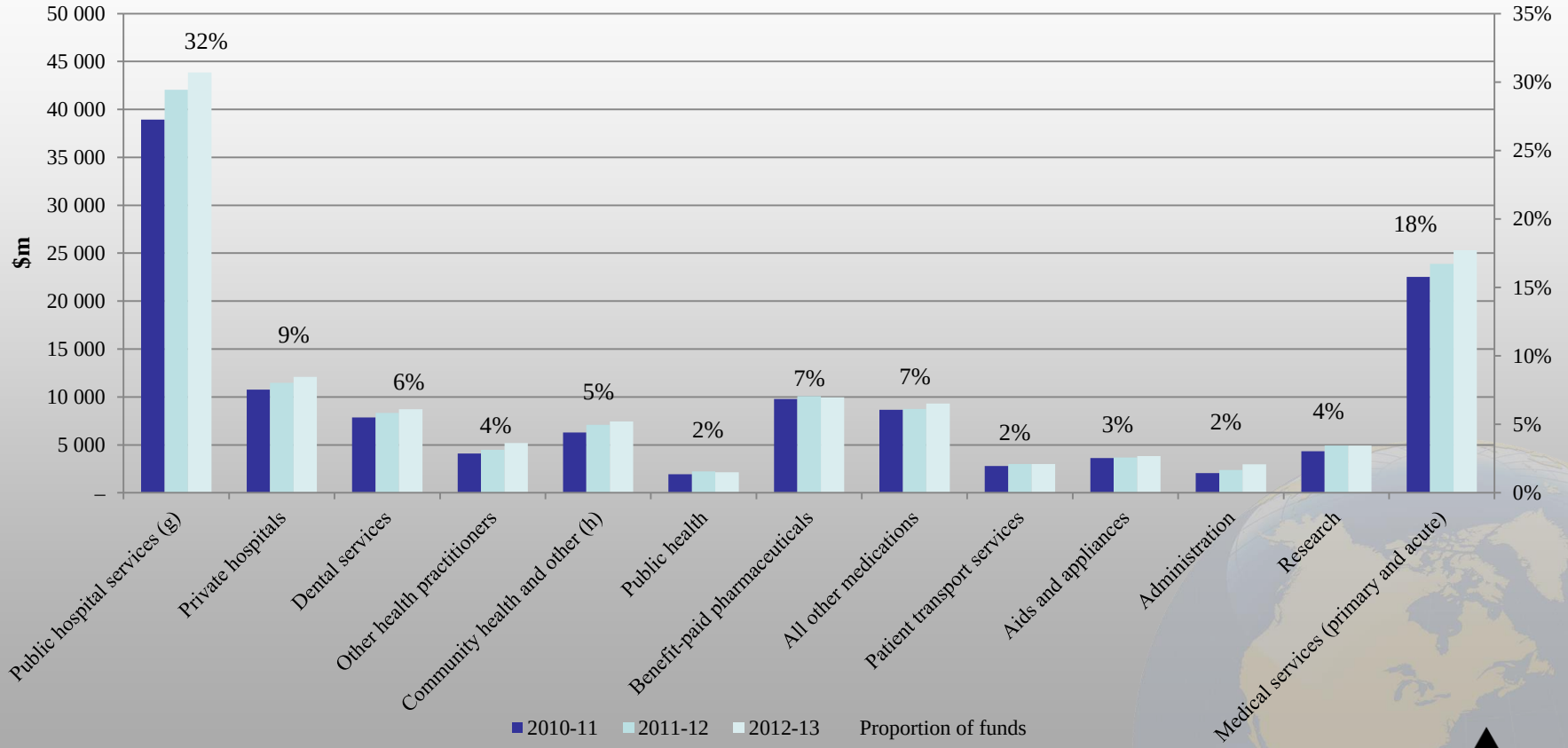
Share of recurrent health expenditure 2012-13



Source: Steering Committee for the Review of Government Service Provision, Report on Government Services 2015

40% spent on hospitals, 40% on primary care and the balance on other

Recurrent Health Expenditure by area of expenditure



Source: Steering Committee for the Review of Government Service Provision, Report on Government Services 2015, 2014 and 2013

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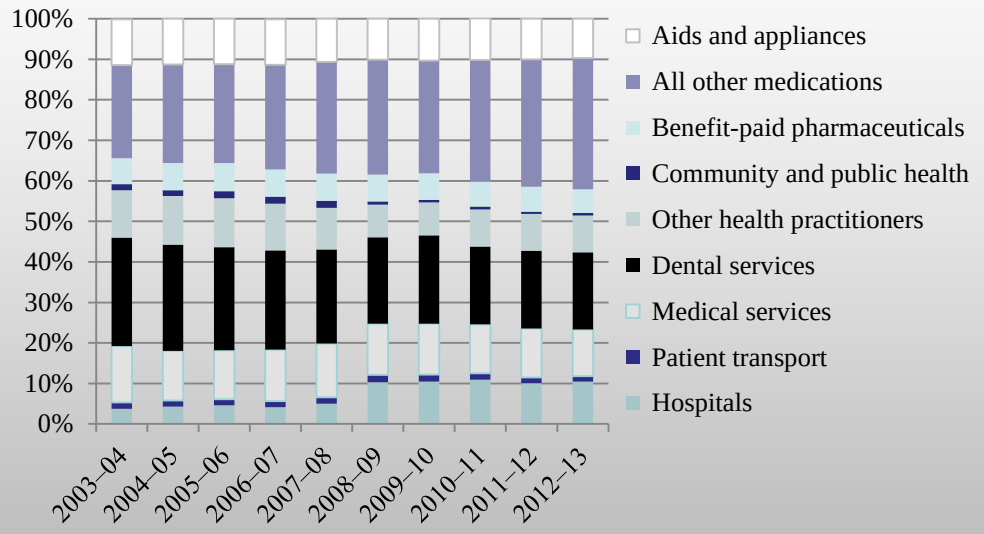
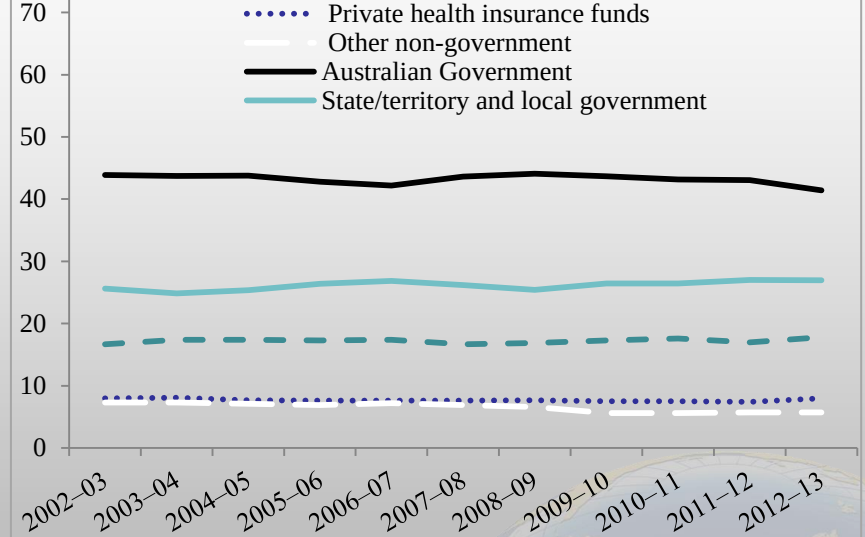
Out-of-pocket has remained stable but components of spend have changed

Split of out-of-pocket expenditure per person



% of total health expenditure



Source: Steering Committee for the Review of Government Service Provision, Report on Government Services 2015,

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Agenda

- Health Care in Australia
- Health Care Costs
- Drivers of Health Care Costs and Responses
- Role of the Actuary

Health care cost growth is driven by demographic and non demographic factors

Demographic Factors

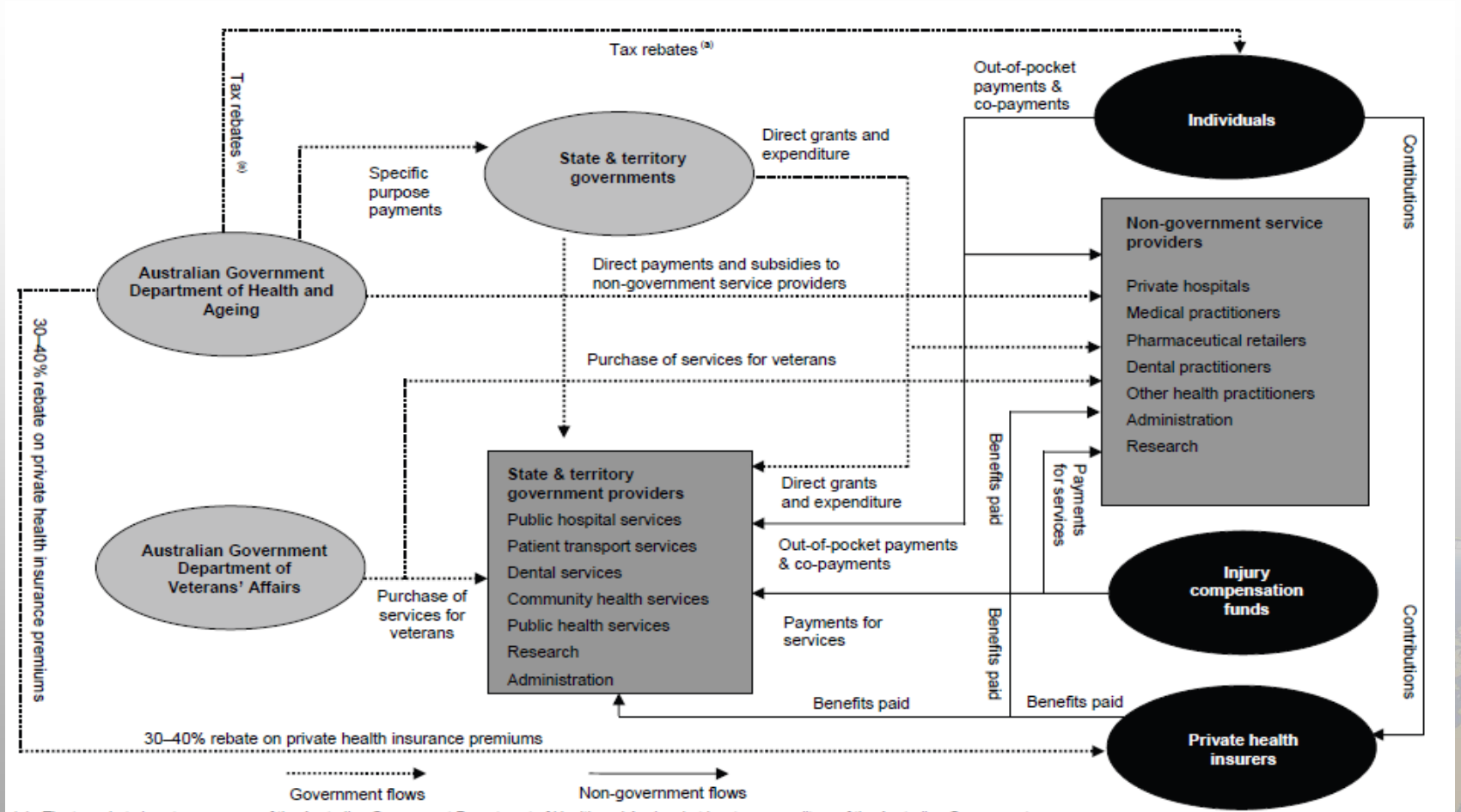
- Ageing population
- Higher levels of chronic disease
- Rising incomes and changing community expectations

Non Demographic Factors

- Cost inflation
- Emergence of new health technologies
- Availability of funding
- Areas of inefficiency

Source: Australia's Health 2014, Australian Institute of Health and Welfare (2014)

The complex health system makes isolating and containing costs difficult…



(a) The tax rebate is not an expense of the Australian Government Department of Health and Ageing, but is a tax expenditure of the Australian Government.

Figure 1.1: The structure of the Australian health care system and its flow of funds

Source: Health expenditure Australia 2012-13, Australian Institute of Health and Welfare (2014)

No single organisation has full responsibility and in many areas responsibilities overlap

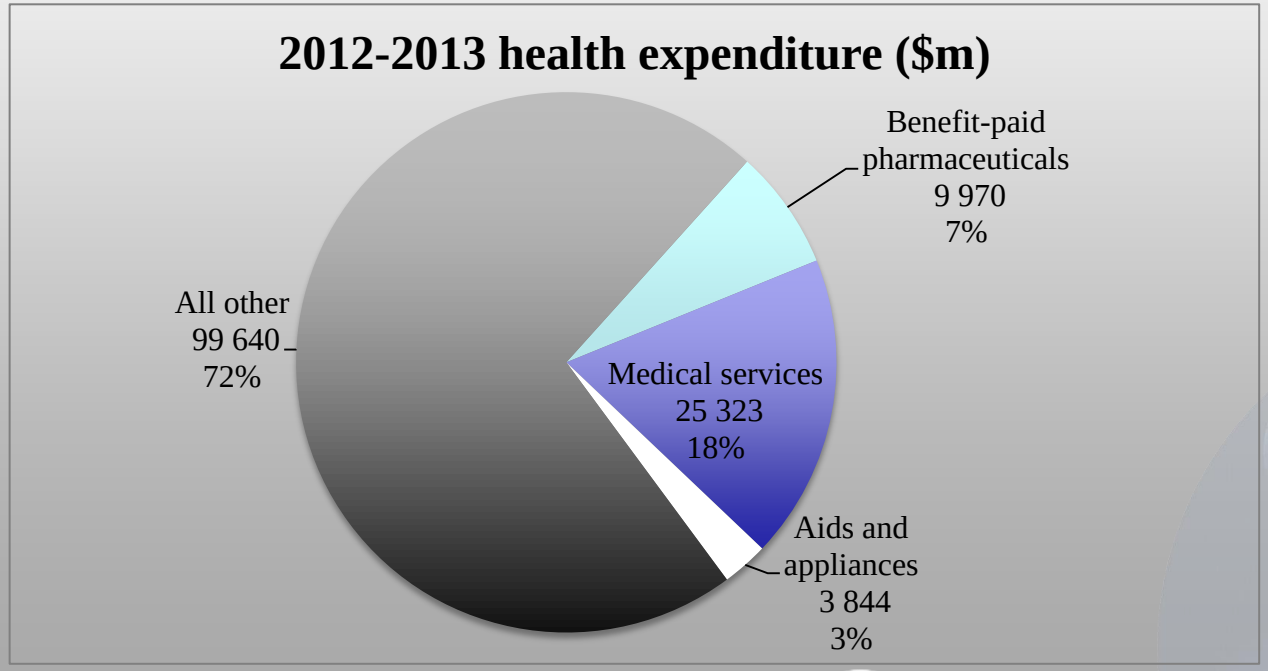
- Australia has a complex system with significant Government involvement with funding at a Federal and State level.
- No single organisation has full responsibility for health and in many areas responsibilities overlap.
- Through the funding role, the AUS government influences supply, regional distribution and quality of services notably through:
  - Direct Funding through - Primary care (GPs, community health services, the PBS and public dental as well Primary Health Networks)
  - Indirect funding through the States and Territories - Public Hospitals (acute care to admitted patients, subacute and non-acute to admitted patients (e.g. rehab, palliative and long stay maintenance), emergency and outpatient services to non-admitted, mental health services, public health services, teaching and research)
  - Mental health management
- Under current legislation, health insurers cannot provide insurance for which a Medicare benefit is payable.
- The mix of Commonwealth, State, Insurer and Individual funding leads to continual cost shifting

…however there are various levers to contain health expenditure

Quality	Economic	Responsibility	Rationing	Markets
Deciding which health care interventions deserve funding	Changing the way health care providers are paid	Rewarding those who use the health system responsibly and penalising those who do not	Constraining the capacity of the health system	Encouraging competition
Examples: - Heath Technology Assessments - Healthier Medicare - PHI contracting	Examples: - Activity Based Funding for public hospitals	Examples: - Co-payments and safety nets - Wellness	Examples: - State Hospitals - Workers in the system	Examples: - National Disability Insurance Scheme

Health Technology Assessment is used to inform public funding of health…

- Australian Governments mainly use HTA in the evaluation of:
  - Medicines and vaccines for listing on the Pharmaceutical Benefits Scheme (PBS) or National Immunisation Program
  - Medical services and devices for listing on the Medicare Benefits Schedule, and
  - Devices for listing on the Prostheses List, which sets benefit levels that private health insurers must pay.

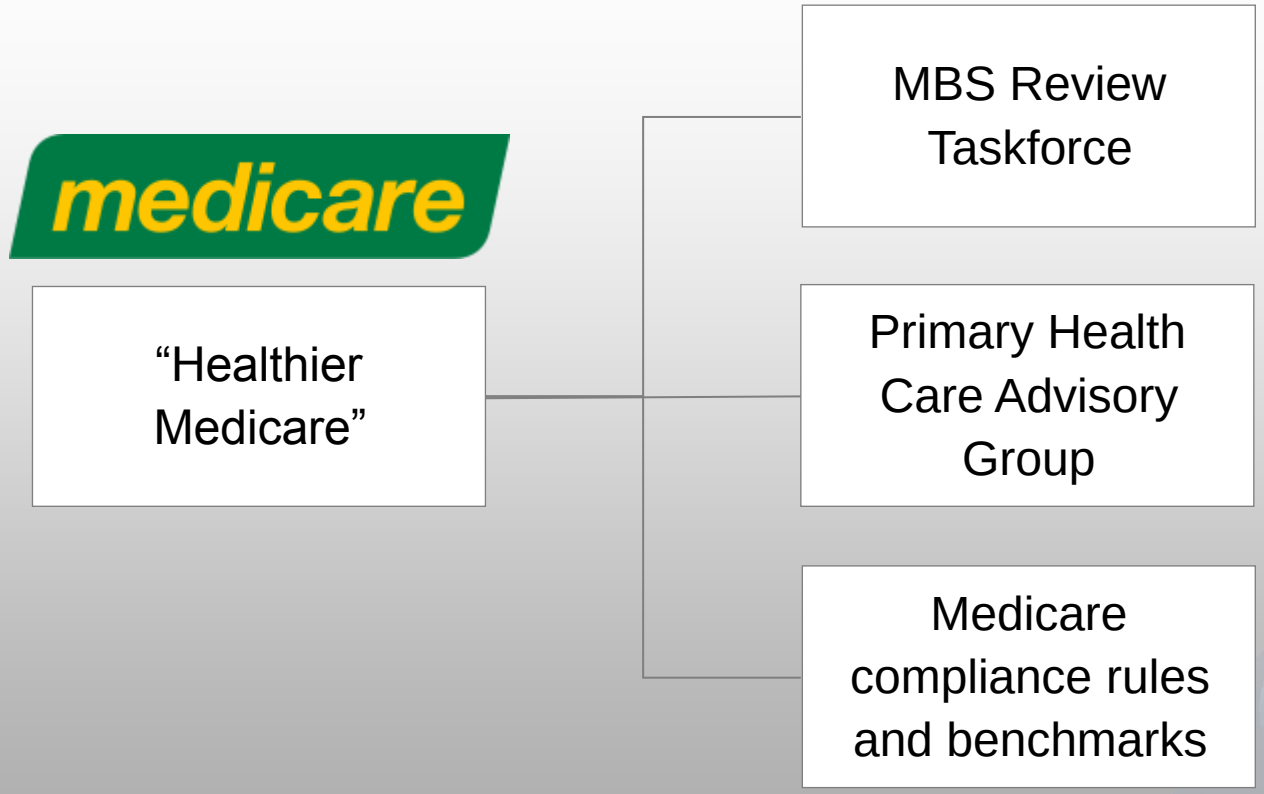


Source: Steering Committee for the Review of Government Service Provision, Report on Government Services 2015

… but fragmentation and lack of ongoing house keeping of HTA has led to waste

- HTA is undertaken at both national and State level and there are separate assessment processes for different types of health technologies
- According to the Productivity Commission report:
  - "as of January 2010, only about 3 per cent of the 5703 items on the MBS had been formally assessed by MSAC (DoHA 2010)
  - up to half of PBS-listed items have not been subjected to an economic evaluation (Martin 2015)
  - Even where listed items are reviewed, and a compelling case for reducing or removing public subsidies emerges, there can be barriers to disinvestment occurring e.g. cataract surgery."
- With increasing prevalence of Chronic Diseases and ageing, being inefficient will cost us more.

Government activity to address these criticisms and concerns



Private funders also changing the game to make providers more accountable

BUSINESS REVIEW

Time for hospitals to share the load

- **Medibank vs Calvary Hospital**

Refusing payment when any of a list of 165 of what it calls "highly preventable adverse events" occur

- **Bupa agreement with Healthscope**

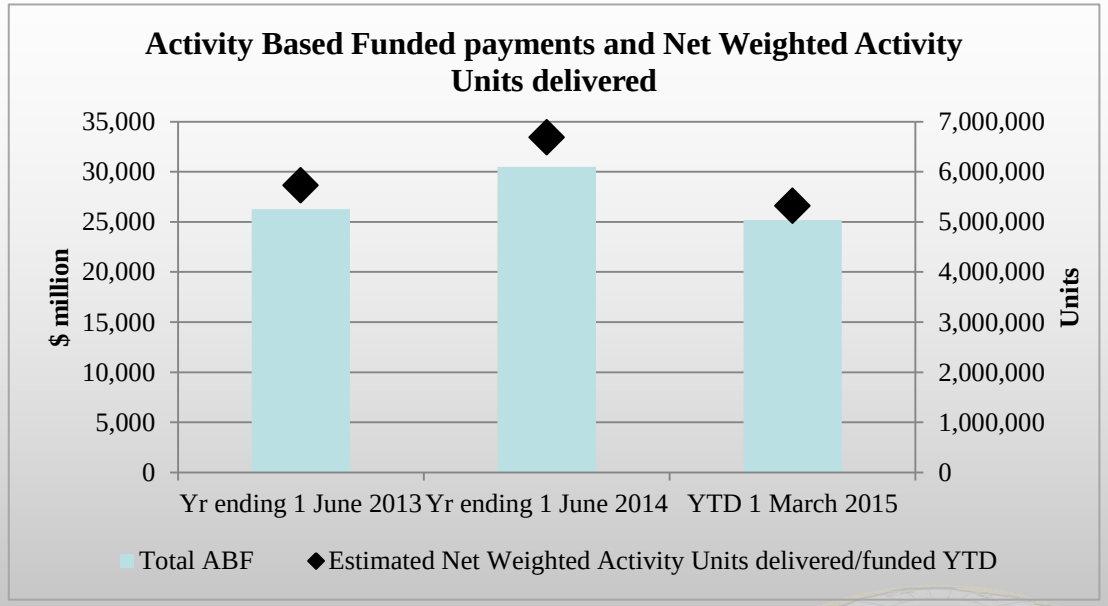
Hospitals are not reimbursed when one of 14 defined 'never events' occur in hospital

"A complete solution will not be found by politicians alone. The discontinuity between public and private, between acute and primary care, and state and federal funding, demands a broader approach to a more affordable, sustainable health system for the future." -George Savvides MD of Medibank

Multiple sources: News.com.au, The Australian, Sydney Morning Herald, ABC News

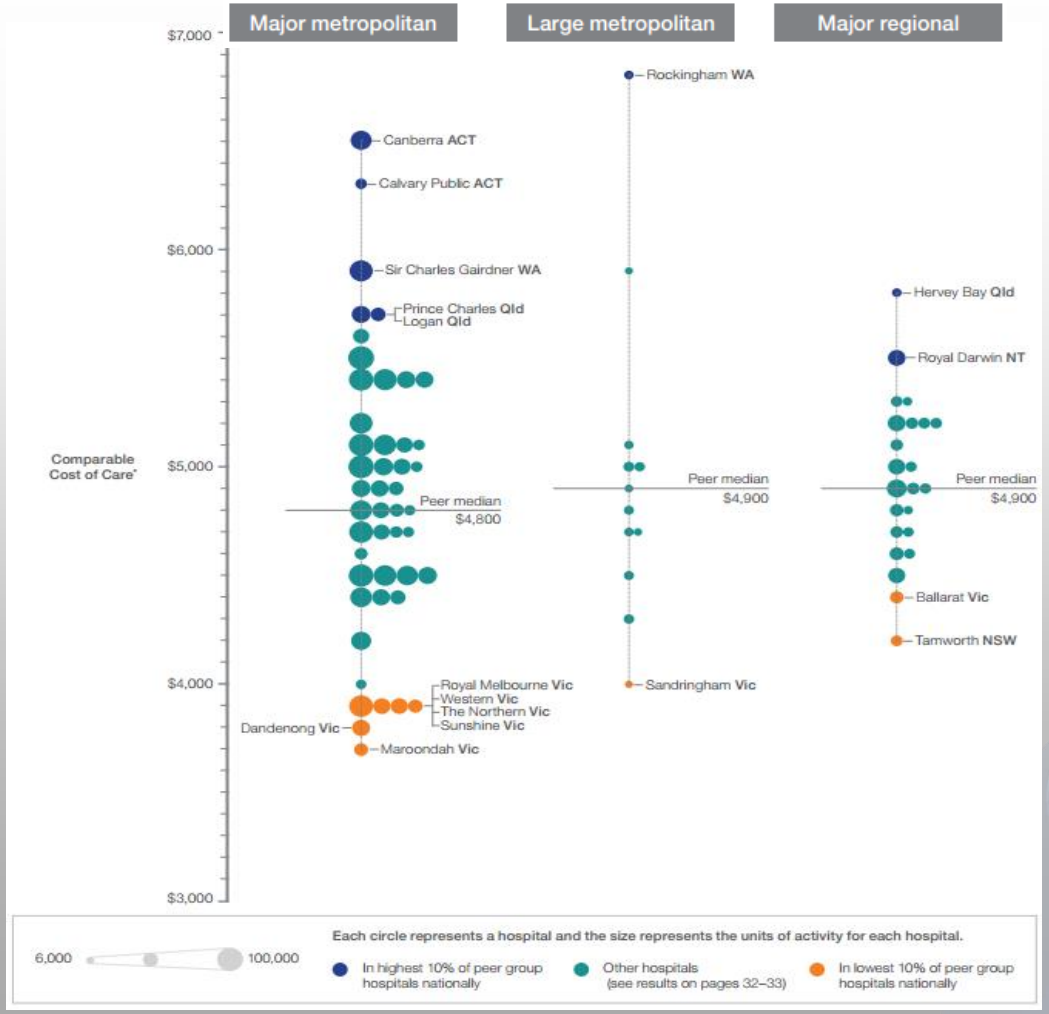
Activity Based Funding for public hospitals has been a major reform in health funding…

- A revision to funding - a result of the "National Reform Agreement" signed in 2011 by the Coalition of Australian Governments.
- New arrangements formally implemented from 1 July 2012, with a phased approach to services budgeted and funded on an ABF basis



- In the 2014/2015 Federal budget, the Australian government announced future hospital funding would be linked to CPI and population growth instead of volume of hospital activity from 1 July 2017 – passing the remaining costs to State Governments and potentially destabilising current ABF framework

… fostering competition and assisting consumers with access to information



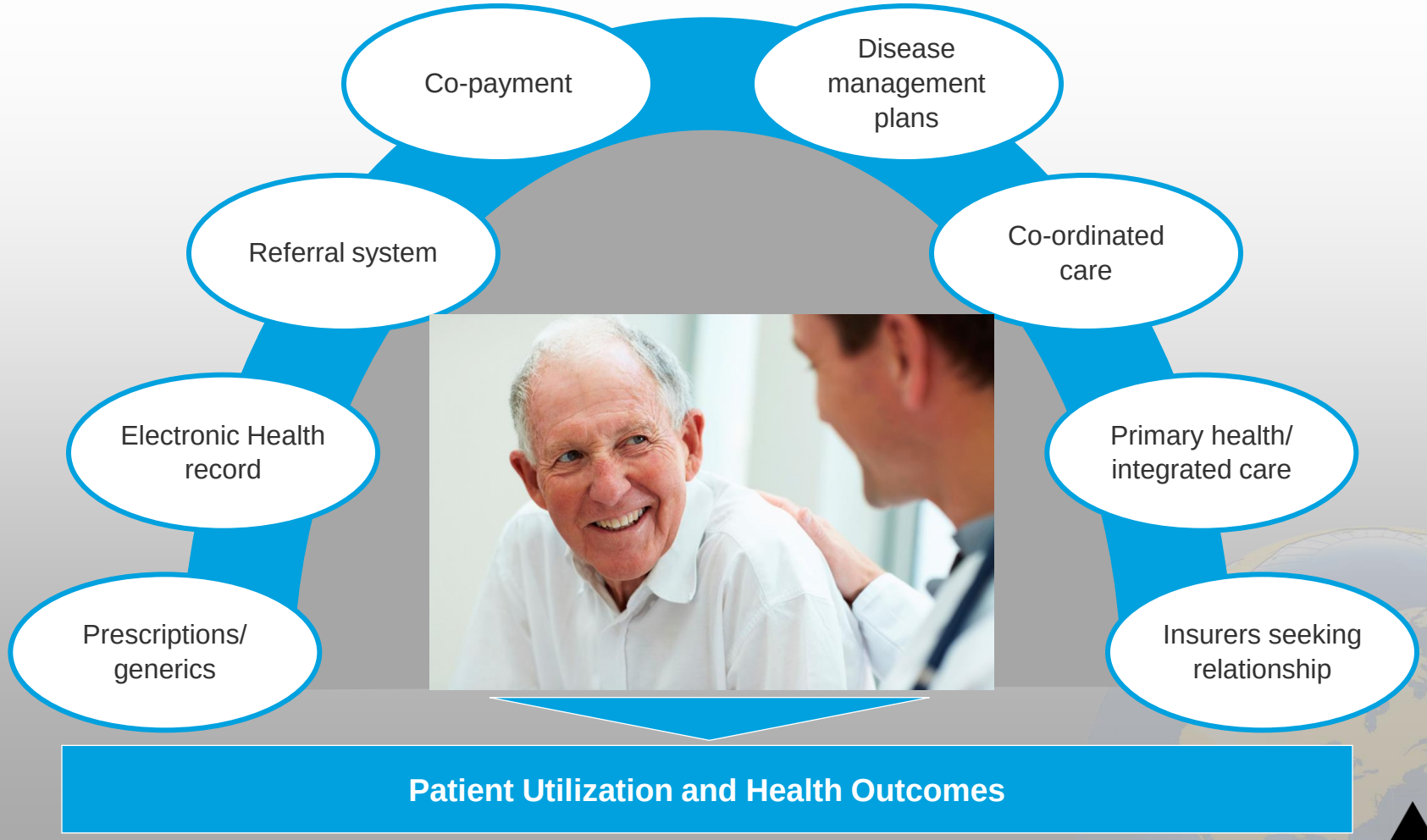
National Disability Insurance Scheme

"The current disability support system is underfunded, unfair, fragmented, and inefficient, and gives people with a disability little choice and no certainty of access to appropriate supports. The stresses on the system are growing, with rising costs for all governments."
- **Productivity Commission Inquiry Report Disability Care and Support 2011**

National disabilityinsurance Scheme

- Aims to empower the patient making him/her exercise choice and control in the purchase of support that meets their needs (vs current approach of government funding suppliers directly, who in turn deliver a prescribed set of services to individuals)
- Each NDIS participant will have an individualised plan setting out their goals and aspirations, the disability services and products that will be funded by the NDIS, and other support the person requires.
- Providers are engaged by participants to deliver supports in accordance with the participant's plan.
- Currently being trialed in 7 states with national roll-out from 2016
- Ongoing work: Scheme architecture; Transition; Governance

The GP is central to 'good' system utilization and prevention



Continuous innovation: Fail fast and try again

- **Diabetes Care Project (3 year trial, 2011-2014)**
  - Run by the Australian Government DoH, several State governments, health care providers and others.
  - A pilot of coordinated models of primary care for diabetes.
  - 184 general practices in QLD, SA and VIC reimbursed through different payment models, one of which was a mixture of capitation and performance payments to care for patients with diabetes (AIHIN 2014).
  - Conclusions: Improved information technology and continuous quality improvement processes were not on their own sufficient to improve health outcomes but combining these changes with a new funding model did make a significant difference. The funding model used in the pilot was not cost-effective, needed further research and refinement.
- **GP co-payments**

Budget papers outline proposed GP co-payment
May 13, 2014

Tony Abbott leaves room to move in 'refining' the GP co-payment
June 1, 2014

Federal Government considering exempting the elderly
August 13, 2014

Tony Abbott flags dumping budget plan for 'optional co-payment'
December 9, 2014

Sussan Ley suggests GP co-payment could see more changes
January 16, 2015

Tony Abbott: no policies without 'broad backing' of doctors
February 9, 2015

Tony Abbott says Government 'rethinking' some policies
February 28, 2015

MPs told of co-payment's demise
March 3, 2015

* For overseas readers, Tony Abbott is the Prime Minister and Sussan Levy is the Minister for Health and Sport

Source: ABC News

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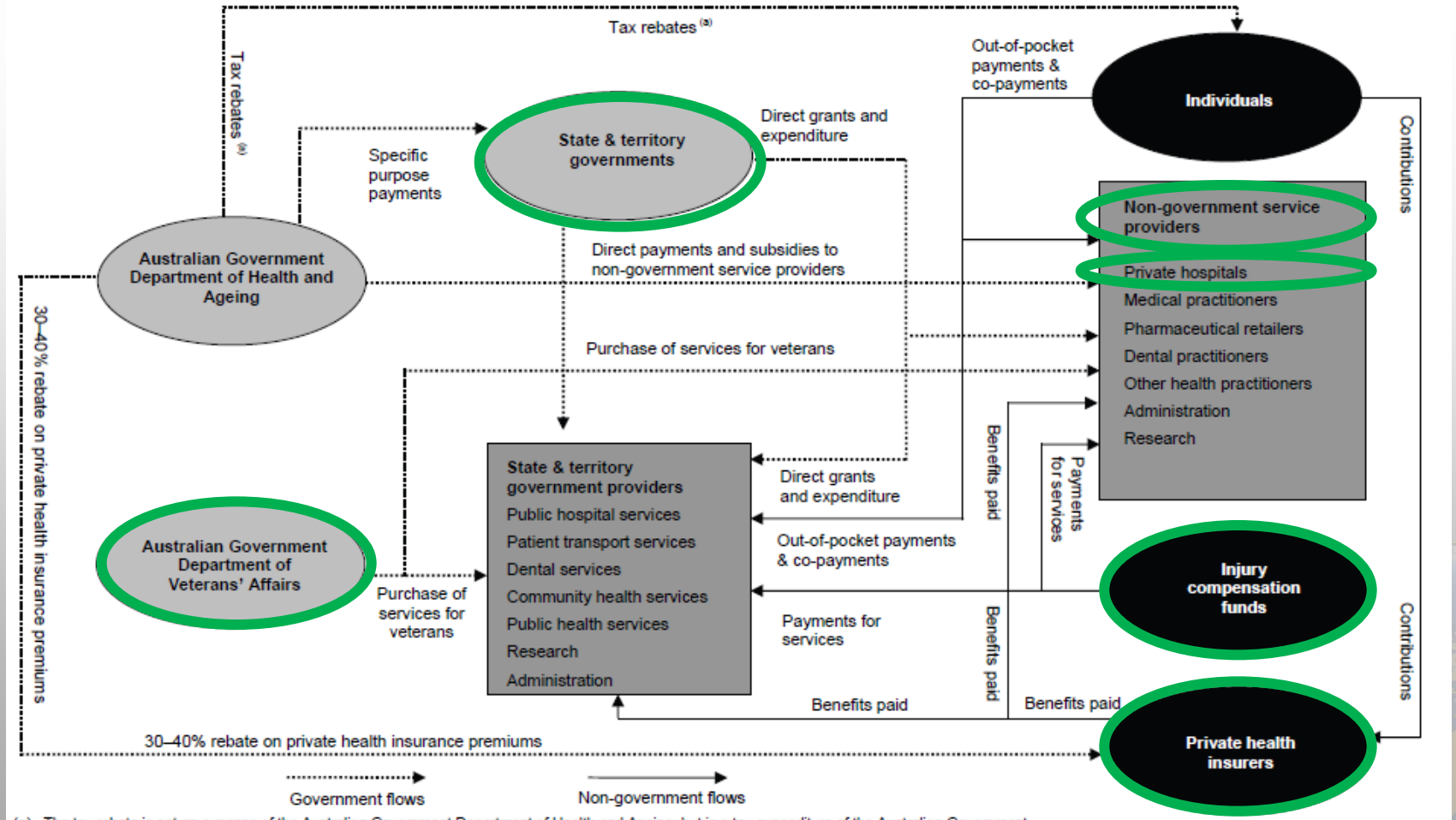
Role of the Actuary

- Appointed Actuary role for Health Insurers introduced in 2004 and has since been introduced in primary legislation.
  - Main tasks are to advise on changes to the business (products, strategy, risk profile, capital management and investments, etc);
  - Traditional liabilities/risk margins and
  - Financial Condition Report

The flow of finances in the system has several points where actuarial insights could improve the outcomes



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End

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Question and Answer

Question and Answer Session

Next Webinar

Exploring Global Health Care Cost Drivers: Canada and Chile

November 4