medibank
For Better Health

Medibank's Senate Inquiry Submission

Submission to the Senate Inquiry into the Value and Affordability of Private Health Insurance

28.07.2017

Contents

Executive Summary

Private health insurance is a critical element of Australia's healthcare system.

Australia's health system is strong precisely because it is a mixed system that relies on both public and private providers. All Australians benefit from private health insurance as it takes pressure off the public health system, provides greater consumer choice, and reduces costs for taxpayers.

Private health insurance funds two in every five hospital admissions in Australia – admissions that would otherwise be borne by an already pressured public health system.

Around 90 per cent of day admissions for mental healthcare, 50 per cent of all mental health admissions, 70 per cent of joint replacements, 60 per cent of chemotherapy, and 88 per cent of retinal procedures take place in the private health sector and are supported by private health insurance.

Far from being a saving, adverse changes to private health insurance incentives – such as eroding the rebate – will add costs to the Commonwealth over time, diminish competition in the health system, undermine consumer choice, and place greater demands on the public system, leading to longer wait times for patients and deteriorating health outcomes.

Given private health insurance pays nearly $20 billion in benefits to consumers, this means that for every $1 spent on the rebate, around $3 does not have to be spent in the public system.

Without the rebate a typical family with teenage children with hospital and extras cover receiving the standard rebate of 26 per cent would pay around $1,500 a year more for their health insurance, which is an onerous burden on families.

The sustainability of the health system – not just private health insurance – necessitates practical policy reforms that address the inefficiencies and market failures that add unnecessary cost and result in poorer health outcomes. Practical policy reforms to enhance health outcomes and the affordability and value of private health insurance, as well as the broader health system, include:

- Significant scope to reduce prostheses prices paid by private health insurers and our customers, which will place downward pressure on premiums – for example, Medibank's 2017 premium increase (the lowest in 15 years) is 35 basis points lower than it otherwise would have been because of the Government's recent reductions to some prostheses prices (see page 13 of our submission).
- Ensure more informed choice for consumers considering using their private health insurance in public hospitals (see page 14).
- Reform the second-tier default (see page 14).
- Require greater transparency in the price, performance, and quality outcomes of healthcare providers, which is fundamental to improving consumer choice, to placing downward pressure on costs throughout the public and private health system, to delivering better targeted and effective treatment for patients, and to developing improved health outcomes (see pages 15 and 26).
- Maintain effective and ongoing incentives for the take-up of private health insurance (see page 17).
- Deliver better preventative programs and health strategies for individuals with chronic disease (see page 21).
- Ensure any classification system for private health insurance policies avoids unnecessary requirements that will add to premiums and/or restrict product innovation (see page 25).
- Facilitate the adoption of updated diagnostic related group systems by private hospitals and private health insurers (see page 30).

Medibank is committed to improving the value of health insurance for Australians and to strengthening our health system.

In 2015-16, Medibank spent $5.1 billion on our customers' healthcare, covering more than 1.3 million hospital admissions, over 26 million ancillary services like dental and optical, and more than half a million surgeries. In the last five years the number of hospital admissions per Medibank customer increased 19 per cent, while the average amount Medibank pays per customer in benefits has increased 31 per cent and our total average premiums have risen 29.5 per cent.

Australia's health system, our public hospitals, and our health outcomes are stronger because of private health insurance.

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About Medibank

Medibank is one of Australia's largest providers of private health insurance, with 40 years' experience delivering better health to Australians. We look after the health cover needs of 3.8 million Australians through our Medibank and ahm brands and deliver a range of programs to support health and wellbeing in the community.

Medibank is committed to improving the value of health insurance for Australians and to strengthening our health system.

Our Business

Headquartered in Melbourne, Medibank has corporate offices in Canberra, Brisbane, Perth, Sydney, St Leonards, and Wollongong. We have more than 80 retail stores across Australia, with over 20 in regional areas, employ over 3,100 people, and handle more than 40,000 phone inquiries a week.

For the 2015-16 financial year, Medibank recorded a net profit of $417 million and paid nearly $130 million in tax. For the first half of the 2016-17 financial year, Medibank recorded a net profit of nearly $232 million and paid $91 million in tax.

Around 270,000 Australians own shares in Medibank.

In addition to private health insurance, Medibank provides healthcare to 60,000+ permanent and 20,000+ reservist uniformed Australian Defence Force personnel, employs nearly 1,000 clinicians across Australia, delivers 800,000 nurse advice calls for Australians and 70,000 GP tele-consultations per year as part of the more than 1.8 million interactions a year we deliver through our telehealth services, delivers the beyondblue support service, and provides telephone and online counselling services for those experiencing sexual assault or domestic and family violence through 1800RESPECT.

More than half of our board and senior managers are women and we are committed to increasing the representation of people with disabilities, Indigenous Australian Peoples, and those aged over 55 within our workforce.

Medibank's Commitment to Deliver Value for Our Customers

Medibank has a fundamental stake in the health and wellbeing of our 3.8 million customers. We spent $5.1 billion on our customers' healthcare in the 2015-16 financial year.

We covered more than 1.3 million hospital admissions, over 26 million ancillary services (such as dental, optical and physiotherapy), and more than half a million surgeries.

Medibank knows that affordability of private health insurance is a real issue for many Australians. That is why our premium increase for 2017 is the lowest in 15 years and 24 basis points lower than the industry average. We are working hard to deliver greater value to our customers and to address the affordability challenges that the private healthcare industry faces. Some of our recent initiatives to bring greater value for our customers include:

- Giving 100 per cent back on annual dental check-ups, which will benefit our 2.7 million customers with extras cover and save a family of four up to $400 a year.
- Passing every dollar in savings realised through recent changes to prostheses pricing back to our customers.
- Investing over $20 million per annum in our CareComplete program to improve chronic disease management, collaborating with more than 3,600 GPs to reduce avoidable hospitalisation for people with chronic health needs.
- Investing $6 million per annum to improve our service and engagement with customers.
- Delivering more personalised services to our customers to improve their quality of life, help them to stay out of hospital (e.g. non-hospital palliative care, rehabilitation and chemotherapy), and take pressure off premiums and the healthcare system.

Supporting the Community

Medibank supports many community programs, including our $1.5 million investment to the Stephanie Alexander Kitchen, which tackles childhood obesity in more than 1,200 primary schools, and initiatives to improve Indigenous health outcomes. Our Medibank Better Health Foundation has provided $4 million in funding for more than 20 health research projects since 2013. We are a principal partner of the 2018 Sydney Invictus Games and we sponsor the Sydney Mardi Gras, the Parkrun fitness program throughout Australia, and the Melbourne Marathon.

Value of Private Health Insurance

Private health insurance is fundamental to the effectiveness and strength of Australia's health system.

The majority of Australians – 13.4 million people, representing 55 per cent of all Australians – hold an insurance policy covering them for hospital and/or extras cover.[1]

Nearly half of the Australians with private health insurance have disposable incomes under $50,000 per year.[2]

Private health insurance delivers tangible benefits for all Australians by taking pressure off the public system, providing greater consumer choice (e.g. choice of doctor, choice of procedure timing, choice of hospital), and reducing costs for taxpayers.

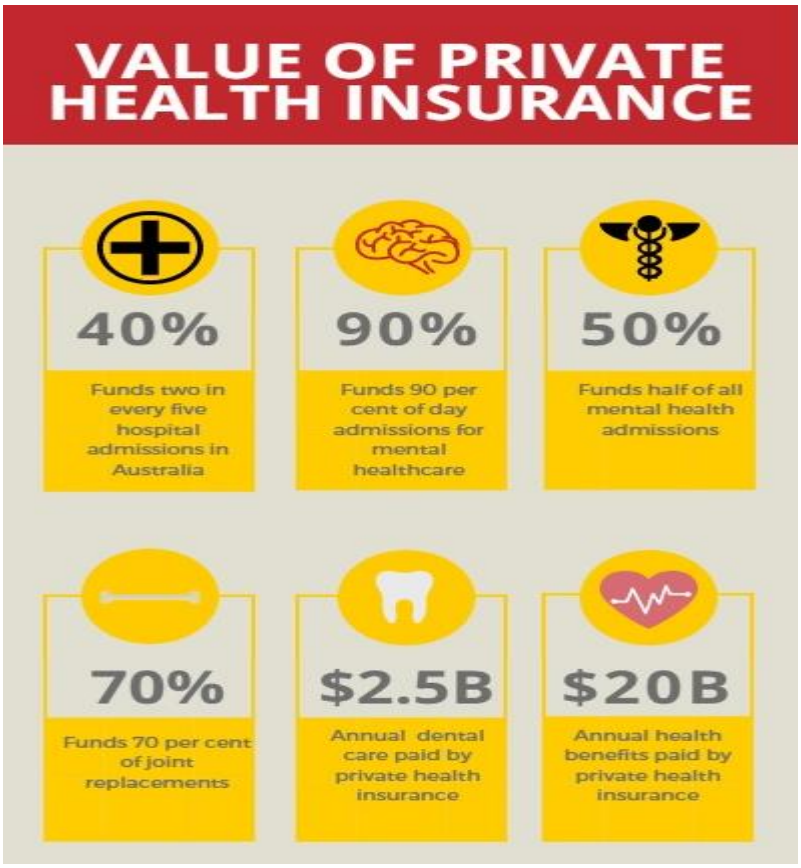
Taking Pressure off the Public Health System

Private health insurance relieves pressures on the public health system by improving the quality, affordability, and access to healthcare in Australia.

As the Commonwealth Department of Health states, a key community benefit of private health insurance is to reduce pressure on the public hospital system:

> "The Government has reduced the pressure on the public hospital system by supporting individuals to purchase private health insurance."[3]

Private health insurance funds two in every five hospital admissions in Australia, representing 33 per cent of all days of hospitalisation that would otherwise be borne by the public system.



Around 90 per cent of day admissions for mental healthcare, 50 per cent of all mental health admissions, 70 per cent of joint replacements, 60 per cent of chemotherapy, and 88 per cent of retinal procedures take place in the private health sector.[4]

The majority of elective surgeries (around 67 per cent) in Australia are performed in private hospitals, which reduces waiting times for elective surgery and lowers demand for hospital beds in the public system.[5]

More than $2.5 billion in dental care is paid for by private health insurance, more than the Commonwealth pays for dental care. Around 90 per cent of dental health services provided to low and middle income earners are subsidised by private health insurance.[6]

The statistics demonstrate the role of private health insurance in taking pressure off the public health system.

Government and the health industry recognise the positive impact of private health insurance on Australia's public health system.

As the Commonwealth Government states:

> "The proportion of Australians with some form of private health insurance is now around 56 per cent, providing a high level of access to private health services and taking pressure off the public system."[7]

Consequently, any consumer shifts from private health insurance – and any adverse policies that undermine the affordability and value of private health insurance – will only increase pressure on our public health system. As the Australian Medical Association notes:

> "If consumers withdraw from the private sector, demand for these services will move to the public sector, which under current capacity, will not meet the additional need or only at a higher cost to governments."[8]

Similarly, the Pharmacy Guild observes that:

> "The reason that the Federal Government encourages and subsidises private health insurance is that patients accessing care through private hospitals reduce the overall demand on the public hospital system. The Government should focus its investment in private health insurance on reducing the burden on public hospitals, by encouraging patients to utilise the private hospital system and related services that are cost-effective in reducing hospitalisation and preventable use of the wider public health system."[9]

The Queensland Government notes that:

> "...suspending rebate thresholds for private health insurance could increase demand for public hospital[s]."[10]

Victoria's Auditor-General recognised decades ago that demands on public hospitals are:

> "...increasing due, in part, to a larger proportion of the population not having private health insurance."[11]

And Western Australia's Auditor-General notes that:

> "...the State's public health system is subject to increasing demand pressures...[but] this pressure has been alleviated to some extent by improved efficiencies in same day surgery and bed management as well as by more people having their surgery performed at private hospitals following the introduction of the 30 per cent health insurance rebate."[12]

Private health insurance plays an important role strengthening Australia's health outcomes by taking pressure off the public system and, consequently, reducing waiting times for patients and reducing costs for taxpayers.

Providing Greater Consumer Choice

Private health insurance provides consumers with greater choice – choice of doctor, choice of hospital, and choice of timing for health procedures.

As the Productivity Commission observes:

> "Private health insurance allows consumers to insure for a level of service above that which governments would usually provide through universal health care arrangements. While any Australian can seek 'free' treatment in a public hospital, those with private hospital cover can choose to be treated as a private patient, and typically have shorter waiting times for elective surgery and greater choice of doctor."[13]

Consumers with private health insurance benefit from greater choice and control, such as choosing to be treated by one's own doctor, shorter waiting times for elective surgery, and financial support for services not covered by Medicare (such as dental, optical and physiotherapy), and having more say over when and where to be treated.

Private health insurance is fundamental for consumer choice and a stronger public health system.

As the Commonwealth Department of Health states:

> "Australia's mixed and balanced model of private and public health insurance is integral to the provision of universal access to high quality affordable health care services for all Australians. People have a choice about whether to use the public or private systems. The decision to purchase private health insurance is a personal choice. People who cannot afford private health insurance or who do not wish to take out private health insurance for any other reason, continue to have the right to access free treatment in public hospitals.
>
> Private health insurance has many benefits such as providing access to private in-hospital services. Private health insurance members can be treated in a private or public hospital as a private patient. This means that depending on the circumstances, they can choose the doctor that treats them, the hospital they are treated in and at a time that suits them.

> Private health insurance also provides cover for non-MBS services such as physiotherapy, dental and podiatry services, and some aids and appliances. Many people rely on private health insurance to access services they would otherwise be unable to afford."[14]

Choice has clear benefits for consumers – and 84 per cent of Australians with private health insurance value the product and want to keep it – and also for Australia's health system.[15]

Providing consumers with greater choice and control means there is more competitive pressure in the health system, which promotes greater innovation, better health outcomes, and downward pressure on costs. Consumer choice through private health insurance means consumers have greater control over their treatment options.

As the Australian Medical Association states:

> "Private health insurance offers Australians greater choice in their doctors and their treatment and may offer shorter waiting times for some services."[16]

Private health insurance also means consumers have greater capacity to choose to use private facilities, which they otherwise may not be able to afford – and which subsequently helps take pressure off the public health system.

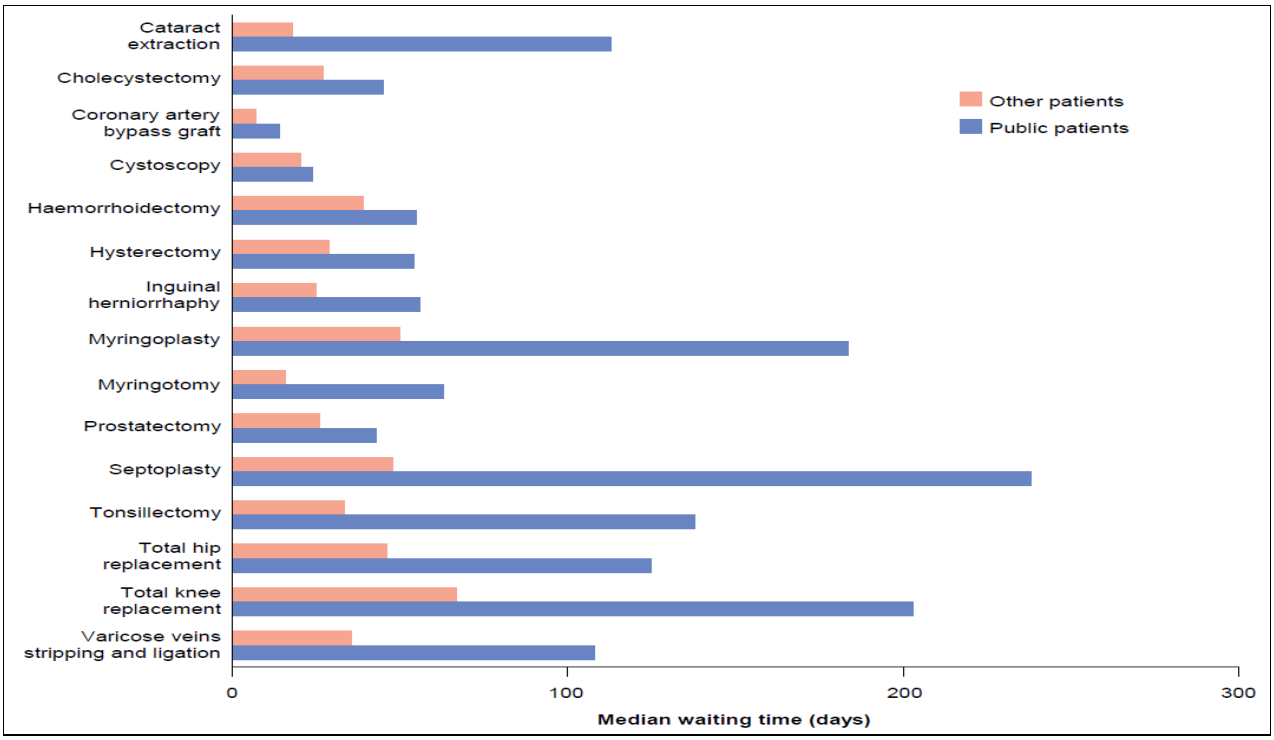
As the Productivity Commission states:

> "..,the accessibility of private hospital services improved with the increased take-up of private hospital insurance."[17]

This consequence is important given the Australian Medical Association recently found that the median waiting times for elective surgery increased to 37 days in public hospitals.[18] The finding of the Australian Medical Association is consistent with that of the Australian Institute of Health and Welfare, which found that in 2015-16:

> "The median waiting time for public hospital elective surgery was 38 days overall—42 days for public patients and 20 days for patients who used private health insurance to fund all or part of their admission."[19]

As indicated below, there is already significant waiting times in public hospitals for many procedures – waiting times that will only increase if patients transfer from private health insurance to the public system.[20]



The ability of private health insurance to promote consumer choice means that pressure is taken off waiting times at public hospitals, which in turn promotes better health outcomes and reduced cost for taxpayers.

Reducing Costs for Taxpayers

By taking pressure off the public hospital system, private health insurance delivers cost value for taxpayers. As the Productivity Commission observes:

> "Private health insurance plays a major role in supplementing public funding in some areas, and replacing public funding in others."[21]

Private health insurance paid nearly $20 billion in healthcare benefits in the 2016-17 financial year – this is $20 billion that would otherwise have to be paid by government and taxpayers. For every dollar that people spend on private health insurance, the industry returns 86 cents back in benefits – a higher benefit return than for other insurance products.[22]

The Commonwealth Government encourages private health insurance through a means-tested rebate, but the rebate delivers significant returns to taxpayers. Given private health insurance pays nearly $20 billion in benefits to consumers, this means that for every $1 spent on the rebate, around $3 does not have to be spent in the public system.[23]

The capacity of private health insurance to take pressure off the public system, promote consumer choice, and reduce costs for taxpayers was noted by the OECD as early as 2003:

> "Private health cover in Australia promotes health system responsiveness. Insurees benefit from having greater choice over hospitals and the timeliness of hospital care. Private health insurance helps finance private hospital care, and, to the extent that demand shifts from public to private care, it helps relieve capacity and financial pressures from public hospitals, especially for elective surgery."[24]

Similarly, the World Health Organisation noted as early as 2004 that Australia:

> "...used private insurance to provide principal coverage for significant segments of their population and it is now used to relieve pressures on the public system...[Private health insurance] contribute[s] directly to the costs of health care, and serves as a mechanism to capture private funds to finance growing demands on the health care system."[25]

It is thus not surprising that both major political parties support a sustainable private health insurance industry, with the Australian Labor Party stating:

> "Both public and private sectors play critical roles in Australia's world-class health system. While governments have sole responsibility for managing the public health sector, they should also support a strong and sustainable private health care industry."[26]

And the Coalition stating:

> "The Coalition understands that private health insurance is a fundamental element of our health system that offers consumers greater choice over their care whilst taking pressure off Medicare and public hospitals so that their universality remains sustainable."[27]

The private health insurance system delivers tangible benefits for all Australians by taking pressure off the public system, providing greater consumer choice, and reducing costs for taxpayers.

Delivering Value for Our Customers

Medibank delivers value for our customers and Australia's health system.

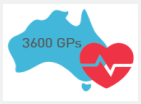
In the last five years the number of hospital admissions per Medibank customer has increased 19 per cent, while the average amount Medibank pays per customer in benefits has increased 31 per cent.

We have introduced an initiative to give 100 per cent back on annual dental check-ups, which will benefit our 2.7 million customers with extras cover. This can save a family of four up to $400 a year.

Through our hospital contracts, we work collaboratively with our hospital partners to reach the best possible agreements to provide value for our customers, including low or no out-of-pocket costs.

We are continuing to invest in our primary care program, CareComplete, as one in five Australians is now living with two or more chronic conditions.[28] We have recognised the need for a fresh approach to patient care that drives better outcomes and are collaborating with more than 3,600 GP clinics on this evidence-based approach.

CareComplete



CareComplete is now one of the largest chronic disease management programs in Australia, with more than 10,000 participants enrolled since the programs started in 2014. We have worked with more than 1,800 GP clinics and 3,600 GPs to deliver CareComplete.

One in five Australians are living with two or more chronic conditions.

The greatest prevalence of chronic disease among program participants were observed for diabetes, heart disease and osteoarthritis.

After just seven months of participation in the CarePoint program (out of a two year intervention period), compared to matched controls, CarePoint participants experienced the following:

- Reduction in admissions for target conditions
- Improved identification of 'unmet' needs
- Greater survival rates

Graduates from the CareFirst program have demonstrated positive trends in all clinical indicators, with significant improvement in blood pressure, physical activity, waist circumference, health-related quality of life and decreased risk of hospitalisation.

Program participants reported improvements in their confidence to manager their health condition and appreciated the access and time spent with a broad range of health professionals.

The programs are associated with high participant satisfaction.

Medibank is committed to improving the value of health insurance for Australians and to strengthening our health system.

Medibank's Benefit Contributions to Customers

Medibank paid $5.1 billion in benefits to our customers in 2015-16.

Over the period 2004 to 2016, Medibank paid an average annual benefit of 86.59 per cent relative to contributions (based on annual data from the Ombudsman's 'State of the Health Funds' reports).[29] Our average annual benefit over this period is consistent with the average benefit ratio of 86 per cent paid by the private health insurance industry.

There has been no materially significant change in our benefit payment ratio since privatisation – over the period 2004 to 2014 our average annual benefit was 86.85 per cent relative to contributions, compared to 85.15 per cent over the period 2015 and 2016.

While Medibank's benefit ratio of 83.9 per cent for 2016 is lower than the industry average, the ratio reflects efficiency improvements and is an indication of the business' focus on placing downward pressure on health costs and premium increases.

Far from signalling any reduction to customer benefits, Medibank's benefit ratio is an indication of the capacity of health insurers to deliver both cost and quality improvements in the delivery of healthcare.

Medibank notes that:

- High benefit to contribution ratios are not a signal of better quality healthcare, but can be an indication of inefficient and high cost practices that are likely to place upward pressure on premiums.
- Our benefit payments have increased 17 per cent over 2011-12 to 2015-16 and by 4.2 per cent over 2014-15 to 2015-16.
- Medibank paid $150 million more in extras benefits last financial year compared to five years ago, with dental services making up 44 per cent of the claims Medibank customers made.

- Our 2017 premium increase would have been 55 basis points higher in the absence of efficiency gains and cost leadership in contracting with service providers. Our contracting arrangements allow us to minimise waste and higher than necessary costs in our supply chain, subsequently reducing expenses without degrading the quality or extent of health services available to our customers.
- Medibank's benefit inflation for 2017 is expected to be 5.5 per cent (i.e. the expected increase in benefits paid), but our premium increase is only 4.6 per cent due to efficiencies and reductions in prostheses prices.
- Our average management expense ratio of 8.10 per cent for the period 2015 and 2016 is significantly lower than the average for open membership funds of 10.01 per cent, indicating the business is proactive in reducing overheads and internal expenses and thus placing downward pressure on premium increases. Our average management expense ratio of 8.10 per cent for the period 2015 and 2016 is also lower than the 9.59 per cent average over the period 2004 to 2014, prior to privatisation.
- Medibank's payment integrity program has delivered positive savings to outlays by identifying, preventing and recovering improper claims.
- Our efficiency improvements contribute to the business' ability to invest in new customer health initiatives, including our CareComplete program for chronic disease management.

Medibank's benefit to contribution ratio reflects, in other words, a sustainable and competitive approach to the delivery of healthcare that minimises upward pressure on premiums.

Affordability of Private Health Insurance

The affordability of private health insurance is critical to the sustainability of Australia's health system.

Medibank is working to provide greater value to our customers and to address the affordability challenges that the private healthcare industry faces.

Affordability of private health insurance is a real issue for Australians and, in response, Medibank's premium increase for 2017 was the lowest in 15 years, and 24 basis points under the industry average, even as total spending on healthcare increased by approximately 7.1 per cent per annum over the past decade.[30]

Medibank is committed to making private health insurance as affordable as possible.

We have worked with healthcare providers to eliminate unnecessary waste in health services, we introduced our CareComplete program to provide better and more targeted care for people with chronic diseases, we are delivering greater value to customers (for example, as previously mentioned every Medibank extras customer now has a dental check up on top of their existing extras balance, which can save a family of four up to $400 a year), we are investing more in our customer service centre, and we are improving the efficiency, transparency and accuracy of claims management.

Importance of the Private Health Insurance Rebate

The Commonwealth rebate is essential to the affordability of private health insurance.

It is important to emphasise that the rebate is paid to individuals and families, **not** private health insurers.

The private health insurance rebate is eroded every year as its indexation is linked to the lower of the consumer price index or the annual increase in premiums, effectively making private health insurance more expensive every year. The income thresholds for each tier of the rebate are also frozen, which as the Australian Taxation Office notes means that:

> "Not adjusting the income thresholds for three years may result in individuals with incomes just below each threshold moving into a higher income threshold sooner if their income increases. This means…if you have private health insurance, your private health insurance rebate percentage entitlement may decrease."[31]

Additional adverse changes to the private health insurance rebate will be detrimental as this will cause many consumers to consider dropping private health insurance with a view to relying on the public health system only.

The Parliamentary Budget Office also acknowledges that a phasing down of the rebate will:

> "…increase the out-of-pocket cost of PHI [and] fewer people would take out PHI…[particularly] those on low incomes." [32]

Far from being a supposed saving to Government, any phasing down of the rebate will add costs to the Commonwealth over time, diminish competition in the health system, undermine consumer choice, and place greater demands on the public system, leading to longer wait times for patients.

Claims that a phasing down of the rebate will result in a net saving to the Commonwealth ignore or discount the adverse impact on public hospitals. Modelling by the Parliamentary Budget Office, for example, is based on the assumption there will be "no flow-on effect to public hospital expenses" and is acknowledged by the authors as being of only "medium reliability" that is sensitive to a raft of factors (such as premium increases, income changes, and behavioural responses).[33]

Similarly, adverse changes to the application of the private health insurance rebate to extras cover will increase premiums in the long-term as some customers will opt-out of health insurance or downgrade their policies if extras cover is made more expensive. As extras cover cross-subsidises hospital only cover, downgrading or withdrawal by customers from extras cover will result in higher premiums for hospital cover.

The Commonwealth Department of Health notes that the PHI rebate:

> "…helps make private health insurance more affordable, provides greater choice and accessibility to access private health care options, and reduces pressure on the public hospital system."[34]

Without the rebate a typical family with teenage children with hospital and extras cover receiving the standard rebate of 26 per cent would pay around $1,500 a year more for their health insurance, which equates to more than the entire weekly

earnings of an average household and will inevitably lead to a significant decline in industry participation and thus more pressure on the public system.[35]

Around 90 per cent of Medibank's customers are claiming a private health insurance rebate to reduce their premiums – and the current rebate results in an average 26 per cent discount for these customers.

Eroding the private health insurance rebate will have a clear, negative impact on premium costs and increase cost of living pressures for families.

The Australian Competition and Consumer Commission notes that the affordability of private health insurance is a concern for consumers:

> "The affordability of insurance remains a significant concern for consumers, which is supported by research confirming real household expenditure on private health insurance premiums has increased steadily over the past decade...as real household expenditure on private health insurance has increased, affordability has become a significant consumer concern."[36]

If the private health insurance rebate is abolished, there will be an effective 35 per cent price increase for private health insurance.

Such an increase would be around five times higher than the largest annual premium over the past 15 years.

Around 3.2 million Australians covered by Medibank will be financially worse off if the private health insurance rebate is abolished (based on those claiming the rebate). A similar number would be affected by any adverse changes to the rebate, depending on the scope of change.

There would also be adverse effects for Australia's public health system, meaning increased waiting times and more pressure on doctors and nurses in our public hospitals.

Medibank estimates that around a quarter of our customers could drop their private health insurance entirely if the rebate is abolished, placing an additional 900,000 people onto the public health system (which suggests a total of around 3.3 million will opt out of private health insurance across the industry). Such an exit from the industry will subsequently place greater pricing pressure on members retaining their cover and will likely lead to a higher than normal premium increase in the subsequent year, which will make private health insurance only less affordable.

The rebate is critical to the affordability of private health insurance and fundamental to a stronger public health system.

Need to Address Cost Drivers in the Health System

The sustainability of the health system – not just private health insurance – necessitates practical policy reforms that address the inefficiencies and market failures that add unnecessary cost and result in poorer health outcomes.

Costs in the health system continue to increase.

Private health insurance claims have increased by an average annual rate of 8.1 per cent over the 10 years to 2015-16, with Medibank's claims expenditure increasing at an annual rate of 6.7 per cent over this period.

Private health insurance premiums have consequently risen by an average of around 6.1 per cent per annum since 2002, well beyond the rate of wage growth.[37] Equity market analysts have recently estimated that:

> "...premium rates would need to increase by 6 per cent per annum to hold net margins steady. This level is politically unpalatable and the Australian consumer wallet has simply run out of capacity to absorb this."[38]

Concurrently, charges for health services have increased and the portion of those charges beyond the benefits or rebates that consumers can claim from private health insurance or from Medicare have increased, leading to higher out-of-pocket amounts that consumers are required to bear themselves.

The Commonwealth Treasury estimates that real health expenditure per person will double over the next 40 years, with the Commonwealth Government's expenditure on health to increase from 4.2 per cent to up to 7.1 per cent of GDP by 2054.[39] This excludes expenditure by state governments, insurers, and consumers.

Some of the cost drivers are unavoidable, such as population growth, increased life expectancy, and improvements in technology and treatment methods.

But costs are also being driven by inefficiencies in the health system, including poor information transparency and well-intended regulations that are unfortunately resulting in higher costs and poorer outcomes for consumers.

These regulations create perverse incentives where some providers in the private system pursue an inefficient growth strategy, regardless of the inflationary impact on the Australian health consumer. The number of private hospital beds increased 26 per cent over the period 2005-06 to 2015-16, with private hospital income doubling and capital expenditure more than tripling over the same period.[40] Between 2011-12 and 2015-16, the rate of hospital bed growth in private hospitals tripled that of public hospitals.[41]

By way of example, there has been double digit annual growth in private inpatient rehabilitation over the previous five years. There is also significant variation in inpatient rehabilitation rates across States, with New South Wales and Victoria having twice the rates of inpatient rehabilitation compared to Queensland and nearly four times the rates in Western Australia – and 43 per cent of private patients are referred to inpatient rehabilitation following knee replacement in private hospitals compared to only five per cent in public hospitals.[42] Further discussion on rehabilitation is at page 28.

As the MBS Review is demonstrating, there are many areas where low/nil value care is driving unnecessary utilisation and cost growth, yet without significant reform these procedures continue to be performed and government and private insurers are compelled to fund them in the current regulatory environment.

More significantly, costs are being driven by waste, unnecessary and/or low value care, which are estimated to account for up to 30 per cent of total healthcare expenditure, and with the chair of the MBS Review Taskforce noting that:

> "...roughly 25 per cent of all items on the [MBS] schedule do not have some form of evidence to support them."[43]

While the Government has taken some welcome steps to address these problems (such as through the MBS Review), more must be done, including steps to enhance payment integrity of the MBS.

Implications of Unaffordable Private Health Insurance

Australians have access to excellent healthcare, due in large part to the complementary public and private health systems.

However, a combination of demographic trends, industry dynamics and regulatory issues is making private health insurance less affordable, creating a need for careful and balanced reform.

As private health insurance becomes increasingly unaffordable, the public health system will face greater strain and the Commonwealth will have to spend an ever greater proportion of its budget on health.

More importantly, an unaffordable private health insurance system will place added burdens on the public system, resulting in a lack of timely access to services and poorer health outcomes for Australians, as well as significantly higher outlays for the Commonwealth.

Unless reforms are taken to address cost pressures, government and private insurers will invariably need to continue increasing expenditure on health, which can only be funded in the public system via higher taxation or rationing and in the private system by increased premiums.

The impact of increasing premiums has been to drive downgrading to more exclusionary and lower cost products by consumers. This will inevitably result in greater pressure on the public health system.

Medibank is of the view that a series of clear and immediate reforms can be realised that will deliver unequivocal savings, produce better health outcomes for consumers, and make private health insurance more affordable.

Reforms to Improve the Value and Affordability of Private Health Insurance

The sustainability of private health insurance – and better health outcomes – depends on addressing cost drivers in the health system.

It is important to distinguish between changes that address structural cost problems and changes that lift the incentive for private health insurance in the short-term, but otherwise defer the structural problem.

A balanced mix of reforms that provide more immediate incentives for private health insurance, as well as those which address structural costs in the health system, will be optimal. Australia's health system, the Commonwealth Budget, consumers, and the private health insurance industry will all be stronger if such a balanced approach is taken.

Premium increases are necessary due to increases in input costs that health insurers have limited ability to control (e.g. provider fees and the cost of medical devices).

The sustainability of the health system – not just private health insurance – necessitates practical and meaningful policy reforms that address the inefficiencies and market failures (such as poor cost transparency) that not only add unnecessary cost, but result in poorer health outcomes.

We know our customers are hurting and a growing number of young people are falling out of health insurance, while older Australians with much higher propensity to seek healthcare are joining the private health insurance system.

The challenge is to get the balance right between meeting the rising costs of healthcare in Australia and ensuring private health insurance products remain affordable and meet the health needs of Australians.

Reduce Prostheses Prices

In the 2015-16 financial year, Medibank spent $540 million on prosthetic devices as part of the $5.1 billion we spent on our customers' healthcare.

While we welcome the Government's recent reductions to some prostheses prices, further reforms to prostheses pricing will result in greater savings to consumers.

As the Commonwealth Department of Health states:

> "If prostheses prices get lower, in the end, patients start paying lower private health insurance premiums."[44]

Prostheses pricing has long been a concern to Medibank as more than 138,000 of our customers receive an implantable prosthetic device each year.

The Prostheses Pricing List sets the minimum benefit amount that private health insurers must pay in respect of private patients in private hospitals and also for private patients in public hospitals if those public hospitals do not charge a lower amount.

The problem is that the prices that private health insurers must pay are inflated relative to the amounts that the public health system pays for the same devices for public patients.

Consequently, the current Prostheses List pricing is inflating prostheses costs, which results in higher than necessary premiums for consumers.

Medibank is aware of some prostheses devices costing up to seven times more on the Prostheses List compared to the price paid by public hospitals. This disparity is detrimental to consumers, private healthcare providers, and the Australian Government.

A recent Senate inquiry into the prostheses list found that:

> "...action is needed to reduce the prostheses costs and that savings should be delivered as soon as possible and have an evidence base."[45]

Medibank is committed to returning every dollar saved through prostheses reform to customers.

We estimated the Government's recent price reductions to prostheses would realise $24 million in savings to our customers and we have fully passed on these savings in advance of these savings emerging.

Our 2017 premium increase is 35 basis points lower than it otherwise would have been because of the Government's recent reductions to some prostheses prices. Prostheses reforms are, in other words, delivering material benefits to consumers by helping to keep downward pressure on private health insurance premiums.

Further regulatory reform of prostheses pricing is essential to keep private health insurance premiums affordable.

Moving the Prostheses List to a reference pricing system – using domestic and international benchmarks – will assist Medibank and other private health insurers to keep premiums affordable and provide better value private health insurance in an environment of rising health needs and costs.

More Informed Choice for Consumers Using Private Health Insurance in Public Hospitals

Medibank supports informed choice for consumers when they consider using their private health insurance in public hospitals.

Public hospitals often encourage patients with private health insurance to use their private health insurance when seeking treatment in the public system – page 23 of our submission discusses this point in further detail.

The problem is that public hospitals often fail to properly inform these patients that they have the right as Australian citizens to receive the exact same treatment at no cost through the public system.

The consequences are a lack of informed financial consent and informed choice by consumers, as well as cost shifting from the public system to the private system that contributes to higher overall health costs of private health insurance.

In effect, privately insured patients are paying twice (as patients who opt to use private health insurance in public hospitals will have paid for their private health insurance premiums and for public healthcare through taxation and the Medicare Levy).

We recommend that public hospitals be required to disclose to patients that they can receive treatment as public patients at no cost and that a decision to use private health insurance in public hospitals will affect neither the quality and type of care provided nor the health outcomes.

This is an important step to improving consumer health choices.

Even when patients use their private health insurance in public hospitals they are not guaranteed any additional options or services that may be associated with their private hospital insurance coverage, although they may receive procedures sooner.

For example, Medibank estimates that up to 57 per cent of all private admissions at public hospitals begin in the emergency department, but patients admitted in such a manner do not get to choose their doctor or access other benefits associated with private health insurance.

Patients should be informed of these consequences when they are given the option to use their private health insurance in public hospitals.

Reform the Second-Tier Default

The second-tier default is not functioning as intended.

The default was put in place to ensure smaller hospitals were not disadvantaged in contracting negotiations with private health insurers.

Medibank supports the original intent of the second-tier default.

However, as the market has changed over time, the second-tier default has unintentionally led to large hospital provider groups holding disproportionate market power over contract negotiations – which is resulting in higher costs and higher premiums for consumers.

In the absence of contracts with insurers, large private hospital groups are not only guaranteed the second-tier default rate, but can then charge the consumer any out-of-pocket co-payment they choose. Additionally, non-contracted hospitals are not subject to stricter contracted terms around quality or payment integrity.

Private healthcare is one of the few areas of the economy where, if two parties cannot reach a mutually acceptable commercial agreement, one party is compelled to fund services from the other party, even when meeting quality and performance standards that would be reasonability expected by a purchaser are not able to be implemented. This gives private hospitals asymmetrical power in their contract negotiations with private health insurers and could even mean being compelled to contract with low value providers.

The criteria required by a private hospital to nominate for second-tier status is relatively easy to obtain.

New operators who gain second-tier status soon after (or even before) commencing operations can quickly access near market contracted rates, thus lowering the natural barriers to entry for new start-up private hospitals and competition constraints normally applied in other markets and industries.

Second-tier arrangements result in an inefficient use of health insurance funds as they allow new or existing facilities to operate in regions which are already well-serviced.

Reducing (or eliminating) the second-tier default for certain provider segments would improve the affordability of private health insurance, while continuing to protect accessibility for regional Australia.

Alternatively, the regulation could cover out of contract scenarios where there was no contract in place, so that the out-of-pocket charge to the consumer would be capped at a maximum of the difference between the peer group average rate and the 85 per cent of the peer group average rate paid by the insurer under the second-tier regulation.

The latter option would provide a more beneficial solution for customers as it would enable the insurer to guarantee to pay any out-of-pocket charge to the customer in an out of contract scenario. Under the current regulation the insurer is unable to guarantee to pay the out-of-pocket charge levied by the hospital in an out of contract scenario as there is no cap to the out-of-pocket fee that the hospital could levy on the consumer.

Such reform will redress the imbalance, place downward pressure on costs, including encouraging system efficiency, enable insurers to drive better quality health outcomes for their customers, and will ultimately make private health insurance more affordable.

Improve Information Sharing for Consumers and Insurers

Requiring greater transparency in the price, performance and quality outcomes of healthcare providers will deliver better health outcomes for consumers.

Our customers want us to do more to help them understand the potential for out-of-pocket costs and they want improved transparency to help them navigate Australia's healthcare system.

There are currently no requirements for providers to make publicly available information that is of high relevance to consumers. For example, consumers are unable to know if a given surgeon has a high rate of re-admissions, with consideration given to the complexity of procedures – this is basic information that would greatly help inform consumers and lead to better health outcomes.

As the Productivity Commission states:

> "Good information is a prerequisite for an efficient and effective health care system. But transparency has fallen short of its potential in health because data do not exist or are not made available. Data on individual hospitals' costs are collected but not published, and there is almost no reporting on the performance of individual health professionals against cost or quality metrics...
>
> ...Transparency can be improved by all health ministers taking steps immediately to publish more information on the performance of individual health care facilities and clinicians, and to allow researchers greater access to government-held datasets."[46]

The Australian Competition and Consumer Commission has also stated that:

> "In the case of hospitals and health facilities... the sharing of information regarding medical treatment, patient management and other issues which relate to the health and wellbeing of patients can lead to improvements in the mode, quality or efficiency of medical treatment and care."[47]

Furthermore, providers are not compelled to obtain informed financial consent from consumers and there is little, if any, price transparency for consumers or referring doctors.

There is significant and powerful scope to improve not only the transparency of fees and out-of-pocket expenses, but also the health outcomes delivered by health providers.

Introducing reporting of quality metrics for all healthcare providers is, for example, an axiomatic reform that makes the health system more transparent, more accountable, and more likely to deliver higher quality outcomes for patients.

Greater transparency will significantly increase competitive pressures in the health system, resulting in more information for consumers, better informed choices by consumers and their GPs, downward pressure on prices, and better health outcomes.

Medibank has, for example, facilitated greater information transparency through our work with the Royal Australian College of Surgeons. Our collaboration has resulted in six surgical variation reports to date, with updated reports to follow in coming months, as noted below.

Collaborative Surgical Variation Reports by Medibank and the Royal Australian College of Surgeons	
2017	
General Surgery	
2016	
General Surgery Report	Urology
Ear, Nose and Throat	Vascular Surgery
Orthopaedic Procedures	

As the latest surgical variation report states:

> "These reports highlighted variation between surgeons in clinical and other indicators for a number of high volume procedures. In shining a light on this variation, the reports identified opportunities to provide guidance on best practice. One example was variation between surgeons in same day rates for hernia repair surgery. In response, RACS undertook a literature review on the evidence for same day hernia surgery, and have released a report which recommends a target for day hernia rates."[48]

Consumers would also benefit from greater transparency of the fees and financial incentives provided to third party aggregators who 'assess' or promote private health insurance policies online. For example, aggregators should be required to disclose commissions paid to private health insurers.

Additional discussion and policy reforms related to health data transparency is considered on pages 26 to 27 of our submission.

Structural Reforms to the Health System

The healthcare sector is a complex network of critical importance to Australia's well-being.

A less fragmented system to tackle chronic and complex diseases, for example, would result in better health outcomes.

The current fragmentation of funding lessens the incentive for any payer to invest more upstream with a view to diminishing avoidable utilisation in the hospital system.

The fee for service model rewards providers for activity and not for outcomes and does not incentivise providers to address many of the underlying causes of hospital utilisation. System fragmentation and the suboptimal funding model is particularly problematic for chronic and complex patients that require coordination of care, yet are confronted by a system that is largely unconnected.

Medibank believes that meaningful and targeted reforms can realise clear cost and quality benefits for consumers and be realised through immediate measures, as outlined above. But there is a need to consider longer-term and more systemic health reforms that address demand pressures and ensure funding for health measures are grounded on sound, empirically-based clinical evidence.

Take-Up Rates of Private Health Insurance and Government Incentives for Private Health Insurance

Around 55 per cent of all Australians – more than 13 million people – hold an insurance policy covering them for hospital and/or general treatment.

Nearly half of the Australians with private health insurance have disposable incomes under $50,000 per year.[49]

Private health insurance delivers tangible benefits for all Australians by taking pressure off the public system, providing greater consumer choice, and reducing costs for taxpayers.

With health costs rising, the population aging, and chronic disease becoming more prevalent, a strong private health insurance industry is essential to keep unnecessary pressure off the public health system.

Reforms to assist the affordability and value of private health insurance have been outlined, as has the importance of existing Government incentives for private health insurance.

Medibank supports the incentives and regulations in place to encourage private health insurance, including the rebate, the lifetime health cover loading, and the Medicare levy surcharge.

Adverse changes to these incentives and regulations will undermine the affordability of private health insurance, which will be detrimental to consumer choice, the public health system, and taxpayers.

Private Health Insurance Rebate

Medibank noted previously in this submission that adverse changes to the private health insurance rebate will be detrimental as consumers will simply shift from private health insurance to the public system (see pages 7 to 8).

The private health insurance rebate is critical to the affordability of private health insurance.

The Commonwealth Department of Health notes that a key community benefit of private health insurance is to reduce pressure on the public hospital system:

> "The Government has reduced the pressure on the public hospital system by supporting individuals to purchase private health insurance. Rebates make private health insurance more affordable and provide greater choice."[50]

Medibank knows that the biggest issue facing our customers is affordability – we know our customers are hurting with increasing pressure on the family budget.

What our customers are telling us is that detrimental change to the government health insurance rebate would hurt them. Around 90 per cent of Medibank's customers are claiming a private health insurance rebate to reduce their premiums – and the current rebate results in an average 26 per cent discount for these customers.

As the rebate is not being indexed in response to annual premium increases, in effect, each year the government is incrementally reducing the rebate. The implication is that customers eligible for the rebate are forced to pay more for private health insurance every year, even without any increase in annual premiums.

Without the rebate a typical family with teenage children with hospital and extras cover receiving the standard rebate of 26 per cent would pay around $1,500 a year more for their health insurance, which will inevitably lead to a significant decline in industry participation.

If the private health insurance rebate is removed, there will be an effective 35 per cent price increase for private health insurance for those on the standard rebate. But some people will pay more. For example a typical elderly couple with hospital and ancillary cover receiving the maximum rebate of nearly 35 per cent will see a $2,418 increase in their annual premium to $6,994 (a 53 per cent increase).

These increases will lead to people dropping out of private health insurance.

Such an outcome will then put greater pricing pressure on members retaining their cover and will likely lead to a higher than normal premium increase in the subsequent year, assuming that customers dropping their cover are younger and healthier than average.

The consequence will invariably be greater pressure on the public system.

Private Health Insurance Rebate and Ancillaries/Extras

Only around 325,000 of our 3.8 million customers would be unaffected by a decision to abolish the private health insurance rebate on ancillaries/extras.

For example a typical family with teenage children with hospital and ancillary cover receiving the standard rebate of 26 per cent will see a $1,508 increase in their annual premium to $5,813 (35 per cent), before any annual premium increase.

Abolishing or reducing the private health insurance rebate on ancillaries will undermine the affordability of private health insurance, which will be detrimental to consumer choice, the public health system, and taxpayers.

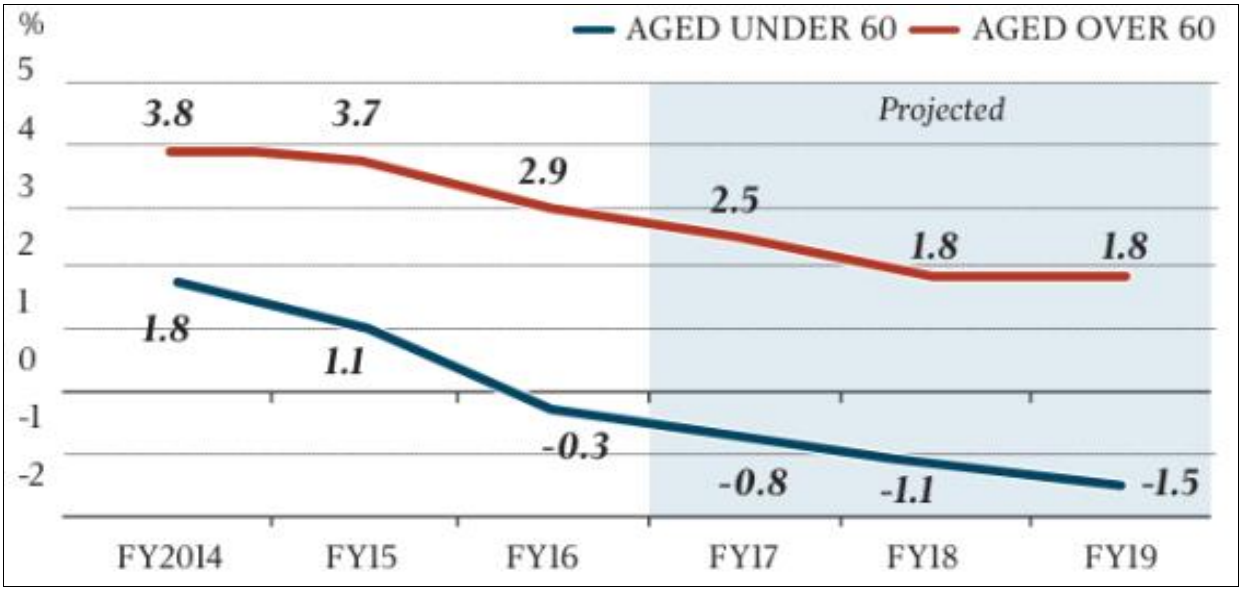
Lifetime Health Cover

Medibank supports the lifetime health cover loading.

The loading is important to encouraging both the take-up and retention of private health insurance hospital cover.

Encouraging younger people to take-up private health insurance is essential to placing downward pressure on premiums.

As indicated below, older people are forecast to take-up private health insurance while younger cohorts exit the industry.[51]



Younger people could be encouraged to take-up private health insurance through an incentive scheme that provided discounts for people aged 25 to 30 to join and maintain private health insurance hospital cover. Such a scheme has been proposed by Private Healthcare Australia and is supported by Medibank.

The industry is united in a view to increasing the attractiveness of private health insurance for young people. The *status quo* is unacceptable with participation dropping in the 25-35 year age group.

We are committed to working with the industry to improve attractiveness and value for these age groups. This is vital to sustaining community rating in the long-term.

Medicare Levy Surcharge

The Medicare Levy Surcharge creates an incentive for people to take-up and maintain private health insurance, although it is unlikely to be a sufficient incentive in isolation. As the Commonwealth Treasury and Department of Health note:

> "In 1997, there was very little impact on participation resulting from the introduction of the MLS [Medicare Levy Surcharge]. The decline in private health insurance participation continued until December 1998 when the lowest participation rate of recent years of 30.3% was observed. This suggests that by itself, the MLS is not a driver of participation and is a relatively minor reason for joining PHI."[52]

But in recent years the relative cost to consumers of the Medicare Levy Surcharge has declined as private health insurance premiums have increased, making it more attractive for some individuals and families to incur the Medicare Levy Surcharge than take-up private health insurance hospital cover.

While not Medibank's preferred approach to encouraging private health insurance hospital cover, an increase to the Medicare Levy Surcharge would provide greater incentive for high income earners to take-up private health insurance and thereafter the Medicare Levy Surcharge should be managed so the incentive to participate is ongoing.

In isolation, a one-off increase to the Medicare Levy Surcharge may not be sufficient to maintain private health insurance hospital cover membership in the long-term as:

- Continued growth of underlying cost and utilisation drivers in the health system will necessitate continued private health insurance premium rises that erode the relative consumer cost of any rise in the Medicare Levy Surcharge.
- An increase in the Medicare Levy Surcharge does not address the inefficiencies and opaque pricing in the health system that are eroding private health insurance affordability.
- The lack of effective competitive drivers in the health system (such as pricing transparency) means there is an incentive for market participants other than private health insurers to increase their costs by at least the same proportional amount of any increase in the Medicare Levy Surcharge.
- Revenue realised through the Medicare Levy Surcharge is not linked to funding of the private health insurance rebate and, as a consequence, any increase may have no impact on the affordability of private health insurance.
- Increased taxation is neither an incentive nor mechanism for economic sustainability in any industry.

Medibank notes that the Henry Tax Review found that "the Medicare levy surcharge is not ideal" and that "the name of the surcharge is also misleading as it is not related to the Medicare levy and does not reflect its link with private health insurance…As a result…tax arrangements for private health insurance, including the Medicare levy surcharge and the private health insurance tax offset, need to be assessed in light of an overall review of this sector."[53]

However, an increase to the Medicare Levy Surcharge will not deliver sustainable or sufficient incentive for private health insurance in the long-term and substantive reforms – such as greater transparency in the health system – are required.

Mental Health

Mental health is a significant health issue and one of economic and social consequence to Australia.

A recent study found that:

> "The total annual productivity loss attributed to the population with high prevalence mental disorders was estimated at AUD11.8b, coupled with the yearly income tax loss at AUD1.23b and welfare payments at AUD12.9b."[54]

This is an extraordinary financial cost and one that is accompanied by undoubtedly higher and harmful personal costs for the sufferers of mental health issues as well as their families, friends, and carers.

While successive Governments have increased support for mental health services, mental health issues are likely to remain a concern for the foreseeable future.

Medibank estimates, for example, that around 1.7 million young adults have one or more mental health conditions.

Private health insurers should have a role in supporting mental health services.

Medibank will continue to engage with the Government on developing services to support and treat mental health issues.

Operation of Relevant Legislative and Regulatory Instruments

Inefficiencies in the regulatory environment for private health insurance that cause increased costs are borne by policyholders through their premiums and also partially by the Commonwealth via the Australian Government Rebate on private health insurance.

The reforms outlined by Medibank will help improve the value and affordability of private health insurance, as well as promote greater efficiency, downward cost pressure, and improved outcomes in the broader public health system.

Three additional legislative and regulatory instruments could be reformed to deliver better health outcomes and without compromising existing legislative requirements, such as community rating.

Inability to Fund on the Basis of Health Benefit

With the requirement of community rating, private health insurers are currently restricted from discriminating on the basis of a person's condition – a restriction that Medibank supports and does not propose changing.

This restriction can, however, result in sub-optimal health outcomes for some patients.

Sub-optimal outcomes arise as there is an incentive on the part of health professionals to provide 'care' to patients that may be unnecessary, ineffective or even detrimental to their health.

For example, knee arthroscopy for arthritis in those over 55 years of age is deemed inappropriate under Australia's Choosing Wisely framework, yet Medibank continues to fund over 10,000 such procedures each year because it is required to do so under existing legislative requirements.

Similarly, hip or knee replacements in the early stages of arthritis often lead to poor outcomes for patients with increased pain and disability, yet Medibank is required to fund such procedures even when the health outcomes for the patients are spurious.

Better health outcomes could be realised if procedures of clearly low or no value to patients were restricted from private health insurance benefits or were at least capped in the total eligible benefits payable over a given period.

Such an approach would provide greater assurance to those who will benefit from surgery, but restrict funding for procedures whose outcome are highly unlikely to enhance health outcomes.

A robust way to address this issue would be for the MBS Review to tackle low value care, which will help address unnecessary care and costs in the health system.

Restricted Definition of 'Hospital'

There are some restrictions on the ability of private health insurers to fund health services outside of a hospital.

To the extent that a treatment attracts a Medicare rebate then a private health insurer cannot pay toward the cost of that treatment for someone outside hospital unless it forms part of an episode of hospital-substitute treatment and the service itself is listed in Groups T1-T11 of the MBS, is one of certain oral and maxillofacial items of the MBS, or is a related anaesthetic or diagnostic item.

Some practitioners subsequently recommend higher proportions of their patients have some procedures done as day patients of hospitals even though the hospital admission may not be clinically required.

Private health insurers thus pay for admissions that may not be necessary and which pose costs that unnecessarily add to the pressure on premiums.

There could be scope to broaden the ability of private health insurers to fund treatments for someone outside hospital and which currently attract a Medicare rebate.

Restrictions on Chronic Disease Management

With around half of all Australians suffering from chronic disease, Australia's health system necessitates a more robust and considered approach to chronic disease management.[55]

As the National Strategic Framework for Chronic Conditions states:

> "Focusing attention toward prevention activities, while continuing to ensure chronic conditions are well managed, will provide better health, social and economic outcomes for all Australians…Prevention is key to improving the health of all Australians, reducing health related expenditure and ensuring a sustainable health system."[56]

There is capacity to deliver better preventative programs and health strategies for individuals with chronic disease.

Medibank supports the broader health cover initiatives that were introduced into the regulatory regime for private health insurance with the *Private Health Insurance Act*.

But the regulatory provisions in relation to chronic disease management programs are not well articulated. There is a disincentive to insurers in this area that arises through a combination of those ambiguities and the significant penalties that can apply under the regulatory regime for private health insurance.

Further difficulties arise as an implication of the improper discrimination principles of the regulatory regime. A particular chronic disease management program may have been developed to treat persons in a particular age cohort and it may not be suitable for persons with specific additional co-morbidities (e.g. dementia). The insurer cannot deny access to such a program to persons of other ages or with those conditions.

We consider that the requirement to have at least one type of allied health service from the articulated list being provided as part of a chronic disease management program is too restrictive and that it should be open to an insurer to have services under such a program provided by whatever healthcare provider is considered most appropriate for the achievement of program goals, including social workers and nurses.

Income Tax Regulations

The operation of the Income Tax Assessment Regulations 1997 in combination with the Private Health Insurance Act makes the rules around Private Health Insurance Incentive Beneficiaries (PHIIBs) unworkable. The rules create:

- Unnecessary and impractical administrative overhead for funds;
- Unfair outcomes for Members under the age of 18; and
- Opportunities for individuals to manipulate the Australian Government rebate arrangements.

Section 22-5 of the *Private Health Insurance Act* states that each adult insured under a Complying Health Insurance Product (CHIP) throughout the premium period is a PHIIB, in respect of the premium or amount. The *Private Health Insurance Act* definition of 'adult' effectively requires the person to be 18 years or over. Anyone under the age of 18 is taken to be a 'dependent child' unless they have a partner. This definition does not align with Medibank's fund rules, which allow anyone aged 16 years or over to be a policyholder. Medibank's fund rules allow policies to be taken out by individuals from the age of 16 because there is a consumer need that we should do so.

Section 22-5 (3)-(4) of the Private Health Insurance Act sets out that if a policy only covers a dependent child (or children):

- The parents of that child (or children) will be a PHIIB; or
- If the parents are not married at the end of the financial year, the payer of the premiums will be the only PHIIB, as long as the payer is not a dependent child.

Subdivision 61-G of the tax regulations restricts eligibility for the private health insurance tax offset to people who are PHIIBs of that policy.

The effect is that where a membership has only members under the age of 18: a) those members will not be PHIIBS (and cannot claim the Australian Government rebate) unless they have a partner and b) the only other people who can be a PHIIB on the membership are their parents.

Where a person is under 18 and either does not have parents, is estranged from them or just doesn't wish to have them as the PHIIB, this effectively means they cannot claim the Australian Government rebate.

Section 61 of the tax regulations requires a private health insurer to provide to each PHIIB insured under the policy during a financial year a statement about the policy.

In cases where the oldest member is under 18 and does not have a partner, there will be no PHIIB insured under the policy. Even if there is a PHIIB listed, they will not be an insured person.

This means that insurers are not obliged to issue a tax statement for these memberships.

However, the Australian Tax Office's expectation is that insurers will issue a tax statement for every membership, including child-only memberships, and report on this to the Australian Tax Office at the end of the financial year. This creates administrative overhead and practical difficulty for insurers.

The existing regulations require change to ensure that financially independent 16 and 17 year olds can claim the Australian Government rebate.

A simple solution would be to allow the person who pays the premium to be the PHIIB, with a limitation to state that the person cannot be under 16 years of age. Alternatively, the policyholder could be the PHIIB by default, unless they are under 16. Where the policyholder is under 16, the person who pays the premium would be the PHIIB.

Such a change would remove the ambiguity and difficulty for insurers in recording PHIIBs against memberships.

The necessity of two different regulatory instruments articulating a requirement to provide annual tax statement notifications is also duplicative.

The Interaction Between Public and Private Hospital Systems and the Effect of Co-Payments and Medical Gaps on Financial and Health Outcomes

Patients are increasingly encouraged to use their private health insurance when they attend a public hospital.

In effect, privately insured patients are paying twice (as patients who opt to use private health insurance in public hospitals will have paid for their private health insurance premiums and for public healthcare through taxation and the Medicare Levy). This practice is adding about $1 billion to the cost of private health insurance premiums.

The Australian Institute of Health and Welfare found that:

> "Between 2011–12 and 2015–16, the number of separations in public hospitals for private health insurance patients increased by an average of 10.5% each year and the number of separations for self-funded patients decreased by an average of 10.7% each year."[57]

Rather than focus on process improvements and delivering better health outcomes, some State Governments are increasingly encouraging their public hospitals to pressure patients who present to a public hospital emergency department to use their private health insurance rather than the Medicare system.

A report by Ernst and Young for the Independent Hospital Pricing Authority found that there is:

> "...evidence of private patient targets in selected jurisdictions and a focus on promoting the benefits of private patient election to patients in public hospitals suggests that State and Territory health funding policy parameters are contributing to the recent trend of increased privately funded public hospital separations."[58]

States actively encourage patients to use their private health insurance, creating public service roles specifically intended for this purpose. For example, NSW Health advertises for a Private Patient Services Officer in Camperdown who will have:

> "...a pivotal role in encouraging the use of private health insurance by providing accurate and timely information about using private health insurance in a public hospital."[59]

States also present private health insurance as a way to support public hospitals, with Royal Prince Alfred Hospital in New South Wales indicating to patients that:

> "Patients who use their health insurance directly help Royal Prince Alfred hospital."[60]

Royal Perth Hospital indicates to patients that:

> "By using your private health insurance, the money received assists our hospital to buy additional, new and replacement equipment, maintain facilities, undertake more elective surgery to help reduce patient waiting time and continue to provide a better service."[61]

Royal Adelaide Hospitals indicates to patients that:

> "The income we receive from your health fund helps to improve hospital facilities update equipment and provide staff education and training."[62]

And Queensland Health indicates to patients that:

> "The Lady Cilento Children's Hospital is grateful to families who help support our hospital and health services by using their private health insurance. When families choose to use their private health insurance, the hospital receives additional funding from health insurance providers and Medicare."[63]

States are evidently encouraging private health insurance use in public hospitals with the intent of generating revenue, an intention acknowledged by the New South Wales Government, with that State Government introducing a trial program specifically intended to raise $11 million in additional revenue for the State across just three local health districts.[64]

The South Australian 2017-18 State Budget includes specific targets for private health insurance use in the State's public hospitals, with the targets evidently contributing to revenue projections.[65]

The problem is that this practice contributes to premium rises for private health insurance.

Medibank supports informed choice for consumers when they consider using their private health insurance in public hospitals.

But as noted in our proposed reforms to enhance the value and affordability of private health insurance, public hospitals should be required to disclose to patients that they can receive treatment as public patients at no cost and that a decision to use private health insurance in public hospitals will affect neither the quality and type of care provided nor the health outcomes.

This is an important step to improving consumer health choices.

There are also important data transparency reforms that could be implemented to improve health outcomes, as detailed on pages 22 and 23 of our submission.

At the very least:

- Private patients should not face any out-of-pockets when admitted to public hospitals. At present they often face pathology and radiology charges, particularly when those services are provided by subcontractors to the public hospital. Persons involved in the provision of the patient's treatment seem not always to take responsibility for ensuring that patients are alerted in advance to the possibility of such charges and that the patient's informed financial consent to such charges being incurred is obtained.
- If patients use their private health insurance at public hospitals, they should be given a choice of surgeon and additional accommodation related benefits in accordance with their private health insurance terms and conditions.

Private Health Insurance Product Design

Medibank is committed to delivering products that provide value to our customers.

Our products are designed to:

- Provide choice
- Deliver a range of cover depending on the likely benefits needed by customers
- Improve affordability
- Maximise value for customers
- Ensure certainty and long-term sustainability

Our products are based on transparency so that customers know what they are getting and are encouraged to make the most of the product they purchase.

Medibank delivers value for our customers through unique product offerings, including:

- Unlimited Emergency Ambulance
- Accident Override feature
- 24/7 health advice line access
- Health concierge services for the most vulnerable customers
- The most comprehensive range of products and services for families having children
- 100 per cent back on an annual dental check-up at Members Choice provider
- 100 per cent back on optical on our marketable products

Medibank also provides plain English membership guides and product cover summaries, which convey our terms and conditions in simple, straightforward language to our customers.

Our private health insurance products are, in other words, designed to deliver value and to do so in a transparent way for our customers.

Gold/Silver/Bronze

The Government has proposed implementing a classification system for private health insurance products, with tiers labelled gold, silver and bronze.

Enhancing the transparency and comparability of private health insurance products is welcome, but any classification system must avoid unnecessary additions to premiums and not restrict product innovation.

Forcing the inclusion of some benefits into all classification tiers could, for example, result in substantial premium increases, which will detract from private health insurance and perversely cause product downgrading.

Flexibility to innovate within tiers is also essential in order to ensure price and value competition is maintained within the private health insurance industry.

Applying a classification system to extras would undermine competition as it would restrict innovation and differentiation.

Current products and policy-holders must be grandfathered and exempt from any new classification system.

Customers and private health insurance providers will also need time to implement a new classification system and to ensure both are appropriately informed.

Transparency in Healthcare – Using and Sharing Membership and Related Health Data

Data and information are fundamental to improving competition, promoting more informed consumer choice, encouraging innovation, and delivering better health outcomes.

As the Productivity Commission recently stated:

> "Improved access to healthcare data could enable more effective and timely healthcare services for Australians, including the development of new products and services, earlier identification of population health issues, and more rigorous and better targeted health research."[66]

The benefits of greater information transparency, particularly around costs and quality of outcomes, are widely known.

As noted in our proposed reforms to enhance the value and affordability of private health insurance, there are currently no requirements for providers to make publicly available information that is of high relevance to consumers. For example, consumers are unable to know if a provider has a high rate of re-admissions – this is basic information that would greatly help inform consumers and lead to better health outcomes.

More can and should be done to improve data availability for private health insurers and customers, which will promote better health outcomes:

- There should be a requirement for health service providers to make publicly available information that is of high relevance to consumers, particularly information on re-admission rates for specialists and longitudinal health outcome data, with appropriate confidentiality protections.
- A mandatory requirement should be introduced for health service providers to not only publicly disclose fees and out-of-pocket expenses, but to require informed patient consent to these costs in non-emergency situations *prior* to any health services being agreed to and undertaken.
- Consumers should have access to information that provides easily comparable fees and out-of-pocket expenses of providers through a publicly available website managed by the Commonwealth or an appropriate research body.
- Some Medicare statistics should be made publicly available to facilitate more informed choice by consumers and better health outcomes. Data should be publicly available demonstrating volumes and charges for item numbers by specialist, which could be achieved by allowing the identification of specific practitioners and specialists in the publicly available publication of existing and new MBS and hospital casemix protocol data. Aggregated data should also be made publicly available for both inpatient and outpatient health services, even if only at broad geographic levels (e.g. Western Victoria).
- Public hospitals are not currently required to provide hospital casemix protocol data to private health insurers, which leads to a bizarre situation in which private health insurers have no visibility of the procedures their own customers undergo when they choose to use private health insurance in public hospitals. The outcome is that private health insurers simply see requests for payments from public hospitals, which creates an incentive for excess care by public hospitals. It is not infrequent for private health insurers to be billed for procedures already undertaken by the public hospital that are not even covered by a given patient's private health insurance product - public hospitals do not commonly undertake an eligibility check of the extent of patients' private health insurance coverage.
- Periodic, detailed, and publicly available audits should be conducted of MBS data to identify instances of overcharging and higher-than-peer volume and charging for MBS specific items by service providers. Medibank is, for example, aware of some surgeons who bill up to 15 MBS items for a single procedure.
- The introduction of quality metrics for health service providers, with reporting against these metrics made publicly available and readily comparable.
- Private hospitals are not required to take part in cost studies conducted by the Independent Hospital Pricing Authority. When they decide to take part, private hospitals often negotiate exceptions that reduce transparency, such as aggregating various procedures or having a single price for procedures regardless of care setting. A legislative requirement for private hospitals to take part in costing studies would improve cost transparency for the health system.

Greater transparency will significantly increase competitive pressures in the health system, resulting in more information for consumers, better informed choices by consumers, downward pressure on prices, and better health outcomes.

Medibank also notes that greater information sharing will benefit approaches to managing chronic disease.

The linking of primary, secondary, and acute care data (such as Medicare and information held by pharmacies and private health insurance) would enable a more precise and meaningful understanding of the incidence and impact of chronic disease. Such understanding would allow a more targeted and effective response to particular chronic diseases, which in turn will result in better health outcomes and less pressure on the health system.

The provision of insurer access to this data (upon receipt of patient consent) would benefit members by enabling enhanced coordination between all funders of care. Currently, Medibank has hospital admission and benefit outlay data only, which limits our ability to provide appropriate, comprehensive support to members.

Medical Service Delivery in Homes

Private health insurers are restricted from funding preventative health interventions or home based interventions that would keep patients out of hospital.

This restriction is unnecessary and arguably leading to sub-optimal health outcomes for patients.

More broadly, the restriction on private health insurers funding the delivery of medical services in homes is contributing to unnecessary and costly care.

The Case of Rehabilitation

Rehabilitation is the second largest cost for Medibank (after hip/knee replacements), the leading driver of hospital days, and the largest cost growth area.

Looked at another way: rehabilitation is a significant cause of pressure on the health system and pushes up the cost of health insurance premiums.

Some rehabilitation is highly valuable and necessary for patient care and effective health outcomes and some is not.

Knee replacements are a major driver of referrals to rehabilitation. In 2016, 45 per cent of all Medibank patients receiving a knee replacement were referred to receive rehabilitation in a hospital setting and this group spent on average 11 days in hospital at a cost of $8,300 per person.

The problem is not the cost *per se*, but the high rates of variation and utilisation, which implies consequential waste and unnecessary care in the health system.

In 2015-16, the average referral rate ranged from one to 95 per cent by hospital. The mean rehabilitation referral rate for Medibank (45 per cent) is dramatically higher than the equivalent rate in the Australian public setting (5 per cent) and international benchmarks (e.g. Canada 10 per cent, United States 4-11 per cent). Rehabilitation referrals have decreased dramatically in the USA since 2003, but continue to increase in Australia.

There is significant variation in inpatient rehabilitation rates across States, with New South Wales and Victoria having twice the rates of inpatient rehabilitation compared to Queensland and nearly four times the rates in Western Australia – and 43 per cent of private patients are referred to inpatient rehabilitation following knee replacement in private hospitals compared to only five per cent in public hospitals.[67]

The statistics indicate some hospitals are encouraging unnecessary rehabilitation treatment and are doing so, most likely, as a means to generate revenue rather than deliver effective patient health outcomes.

Medibank recently conducted a study with KPMG to assess rehabilitation rates. The study adjusted for case-mix and thus controlled for whether a patient is more unwell or older than other patients.

The study found that:

- Between 2009 and 2016, inpatient rehabilitation rates for Medibank members after total knee replacements increased from 31 per cent to 45 per cent, even though there was no change to patient profiles during this time.
- After adjusting for patient case-mix, large variation in referral rates persists. The odds of referral to inpatient rehabilitation are 50 times higher at the highest referring hospitals relative to the lowest referring hospital (after adjustment for patient factors).
- Provider factors (e.g. state, hospital group, and surgeon) are more than twice as important as patient factors (e.g. demography, clinical and surgery attributes) in determining whether a patient will be referred to rehabilitation.
- The strongest determinant of rehabilitation referral is the acute hospital where the surgery was performed.
- Analysis of two "clusters of state / hospital groups" with around 80 per cent referral rates found that all surgeons operating within the cluster had consistently high referral rates. However, when the same group of surgeons operated in hospitals outside this cluster, their referral rates were more variable, including some very low referral rates. This analysis highlights that surgeon behaviour changes depending on the hospital.

There are two significant conclusions from our study.

First, some rehabilitation decisions in the private sector are currently not being made based on the clinical needs of the patient (decisions are likely to be driven by revenue-maximisation).

Second, rehabilitation is an area where significant waste exists in the private healthcare system that is contributing to increasing healthcare costs and consequent premium increases for Australians holding private health insurance.

Role and Function of Medical Pricing Schedules

Australia's medical pricing schedules generally function well. Nevertheless, there are limitations to the Medicare Benefits Schedule (MBS) and the Diagnostic Related Group (DRG) systems that could be addressed.

MBS Limitations

Private health insurance products are built on the MBS, which is designed to reimburse the patient for the medical costs of a consultation or procedure.

The problem is that in some instances an effective and appropriate consultation or procedure may be optimal for a given healthcare situation, but the consultation or procedure is not included in the MBS.

The consequence is that sub-optimal services are used as there is little incentive for health practitioners to utilise consultations and procedures that are not incorporated in the MBS.

The MBS review should ensure updated consultations and procedures are included in the MBS.

Further, and as noted in our proposed reforms to enhance the value and affordability of private health insurance, periodic, detailed, and publicly available audits should be conducted of MBS data to identify instances of overcharging and higher-than-peer volume and charging for MBS specific items by service providers. Medibank is, for example, aware of some surgeons who bill up to 15 MBS items for a single procedure.

DRG Limitations

Many hospitals are paid on the basis of the DRGs.

Where private health insurers have contracts in place with hospitals, these are most commonly designed to provide funding on an episodic and not *per diem* basis and the episodic payment model is usually based on one of the versions of the Australian-Refined Diagnosis-Related Groups classification.

The problem is that DRGs are determined after the patient is discharged from hospital. With many medical conditions, the nature of the illness is often not apparent until after investigations have been completed. It can be challenging to determine cover prior to admission. In addition, it incentivises hospitals to discharge early but provides no incentive for supporting post-discharge care which, if required, falls to the member or the insurer.

DRGs are based on resource consumption – accommodation, consumables, theatre time, and staffing costs.

The whole purpose of the DRG is to essentially align resources with the delivery of the best available health outcomes. As the body responsible for managing the DRGs states:

> "The AR-DRGs are used by public and private hospitals, and state and territory health authorities to provide better management, measurement and payment of high quality and efficient health care services."[68]

Although the pricing components are updated regularly, private hospitals have shown great reluctance to move to current versions, unless it is on a revenue neutral basis. This reluctance arises because updated DRGs incorporate more efficient and less costly practices, which has a negative impact on hospital revenue despite the cost of performing these procedures being less over time.

Older versions of DRGs do not always reflect the cost of new technology or current best practice.

Reliance on dated DRGs is due, in part, to reluctance by the health sector, including private health insurers and private hospitals, to move to updated versions, whilst recognising improvements in efficiencies that can translate into lower costs.

Public hospitals currently use AR-DRG version 8 and version 9 is in development.

In addition, a range of procedures (such as knee replacement) can be delivered with very short lengths of stay, which are not envisaged in the current DRG funding models.

Health outcomes and costs will be improved if:

- Private health providers, including private health insurers, are required to adopt the latest version of the DRG within 12 months or where there are existing contractual arrangements within 12 months of those contracting arrangements concluding.
- Private health providers, including private health insurers, are required to transition to any updated versions of the DRG within 18 months of updated versions being approved and published, but excluding existing contracting arrangements.

Role and Function of the Australian Prudential Regulation Authority, the Department of Health, and the Private Health Insurance Ombudsman

The Australian Prudential Regulation Authority (APRA)

The APRA ensures prudential supervision of private health insurers and is thus important to the sustainability of, and confidence in, private health insurance.

Medibank supports clear, principle based regulation that helps support the health of the industry and protects our customers.

Given there are more than 30 private health insurers and there is no record of prudential shortcomings or financial malfeasance, the case for any additional regulatory prescriptions is unwarranted.

A significant prudential risk for private health insurance is sudden or adverse reforms initiated at a political level without appropriate consultation and advice from the APRA. It is important that the APRA is not only capable of, but given the opportunity to, provide independent prudential advice on any potential regulatory changes and legislative changes affecting private health insurance.

The Department of Health

Given continued increases in health costs and projected growth in chronic diseases, the Department of Health should continue to develop a comprehensive strategy to promote a sustainable health industry, including a competitive private health insurance sector.

The Department of Health could, for example, take a lead role to:

- Allow for more targeted and effective management of chronic disease by facilitating greater integration of care between public and private systems.
- Ensure appropriate use of the MBS through more rigorous and periodic audits. Medibank is, for example, aware of some surgeons who bill up to 15 MBS items for a single procedure. While Medicare specifically precludes the surgeon from filing a consultation after a procedure, Medicare continues to pay these items – around 44 per cent of laparoscopic gall bladder procedures are associated with a surgeon claim for a consultation *after* the procedure. There is a case for more rigorous audits of the MBS system.
- Facilitate greater information transparency in the health system, particularly around quality outcomes, fees, service utilisation, and out-of-pocket expenses.
- Ensure global best practice is being adopted in healthcare and, where necessary, ensure appropriate benchmarking of costs (e.g. prostheses).
- Seek advice from the private sector, where appropriate, to ensure effective roll-out of publicly funded healthcare (e.g. Healthcare Homes).
- Address private-public cost shifting, which results in unnecessary and duplicative costs to consumers.
- Facilitate national approaches to address key health challenges (e.g. chronic disease, technology development, and healthcare for vulnerable people).

The Private Health Insurance Ombudsman

Medibank supports the role of the Private Health Insurance Ombudsman and welcomes its independent and transparent approach to consumer issues.

An enhancement would be the Ombudsman releasing quarterly reports on pre-determined dates identified in advance to the public and market.

Conclusion

The private health insurance system delivers tangible benefits for all Australians by taking pressure off the public system, providing greater consumer choice, and reducing costs for taxpayers.

Medibank is committed to improving the value of health insurance for Australians and to strengthening our health system.

Maintaining effective incentives and regulations to encourage private health insurance – including the rebate, the lifetime health cover loading, and the Medicare levy surcharge – is essential to a strong health system.

Adverse changes to these incentives will undermine the affordability of private health insurance, which will be detrimental to consumer choice, the public health system, and taxpayers.

The sustainability of the health system – not just private health insurance – necessitates practical and meaningful policy reforms that address the inefficiencies and market failures that not only add unnecessary cost, but result in poorer health outcomes.

Medibank's submission has outlined a raft of reforms to boost the value and affordability of private health insurance in both the short and long term.

Australia's health system, our public hospitals, and our health outcomes are stronger because of private health insurance.

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