

Private Healthcare Australia
Better Cover. Better Access. Better Care.



Submission: Senate Community Affairs References Committee
*Inquiry into the Value and Affordability of Private Health Insurance
and Out-of-Pocket Medical Costs*

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Contact:

Dr Rachel David
Chief Executive Officer
02 6202 1000

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INTRODUCTION

Private Healthcare Australia (PHA), the peak body representing Australia's major health funds, welcomes the opportunity to submit to this Senate Inquiry into the value and affordability of private health insurance (PHI) and medical out-of-pocket costs. This is a subject of great concern to all Australians, with and without private health insurance.

Preparing this submission has given me cause to reflect on why I choose to have private health insurance, and why I act as an advocate for private health.

Like many households around Australia, in my home we spend time working out how to cover the cost of rising health fund premiums among many other bills. I thought to illustrate the issues PHA will address in this submission, it would be informative to begin with a personal story.

A few years back, when I was 29 weeks' pregnant with the second of three children, I took a family holiday interstate. While celebrating with friends on Christmas Eve, I experienced what doctors call an 'antepartum haemorrhage'. This means bleeding before the baby is ready to be born, which is often a sign something is seriously wrong.

I immediately went to the nearest emergency department, which was understaffed as a result of the holiday season. Minutes went by, and then hours. No-one had checked my blood pressure, checked the baby's heartbeat or put in an IV line. I trained as a doctor and knew this was not right. It wasn't the staff's fault, they were junior and clearly overwhelmed.

I called around and found a private obstetrician who lived locally. Within 20 minutes he was at my side and had taken full responsibility for my care. I was immediately admitted to hospital, with an IV, and my condition fully investigated. I was able to speak to him 24/7 about what was going on.

Furthermore, the staff in the public hospital were freed up to treat people who could not afford private specialist care, and did not have the additional burden of another emergency.

My story has a happy ending. My daughter is now a healthy 12 year old. I wasn't charged a gap, but I would have paid anything to get this outcome and I'm forever grateful I live in Australia and had the options I did.

Over the last 18 months PHA has surveyed 16 000 randomly selected consumers with and without PHI about their attitudes to our health system, including private health.

Most people with PHI value the product and want to keep it. Why? The ability to know exactly when you can be admitted for surgery and other essential medical treatments is a key feature of and value proposition of private health. These days, few people can afford the uncertainty of needing to wait an unknown length of time to get a painful or disabling condition treated. Whether it's a sporting injury that stops you driving your car, failing vision stopping you safely caring for grandchildren, or a child with an eating disorder who is missing school - these are things that can't wait without causing real social and economic consequences.

The second reason people value PHI comes back to my own story. When the unexpected happens, you get a specialist who takes responsibility for your care, and can advocate on your behalf in what can be a complex and bewildering system.

Our research has also identified a system under stress. Consumers are feeling real pain from rising health costs, including premium increases and gaps for medical and allied health. This is a problem for public and private health, as 'health inflation' has galloped well ahead of CPI and household incomes over the last 15 years.

Health funds take the responsibility of keeping premiums affordable very seriously. We have challenged the Federal Government to address a number of concerns about regulations keeping health fund premiums artificially high. We are working together with the Government and other private health stakeholders, like doctors and hospitals, on solutions to drive premiums down. It has been encouraging to see the Government moving to address one of the worst areas of concern, the obscene mark-ups health fund members are paying for medical devices in Australia compared to the rest of the world. Health funds have already passed on the savings to members.

Health funds are also investing in ways to help consumers with out-of-pocket costs. One way we do this is to contract with medical specialists and dentists to cover the gap, and provide 'no-gap' or 'known gap' services. This can't be open-ended however, or premiums would go up significantly for everyone. Most doctors and dentists try and do the right thing, but every day stories emerge about people who have not been told about very large gap payments in advance, leaving them with an impossible choice when they are at their most vulnerable. This is unacceptable, and devalues private health cover.

Many funds have invested in online tools to help patients and GPs navigate referrals to medical specialists and dentists based on expertise and what they are likely to charge. Health fund members can use this information to talk to their GP about likely fees and charges prior to referral.

Some medical and dental groups have expressed concern about robust contracting arrangements and increased transparency of out-of-pocket costs. Failure to deliver these is not an option for private health, as increasingly, consumers demand greater levels of transparency, expect 'no surprises' on costs, and will vote with their feet to obtain them.

In an ideal world, providers would work in collaboration with health funds to deliver financial certainty to private patients, and many do. All Australians benefit when the private health sector works well, so improving the affordability and value of private health should be a priority for all participants, including Australian governments, health professionals, hospitals and health funds alike.

Health funds are collaborating with the Federal Government to bend the cost curve down to reduce waste and address a perceived lack of competition and transparency in our sector. As an industry, we are also investing heavily on ways to help consumers best choose and use their health insurance, and minimise out-of-pocket costs.

Dr Rachel David
CEO, Private Healthcare Australia

OVERVIEW

Private health insurance (PHI) is a mainstay of Australia's hybrid public-private health care system, interconnected through the use of Medicare Benefits Schedule reimbursements for private doctors' fees. PHI pays for close to two thirds of non-emergency surgery in Australia, 90% of day admissions for mental health care and 50% of all mental health admissions, 70% of joint replacements, 60% of chemotherapy and 88% of retinal procedures take place in the private health sector. In addition, under ancillary cover, health funds pay out more than \$2.59 billion for dental care, more than the Federal Government. 90% of dental health services provided to low and middle income earners are subsidised by health funds.

Health is consistently a top-order issue for the Australian public and community support for private health insurance is longstanding. People want improved affordability, quality and access to healthcare services. With changing life expectancy, demographics and rising health inflation, there is concern around the issue of health system sustainability. Market research has repeatedly shown premium affordability is the main reason deterring people from PHI and premium increases the main driver behind dropouts and downgrades.

Premium increases above CPI are hurting consumers in a low wage growth environment. In 5-6 years, price sensitivity modelling shows that premiums will potentially become unaffordable for at least one-fifth of people with PHI. The value of what was originally the 30% rebate is dropping annually, putting additional pressure on members. Despite this, market research (Ipsos) also shows that over 80% of members are satisfied with their health insurance and want to keep it.

More than 13.5 million Australians hold PHI and over half of those have disposable incomes under \$50,000 per annum. Many of these are full pensioners and superannuants who are making considerable sacrifices to maintain their health insurance. 84% of people believe that they get value for money from their private health insurance and cite peace of mind, choice of specialist for continuity of care, choice of hospital, and timing of medical treatment as the main reasons.

The PHI industry acknowledges that there is a need for greater transparency, particularly regarding medical out-of-pocket costs and health fund product exclusions and restrictions. We are working with government and stakeholders through the established PHI Review process to address this and make it easier for consumers to choose and best use their PHI.

PHI – Profit and not for profit funds

PHA member funds operate using a variety of business models including not-for profit, private for-profit, publicly listed for-profit and combinations of the above. Regardless of the business model, health funds must be run successfully, manage risk appropriately, and abide by regulatory guidance on prudential standards.

Health funds paid a record \$19.2 billion in benefits in 2015-16 on behalf of their members, including:

- \$14 billion in hospital treatment – up 4.7% on the previous year (an increase of \$630.7 million from 2014-15). This included
 - \$2.17 billion in payments for medical specialists – up 3.0% on the previous year (an increase of \$63.5 million from 2014-15);
 - \$2 billion in payments for prostheses – up 5.4% on the previous year (an increase of \$101.5 million from 2014-15); and
 - \$4.73 billion in ancillary treatment – up 3.9% on the previous year (an increase of \$176.1 million from 2014-15).

Private health funds are forecast to inject an additional \$1.15 billion into Australia's health care system in 2016-17, bringing total annual expenditure on healthcare services and treatments to nearly \$20 billion in a single financial year.

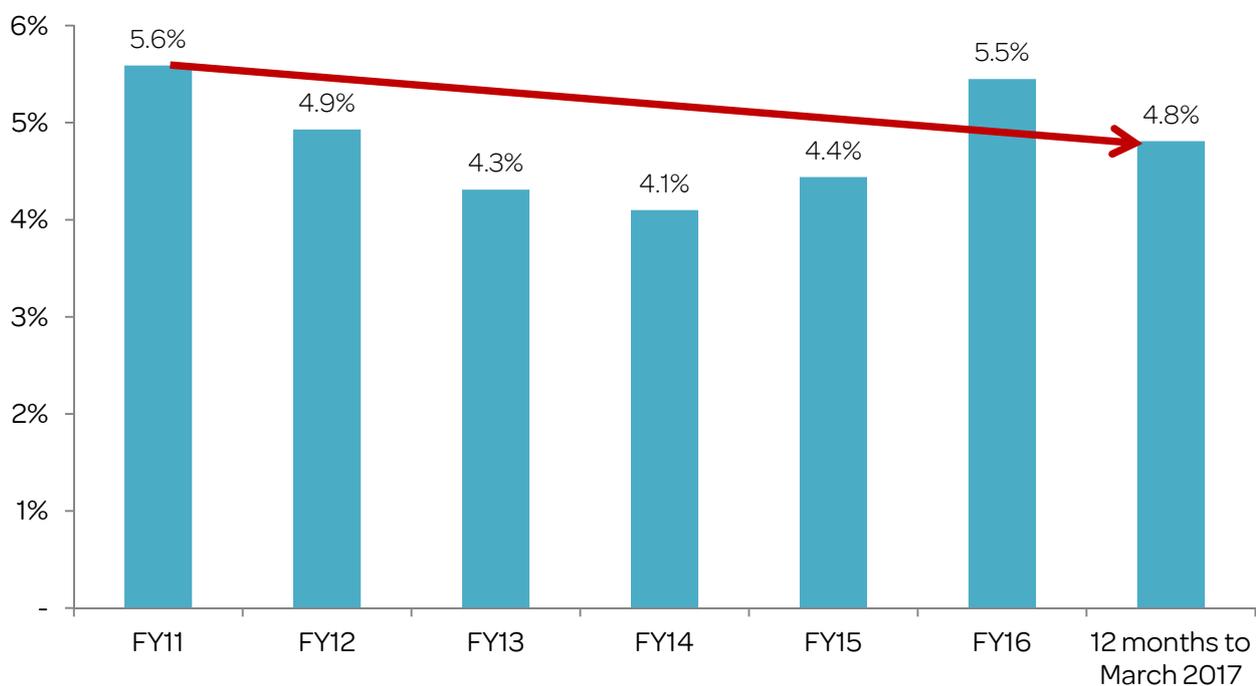
If the business model is fundamentally sound, well-run not-for-profit and for profit funds will make a margin and deliver value to both members and shareholders.

Funds are required to keep surplus revenue for regulatory reasons to ensure they have the ability to pay out on claims in all circumstances. The business model of not-for-profit funds reflects services and non-liquid assets in addition to the provision of PHI, in their capital position. Further, a not-for-profit fund may require additional reserves, as they can't easily raise money by going to equity markets or other sources.

The key metrics to determine the performance of health funds are the EBIT margin, the claims ratio and the management expense ratio.

Private health industry EBIT margins have remained stable throughout this decade at between 5% and 6%. Compared with the rest of the private health 'supply chain' which includes private hospitals and medical specialist practices, these figures are relatively low. The industry is experiencing a downward trend in net margin. APRA has recently published a 12 months trend to March 2017 with industry net margin at 4.8%. It is expected that this figure will be lower when the year ending June 2017 figure is announced by APRA in mid-August.

Private Health Insurance Industry Net Margin

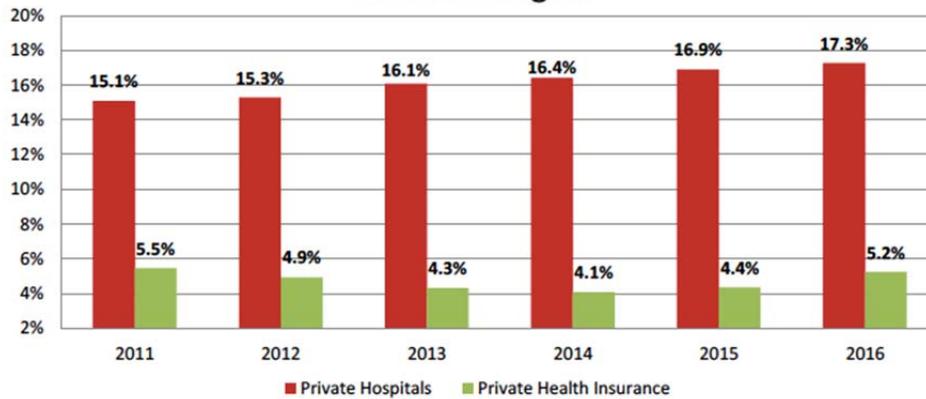


Note: The margins illustrated above are "net margins" (as calculated by APRA) which only include "core" revenues and expenses

Source: APRA

The charts below illustrate how health fund margins compare both to margins from other insurer types and to providers in the private health 'supply chain' i.e., medical specialist practices and private hospitals.

Private Hospitals vs Private Health Insurance EBITDA Margins



Note: The margins illustrated above for Private Hospitals use the average of Healthscope's Hospitals Australia margin and Ramsay's Asia Pacific margin (which consists predominantly of Australia). PHI Industry EBITDA is assumed to be the same as EBIT given the small level of depreciation that is incurred by insurers
Source: Healthscope Annual Reports, Ramsay Annual Reports, APRA Quarterly Statistics

NET PROFIT MARGINS ACROSS HEALTHCARE AND INSURANCE SECTORS IN AUSTRALIA

	Private Health Insurance Industry	Private Acute and psychiatric hospitals	Private Day hospital facilities	ALL Private Hospitals	General Insurance Industry
2006-07	5.64%	7.07%	15.75%	7.60%	23.6%
2007-08	4.28%	not published	not published	not published	13.3%
2008-09	3.20%	8.64%	19.59%	9.40%	10.8%
2009-10	4.54%	7.62%	20.64%	8.62%	18.4%
2010-11	5.59%	9.04%	18.57%	9.76%	15.0%
2011-12	4.93%	9.79%	19.60%	10.55%	13.4%
2012-13	4.31%	9.18%	18.67%	9.94%	17.6%
2013-14	4.10%	10.26%	17.74%	10.84%	15.9%
2014-15	4.44%	10.14%	21.40%	11.05%	8.2%
2015-16	5.45%	9.83%	22.88%	10.90%	9.5%

Source: APRA, ABS

The ABS Private Health Establishments Collection was not conducted for the 2007-08 reference period due to ABS budgetary constraints. This represented a break in the time series for the collection.

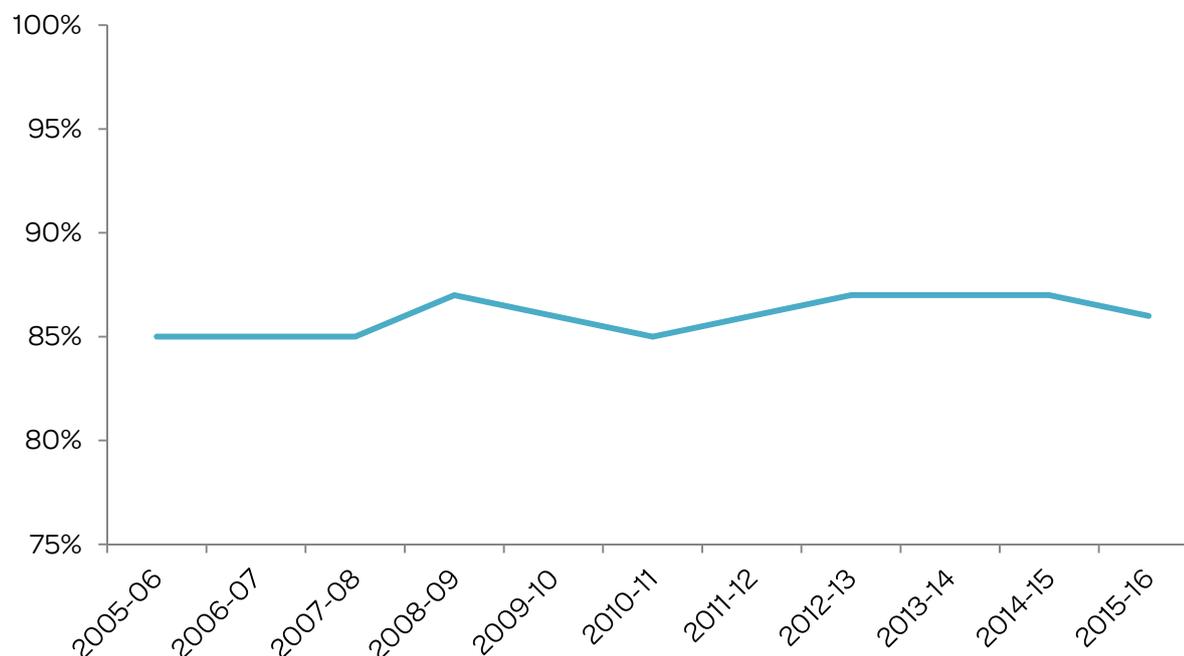
NET PROFIT MARGINS ACROSS HEALTHCARE SERVICES IN AUSTRALIA

Healthcare Services	Net Profit Margins	Operating Profit Before Tax
Optometry and Optical Dispensing Businesses	12.80%	\$313.4 million
Pathology and Diagnostic Imaging Businesses	14.40%	\$797 million
Physiotherapy Businesses	19.80%	\$224.3 million
Other Allied Health Businesses	19.80%	\$518.9 million
Chiropractic and Osteopathic Businesses	19.90%	\$149.1 million
Dental Businesses	24.70%	\$1.6 billion
Private General Practices	27.50%	\$1.8 billion
General Practice Medical Businesses	33.90%	\$4.5 billion
Specialist Medical Businesses	37.30%	\$2.4 billion

Source: ABS 8570.0 - Health Care Services, 2009-10 (Latest Issue released on 7/5/2011)

The claims (benefit loss) ratio is a measure of the percentage of member funds paid out as claims. It has remained consistently high and is currently at 86.1%. For property insurance this is much lower at 67%, and also for general insurance at 66% for 2016.

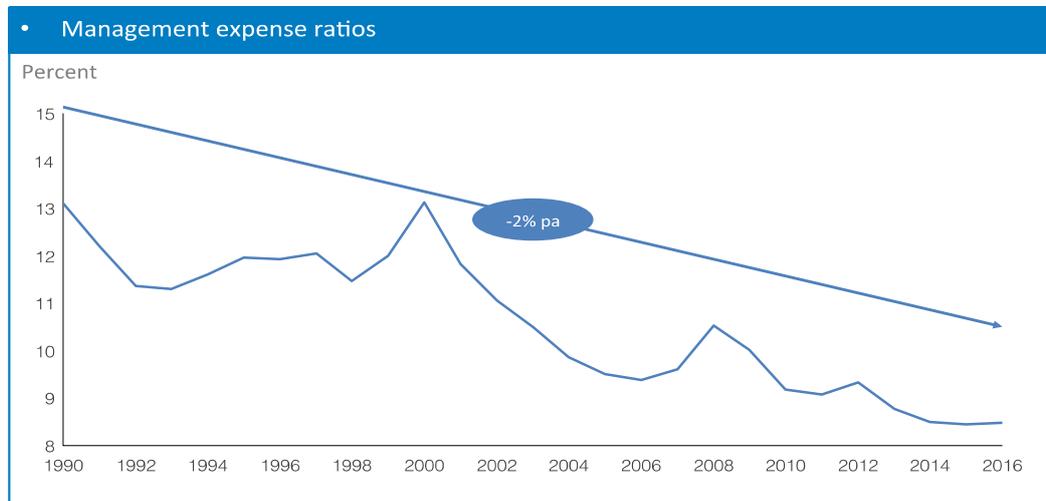
Private Health Insurance Industry Claims Ratio



Source: APRA

Management expense ratios have trended down consistently over the last 15 years, which reflects health funds introducing efficiencies to pass greater value back to the member.

Health fund management expenses are continuously declining due to productivity improvements



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SOURCE: APRA

In addition to the three measures outlined above, there has been commentary as part of this inquiry, on Return on Equity (ROE) for ASX-listed health funds being 'too high'.

ROE is only one financial measure used to assess the performance of businesses and it can be influenced by a range of factors. For example, businesses with low capital assets will generally have higher ROEs. While ROEs can provide security to members of funds that their health cover comes from a well-run business which can manage claims risk, looking solely at ROEs does not provide an indication of the benefits private health insurers deliver for their customers and the broader health system.

Challenges facing PHI

- There is a lack of control over input costs that has the potential to render PHI 'passive payors' for medical devices, hospital accommodation costs, allied health costs and medical specialists. These costs, and increasing rates of utilisation of these services are driving health inflation;
- This lack of control is largely due to the regulatory arrangements regarding health care – which have made transparency around out-of-pocket costs; Informed Financial Consent and medical device prices hard to achieve;
- There has been a 'set and forget' mentality in Government that means many regulations have not been reviewed for over a decade and now operate in a perverse manner never intended, i.e., second tier default benefit payments; inflated Prostheses List benefits; and
- The use and sharing of membership and related health data by insurers is necessary to manage fraud and inappropriate practice, as well as to track outcomes to ensure high quality and safe care is being delivered. This is an appropriate use of data, which is suitably de-identified to comply with privacy regulations. Both Commonwealth and State Government payors use data in the same way; in fact, there is room for greater collaboration between these parties to achieve improvements in health outcomes and cost-effectiveness of services.

PHA member funds have proposed a project to the Federal Government to develop more effective ways to use data to detect and manage fraud and overservicing in the context of the MBS review, and ongoing management of MBS outlays.

The PHI industry is containing costs in its control and improving the value proposition for customers

- PHI has kept premium increases at a rate lower than COAG's payments to public hospitals, which currently stand at a 6.5% funding increase per annum. This is despite input cost inflation which is rising not just in Australia's health system, but in industrialised countries around the world;
- This year the average premium increase was 4.8 %, the lowest in a decade;
- PHI is investing in robust contracting arrangements with providers, which have delivered efficiencies and kept downward pressure on premiums and resulted in no or known gaps for consumers. These arrangements include:
 - Known Gap arrangements with medical specialists
 - Hospital contracting
 - Preferred Supplier arrangements for dental
 - Contracts with optometrists and other groups
- Health funds are developing and targeting products to better address the health and financial needs of members including:
 - Regular preventive health checks, wellness programs and programs for people with chronic conditions to help them stay healthy and out of hospital
 - Mobile apps and other technical support to help people access and understand their PHI better
 - Online directory services to help consumers find a specialist and compare out-of-pocket costs
 - Advanced data analytics to minimise waste, fraud and inappropriate billing, but also to give clinicians confidential feedback about key quality and cost metrics to enable continuous quality improvement.

PHI – Community Rating

Australia's PHI is based on a system of Community Rating which means that everyone can pay the same premium for their health insurance. Health funds are prevented from discriminating against members on the basis of health status, age or claims history. Under the provisions of the *Private Health Insurance Act 2007* in Australia, health insurers are prohibited from charging a premium based on a person's state of health or history of claiming.

Community Rating was developed to make sure that people with a higher level of claims are not disadvantaged – for example if a consumer has a history of health issues, this does not mean they should pay a much higher premium. Community Rating means that everyone is entitled to buy the same product, at the same price, and is guaranteed the right to renew their policy.

PHI's community rated system is designed to keep PHI fair for all Australians. A single, healthy 20-year-old and a single, unwell 60-year-old will both pay the same premium for the same cover with the same insurer. This means private cover is accessible to anyone who needs it regardless of health status, and enables private health insurers to help take the burden off the public healthcare system.

A risk rated system at the community level would adversely affect the sick and elderly potentially causing them to let their health cover lapse and to rely on the already stretched public system.

The PHI industry has been a strong advocate for the concept of Community Rating, however recognises that the current regulatory environment requires some modernising to ensure the system of Community Rating remains sustainable.

CUSTOMER EXPERIENCE OF PRIVATE HEALTH INSURANCE

Australians fundamentally value their private health insurance

Private health insurance is an integral part of Australia's mixed public-private health system. 13.5 million Australians (around 55% of the population) currently hold some level of PHI cover and health funds pay a combined \$20 billion per year in benefits for the treatment of their members. More than half of the Australians with PHI have an annual household income of less than \$50,000.¹

The largest and most comprehensive consumer survey on private health insurance is conducted every two years by Ipsos². The most recent Ipsos survey found that 84% of people with hospital cover and 82% of people with extras cover believe their PHI represents "very good" or "fairly good" value for money.

Reasons customers hold private health insurance

A consumer survey conducted for PHA by Ipsos in 2016 revealed that the most important factors impacting a customer's decision to take out and keep PHI are:

- Security against high costs of care (mentioned by 65% of survey respondents);
- Access to higher quality healthcare providers (57%);
- Access to a wider choice of healthcare providers (55%);
- For control over the timing for a procedure if needed (55%); and
- Reduced wait times for services (54%).

In addition, a significant number of customers report that minimising Medicare Levy Surcharge (MLS) exposure (37%) and minimising Lifetime Health Cover (LHC) penalties (30%) were also important reasons to purchase PHI.³

Greatest concerns are about affordability

While the vast majority of people believe their PHI cover to be good value, affordability is the greatest concern held by Australians when it comes to PHI. Ipsos has found:

- When people who had allowed their PHI to lapse were asked for the reasons why, 61% reported the cost of premiums, while only 3% cited a dispute; and
- 71% of people without private health insurance reported that the primary reason was because premiums were too expensive; while only 29% stated that the reason for not holding PHI was because they were satisfied that the public hospital system would meet their needs.

¹ Australian Taxation Office *Taxation statistics, 2014-15, Individuals*

² Ipsos, *Healthcare & Insurance Australia* (2015)

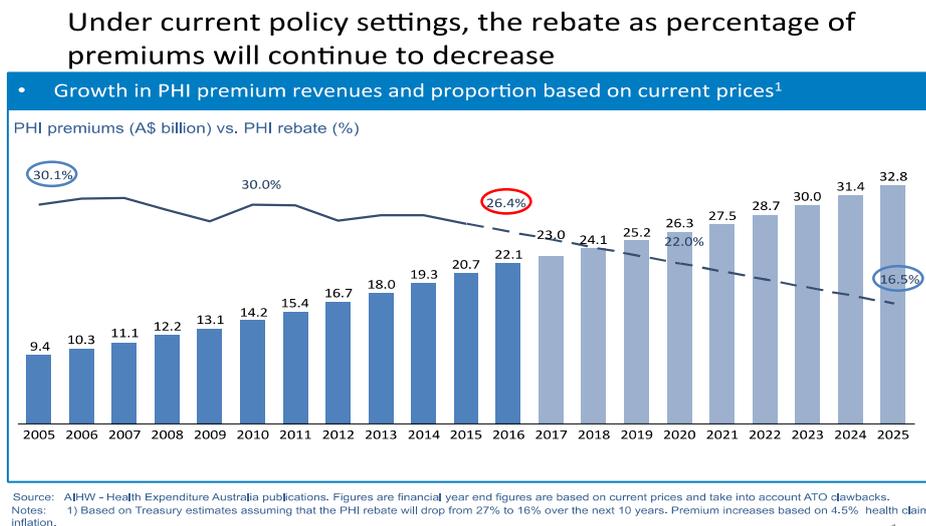
³ Private Healthcare Australia (2016) *PHA Consumer Survey* (n=2384)

Price sensitivity research shows that on current income/premium trends, PHI will potentially become unaffordable for up to one in five current hospital policyholders within the next 5-6 years.

A range of government budget settings introduced over the last seven years have had a significant detrimental impact on the affordability of PHI for many Australians. Beginning in 2010, a series of budget measures has eroded the ‘three pillars’ of government support for PHI, namely LHC, the MLS, and the 30% PHI Rebate. These include:

- means-testing the rebate introduced in the 2009-10 Budget;
- indexation to CPI, uncoupling the rebate from the cost of premiums, legislated in 2012;
- removal of the rebate from LHC loadings, announced in 2009-10 Budget; and
- freezing the income thresholds for rebate eligibility at 2014-15 levels through 2020-21.

The net effect of these measures is to slow the growth of PHI rebate outlays. Taking into account a decline in numbers of people with rebate-eligible policies, expenditure on the rebate is now expected to decline not increase over time. The impact of non-full indexation of the rebate on premiums is to effectively compound interest at the difference between general CPI and health/premium inflation. If health inflation continues at the same rate, the value of the rebate as a percentage of the premium will be 16% in a decade for those still eligible to receive a rebate.



Affordability is problematic across the healthcare system

There has been extensive public discussion around annual increases to PHI premiums in recent years, but relatively little attention is given to the increasing costs of healthcare in Australia. This is despite the fact consumer research shows concern around the issue of health system sustainability. 44% of people believe the mixed public and private health system will not be around in 15 years, and 52% of people are not confident the public hospital system will be around in its current form in 15 years.⁴

The cause of this concern is the inflation of health input costs, which have risen at a rate much higher than CPI over the last decade. The impact on household budgets of rising health costs; perceptions of strain on the public hospital system (such as rising waiting times and reports of poor outcomes) mean people are acutely aware the status quo may not be sustainable under current economic conditions.⁵

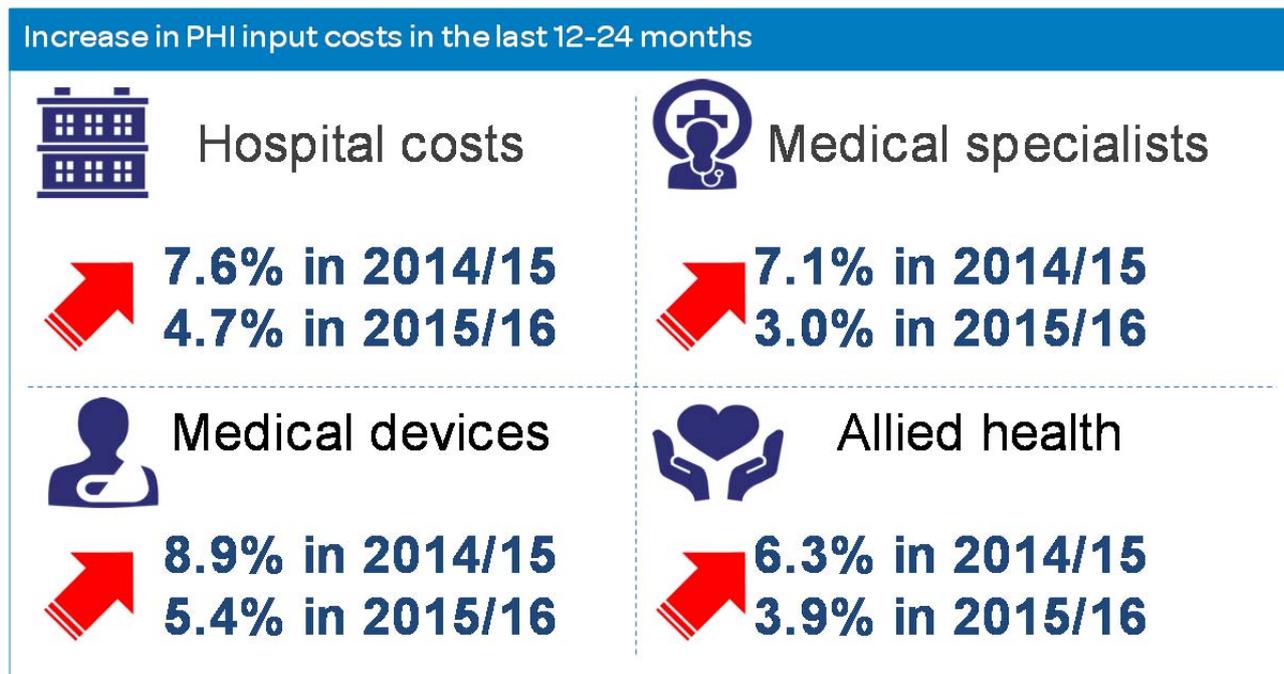
⁴ Private Healthcare Australia (2016) PHA Consumer Survey (n =2384)

⁵ Australian Institute of Health and Welfare (AIHW) ‘Health expenditure Australia 2014-15’

For example, in the year 2014-2015, health system input costs (incorporating hospital accommodation costs of 7.6%, medical specialist gap costs of 7.1%, medical device costs of 9% and allied health costs of 6.3%) rose by close to 8%.

In the same year household incomes rose by just 1.8%. In 2016, to take account of this, health funds were awarded an average premium rise of 5.59%. In 2015-2016 a slowing of the economy has meant 'health' inflation has eased slightly so that input cost growth is currently around 5-6%, but this is still well above the Consumer Price Index and household income growth.

Rising input costs have an inflationary effect on PHI premiums



Source: APRA

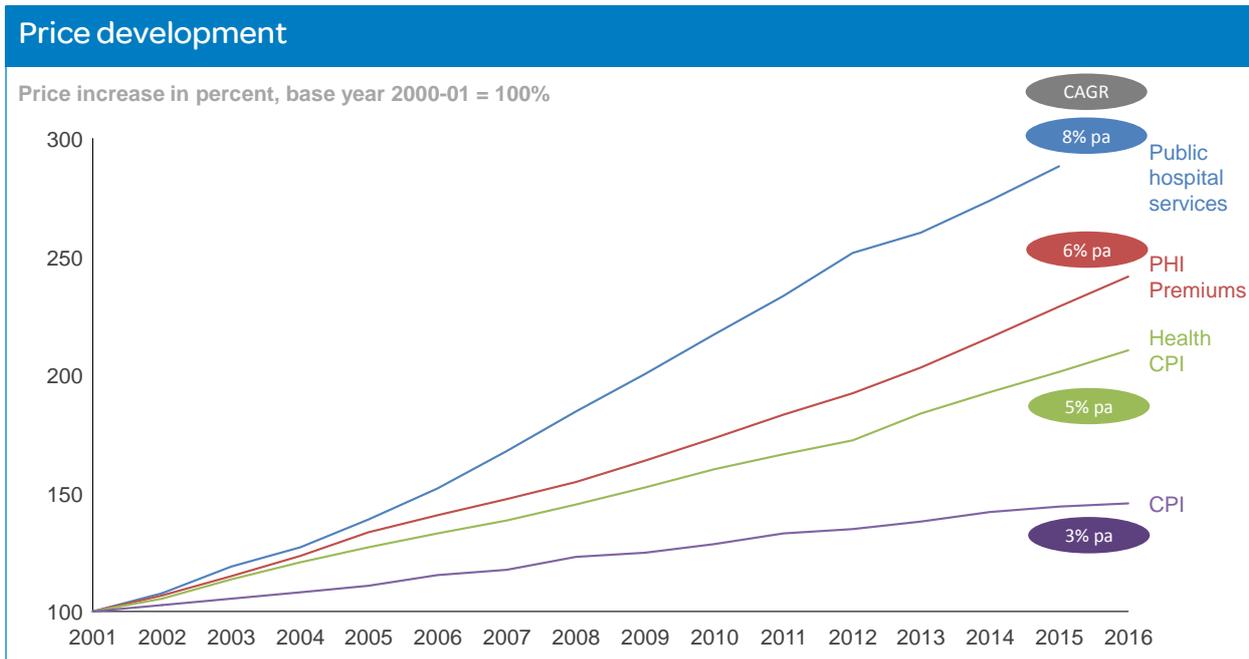
The cost pressures facing PHI in Australia are also being felt by the public hospital system, which in April 2016 was awarded annual 6.5% increases in Commonwealth funding through 2019-20 through the COAG Heads of Agreement on Public Hospital Funding.⁶ In addition to these locked-in funding increases from the Commonwealth, the states and territories have been forced to commit to substantial increases in their own funding to public hospitals by an average of 5.9% per annum over the same period.⁷

This has led to wide speculation about the need for tax increases to fund the rising costs of public healthcare such as a Medicare levy increase (income tax) and a rise in the GST to 15%. Privately insured consumers have a more direct price signal about the rising costs of healthcare through the annual health fund premium increase, which creates heightened concern about the future of private health, particularly at this time of year.

⁶ Australian Medical Association Public Hospital Report Card 2017

⁷ Commonwealth Budget 2017-18

Over the past 15 years, both public health and PHI costs have outgrown CPI measures



Source: AIHW, APRA, ABS

Many of the components of health inflation are beyond the control of health funds. Some of the drivers are a challenge for the whole economy, with many trends consistent with other developed countries around the world. Australians have gained an additional 30 years' life expectancy over the last century and as a result our disease profile has shifted from acute self-limiting conditions to chronic illnesses, which can be treated and managed but not cured.

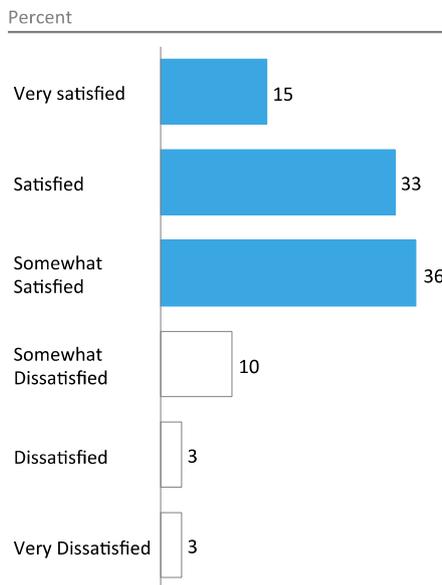
Utilisation of health services has increased dramatically. Improvements in health technology have tended to add to health costs, not substitute for them, leading to a situation where the majority of health expenditure on a single patient occurs in the last year of their life.

Consumer expectations of what the health system should deliver are increasing in line with economic growth and increasing life expectancy. Many people who have a hip or knee replacement these days do so with the expectation of returning not only to work, but also to an active lifestyle. In addition, Australians in general have very good access to health services including the latest treatments and technology. It should be remembered if people were asked to trade this off against lower premiums and lower taxes, many would not do so.

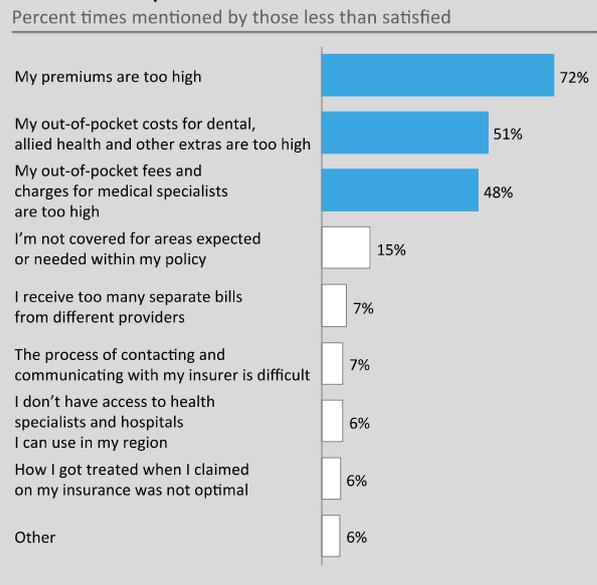
IPSOS Survey for PHA July 2016. n=3600

Most people are satisfied with their PHI, but affordability is a problem

How satisfied are you with your private health insurance?



Why are you less than satisfied with your current private health insurance product?



SOURCE: PHA Consumer survey 2016, n=2,384

In response to consumer concerns about affordability, health funds have increasingly created entry level and life stage appropriate products with particular exclusions such as pregnancy and diseases of old age. While this has increased uptake in younger cohorts and spread the claims risk, it has generated a level of complexity in the system, which has created confusion for consumers at the point of purchase, and the point at which they use their health insurance. It has also led to concerns about whether PHI offers value for money.

Comparisons between premium increases and CPI are misleading

Annual PHI premium increases are often labelled as excessive when they are higher than the Consumer Price Index (CPI) in any given year. CPI is a composite index of 11 consumer goods and services categories, which attempts to chart the cost of living in Australia by measuring quarterly changes in the price of a 'basket' of goods and services which account for a high proportion of consumer expenditure.⁸

Some categories that comprise the CPI reduce in price each year, such as Communications, which includes services such as mobile phone and internet plans which generally become cheaper as technology advances. Communication CPI was -4.8% in the 12 months through March 2017, while Health CPI was +3.8%. Other categories can rise or fall depending on global market factors, such as transport costs being affected by the price of fuel, which is determined in large part by the international price for crude oil.

CPI is useful for measuring overall changes in cost of living, but it is not appropriate to use as a measuring stick for determining whether increases in PHI premiums are reasonable. Even comparisons with the Health CPI category are problematic because Health CPI encompasses

⁸ Australian Bureau of Statistics, 6401.0 – Consumer price Index, Australia, Mar 2017

consumer health costs that are not covered in PHI policies, such as pharmaceuticals and GP visits.

It would be possible to devise a new index to determine whether increases in PHI premiums are a fair reflection of the cost of the healthcare services. This would need to be a weighted formula encompassing changes in the cost of hospital treatment (MBS schedule fees, hospital accommodation charges, surgeon's fees, anaesthetist charges, etc.) and general treatment such as dental, physiotherapy and optometry services among others.

The role of the PHI rebate

In the late 1990s, following an economic downturn and a banking crisis impacting the southern states in particular, the hospital system was in crisis. Public hospitals had been hit hard by funding cuts and the rapid introduction of activity-based 'Casemix' funding as a savings measure. They were struggling to recover and were experiencing waiting list blowouts, industrial action and significant quality and safety problems. Newspaper headlines reported '20 000 avoidable deaths per year' in Australia's public hospitals.

At the same time, private health insurance had become unaffordable for the average family as a result of young people exiting the market, leaving a risk pool of high claimers. This created a toxic cycle of high premium increases, followed by further dropouts of low claimers.

At this time regulation permitted a person to join a fund for the first time late in life when they were certain to claim, and pay the same premium as a young person who had just joined. Multiple double figure premium rises were common in a 12-month period and hospital cover fell to an all-time low of just under 30% of the population. Both small and large funds required intervention to stop them failing. Government market research estimated that over 700 000 people on full pensions were going without food and other essentials to be able to maintain PHI cover because they knew they were going to claim.

To stabilise the PHI market and give public hospitals a chance to recover, the Howard Coalition Government introduced a package of reforms, which included the following measures:

- Lifetime Health Cover (LHC) which penalises people who join a health fund over the age of 30 through a sliding scale of higher premiums proportional to age;
- The Medicare Levy Surcharge (MLS) which penalises higher income earners (singles earning over \$90,000, and families earning over \$180,000) with a higher Medicare levy if they do not take out PHI; and
- The 30% rebate on premiums which was a government rebate which was paid as a percentage of the premium in its original form to all PHI policyholders with hospital cover.

Market research estimates these measures together, underpin 75% of demand for PHI, and successfully stabilised uptake of private health insurance at its current level of approximately 50% of the population.

Since the introduction of this regulatory regime, there have been multiple variations to the regulations governing the rebate aimed at controlling government outlays in this area.

The net effect of these measures is to greatly slow the growth of PHI rebate outlays, and in fact, taking into account a decline in numbers of people with rebate-eligible policies, expenditure on the rebate is expected to decline, not increase, with time.

The impact of indexation of the rebate on consumers cannot be underestimated. The impact of non-full indexation of the rebate on premiums is essentially compound interest at the difference between general CPI and health/premium inflation. If health inflation continues at the same rate, the value of the rebate as a percentage of the premium will be 16% in a decade.

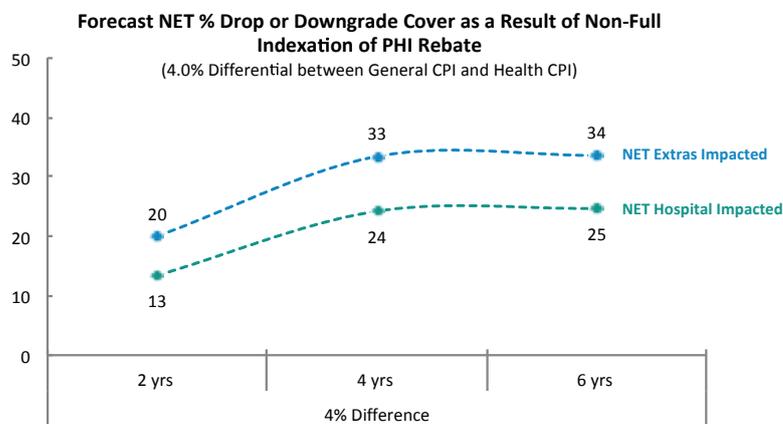
IPSOS has used consumer behaviour survey work to model the impact if the difference is 2.5% and also 4.0% over a six-year period. At a 2.5% differential, one in four extras policies and one in five hospital policies are dropped or downgraded at the six-year mark. At a 4% differential, a truly concerning one in three extras policies and one in four hospital policies are impacted at the six-year point - this is the most likely outcome if nothing else changes.

IPSOS Price Impact and Consumer Reaction simulation model 2015



Forecast impact of non-full indexation: 4.0% p.a. difference

- At a 4% differential, a truly concerning one in three Extras policies and one in four Hospital are impacted at the 6 year point.
- Downgrade more likely than drop ... at 6 years 6% drop Hospital, 14% drop extras.



Section 9.5
9

Further measures eroding the rebate, particularly if they disproportionately impact younger, healthier members will hasten an affordability crisis in private health insurance which will impact the public sector in the key areas of non-emergency surgery waiting lists, mental health and dental care. A 'tipping point' has been reached for the sector.

Economic value of the rebate

The PHI rebate is an important component of the measures stabilising PHI coverage in the community. Health funds nevertheless appreciate the requirement for budget repair and are not arguing for restoration of the rebate in its original form. We do however strongly assert further hastening the phase down of the rebate will be detrimental to affordability of PHI for Australians already experiencing financial stress. We are also of the view the savings generated by the phase-down of the rebate should be reinvested in healthcare, not general revenue.

Criticisms are often made of the PHI rebate, with a central allegation being that the same monies spent elsewhere in the health system (and particularly in public hospital care) would have at least equivalent impact.

These claims generally make a series of what we believe are flawed assumptions:

- Very low price-elasticity of demand assumptions for PHI. The corollary to this is that if we were to cut the consumer subsidy, there would be little transfer from private to public healthcare. As noted above – and based on consumer data rather than interpolations within abstract models – this is an erroneous assumption. We calculate that the marginal elasticity should be higher than often assumed, particularly given means-testing;
- Inclusion of the Medicare Levy Surcharge on top of the rebate. There are two problems with this approach, which is designed to overweight perceived public expenditure on PHI:
 - From a purely technical perspective, it is double-counting. Both cannot occur, as payment of the surcharge means there has been no insurance event to attract the rebate;
 - It relies on a deliberate misconstruction of the facts. If the MLS were to have been introduced as a normal tax increment rather than a penalty, and the PHI event were a form of deduction, then this would be a charge to the Treasury. However, the preferred revenue from this measure is actually zero, as it is strictly a penalty to deter undesirable behaviour (albeit one measured in tax increments rather than penalty units). To include it as an opportunity cost of PHI is equivalent to claiming that people are avoiding revenue contributions by observing the traffic laws;
- As a corollary to the previous point, it would seem particularly unreasonable to remove the levy from those who require it, then apply a tax penalty for failure to enrol in PHI. While we recognise that some people have greater need for the rebate than others (higher income-elasticity) it was the industry's expectation that this was the argument for means-testing. It should equally be an argument against removal;
- Fundamentally, arguments for hypothecation of the rebate amount to public healthcare rely on the assumption that this is purely a question of maximising purchase from Government outlays. However, the social and economic purpose of healthcare finance is welfare maximisation.

This last point is key to understanding the value of the PHI rebate. The value of health insurance is not simply to the insured individual: if it were, then there would be no coherent argument for public subsidy.

The broader benefit is in what PHI facilitates, which for the whole economy and community, is a reduction in waiting times for hospital procedures.

The PHI rebate on 'Extras'

The PHI rebate is payable on any complying health insurance product (CHIP) that provides hospital treatment, general treatment (also known as ancillary or extras) cover or both. From time to time, government and other stakeholders have proposed removal of all or part of the rebate on the general treatment component as a savings measure. This would simply appear to the consumer as a premium increase, as most health fund products are sold as a bundle of hospitals and extras, further exacerbating affordability concerns at the consumer level.

There are a number of risks in taking this approach. It would further dilute the value of a measure that risks 'death by a thousand cuts'. Extras cover delivers real value to younger people who are less likely to make hospital claims, but who derive considerable value from cheaper access to dental and allied health services in the community. In the absence of extras cover, it is less likely that younger people would enrol in private health insurance, because:

- They have lower expected returns (i.e. lower probability of hospitalisation); and
- Insurance is comparatively expensive for young people. While the combination of community rating and lifetime loading address equity goals, the core pricing of PHI is typically over what a risk-rated price would look like for people in their 20s.

Without extras cover, we would expect deferred enrolment in PHI, which is then compounded by lifetime loading, and consequently prices many late entrants out of the market.

Associated with this, younger people who are injured or suffer illnesses which place them on hospital waiting lists will experience greater losses of welfare due to their age and career stage. There are broader economic losses due to this phenomenon. Young people with a mental health disorder for example, will struggle to get admitted to a public hospital, however the loss of productivity this could cause throughout the early stages of working life, will potentially impact them throughout life.

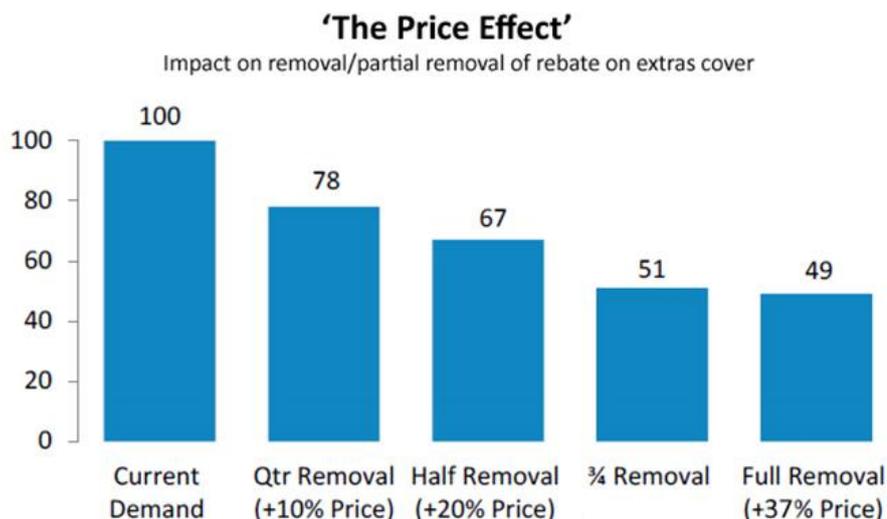
The public health impact of regular preventive dental and eye checks is significant. It is worth noting that when asked about choosing a health fund for hospital cover, many consumers mention attributes related to extras cover, which reinforces the relevance of this product to consumers. Maintaining coverage in this age cohort is critical to be able to spread their risk under the community rating system.

The immediate consequences of the removal of the rebate on extras can be seen below. This equates to a price increase of 37%, which will cause a halving of the demand for extras. This will have a detrimental impact on PHI take up by younger people who are more interested in extras benefits in general than hospital cover.

IPSOS Price Impact and Consumer Reaction simulation model 2015

Forecast impact – Removal of Rebate on Extras

Stated impact of a full removal of the rebate (equating to a 37% price increase) is a halving of demand for Extras



Section 9.5

If the premium for your ancillary or extras cover for things like optical, dental, physiotherapy and the like were to increase by XX%, which of the following would summarise your likely behaviour?

The main benefit of 'Extras' cover is access to affordable dental care

53% of extras claims are for dental care, for which health funds are a major funder in Australia.

One-in-two Australians claim for dental services through a health fund. Health funds pay out over \$2.6 billion per annum in dental benefits, which is more than Federal Government dental programs. The majority of adults with insurance have reported that their insurance paid some (77%) or all (9%) of the dental costs of their last visit. About 10% of insured adults paid all their own dental expense. Almost one-fifth of the insured adults (19%) who covered their own dental expenses said it caused a large financial burden.

Increasingly, health funds are contracting with dentists and vertically integrating with dental practices, thereby consolidating and creating economies of scale. This is driven largely by a need to standardise quality and reduce out-of-pocket costs for consumers. Traditionally, dental care has been a cottage industry, with large variability in costs for the same service. Approximately 85% of dentists work in the private sector in their main practice, ranging from 91% in the Australian Capital Territory to 70% in the Northern Territory.⁹

By contracting dentists, health funds have been able to reduce uncertainty about out-of-pocket costs, and have been able to provide preventive dental services with no gaps in many cases. A report by Health Workforce Australia in 2014, identified there is an oversupply of dentists in Australia until at least 2025, which is particularly acute in urban areas¹⁰. Younger dentists in particular are attracted to work with health funds so they can access a guaranteed patient flow and build up a practice. The funds have used this dynamic to promote fee transparency and lower out-of-pockets for contracted dentists.

Savings measures, such as removing the rebate on extras cover, could potentially undermine the positive ecosystem health funds are creating in dental health and will not save money in the long run. Poor dental health and decay are a cause of pain, poor nutrition and embarrassment. When appearance and speech are impaired by dental disease, opportunities for education, employment and social interactions are impacted. Poor oral health can also cause systemic health problems like heart infections, coronary heart disease, stroke, and poor outcomes in pregnancy and pneumonia. In 2010-11 (the most recent data) there were 60 590 potentially preventable hospital admissions for dental conditions and 129 084 cases of general anaesthesia for dental procedures. This is already very costly, and reducing access to preventive dentistry will risk increasing the cost burden of these conditions, as well as reduce the productivity of impacted individuals.

Policy measures

The PHI industry shares the commitment of the Federal Government to budget repair and reducing national debt. While the sector understands the political climate is not conducive for the introduction of sweeping or fundamental reform of Australia's health system, there is opportunity to address sustainability through sensible policy correction.

The private health sector is highly regulated, and much of the regulation has been put in place with the best of intentions and serves its purpose. There are however a number of regulatory measures that with time have inflated costs and decreased the efficiency and transparency of the sector. While these consequences are unintended, they must be addressed to secure its sustainability. Many of the issues below have been raised in the context of the Health Minister's Review of Private Health Insurance and Review of the Medicare Benefits Schedule.

⁹ Australian Institute of Health and Welfare Oral health and dental care in Australia: key facts and figures 2015

¹⁰ Health Workforce Australia: Australia's Future Health Workforce - Oral Health Detailed August 2014

There is some urgency in implementing regulatory reform of this sector, given the pressure on households from rising prices. This is not without its challenges as some of the proposed changes will result in ‘winners and losers’ should they be implemented.

There are powerful vested interests in the health sector that are capable of running scare campaigns should their historical income streams be threatened. The sustainability of the health sector in the long run however, depends on the system operating at maximum efficiency. Health funds are thus committed to working with government to remove every dollar of wasted expenditure in private health, and every piece of toxic regulation driving up premiums. In return, the PHI sector is actively engaged in a process with government to greatly improve consumer navigation of health fund products and transparency of information on key issues identified by consumers as a major problem, like medical out-of-pocket costs. PHA member funds have already made a significant financial investment as a sector towards implementation of the government’s consumer transparency election policy measures in 2016.

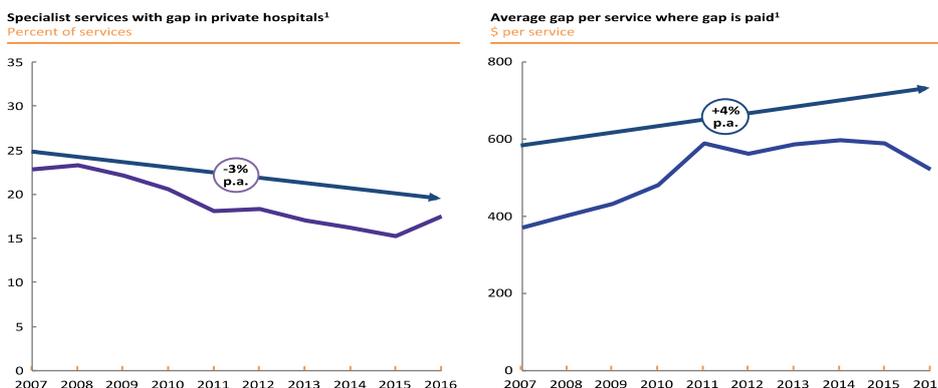
Customers need greater transparency

One of the major concerns for consumers the industry is working to address is the level of out-of-pocket (OOP) costs and the challenges in navigating specialist gaps. A private patient may experience unexpected costs from both hospitals and medical specialists. However, specialist charges, which on average make up over half of the costs of a hospitalisation for consumers, are often outside the control of health funds or private hospitals.

Under Australian law private medical specialists are not treated as employees and can charge whatever they like. They can choose whether or not to enter into ‘no-gap’ or ‘known gap’ arrangements with health funds. The chart below shows that while the percentage of services that attract a gap has remained stable over the last 10 years, for those services, which do attract a gap, it has been increasing. Some highly emotive treatments areas like obstetrics and prostate cancer surgery are very prone to large variations in out-of-pocket costs, which are not easily justified in terms of clinical evidence.

This is the second biggest concern consumers have about private health, after premium affordability.

The proportion of specialist services with out-of-pocket costs has been stable or declining over the past decade, but average costs are increasing

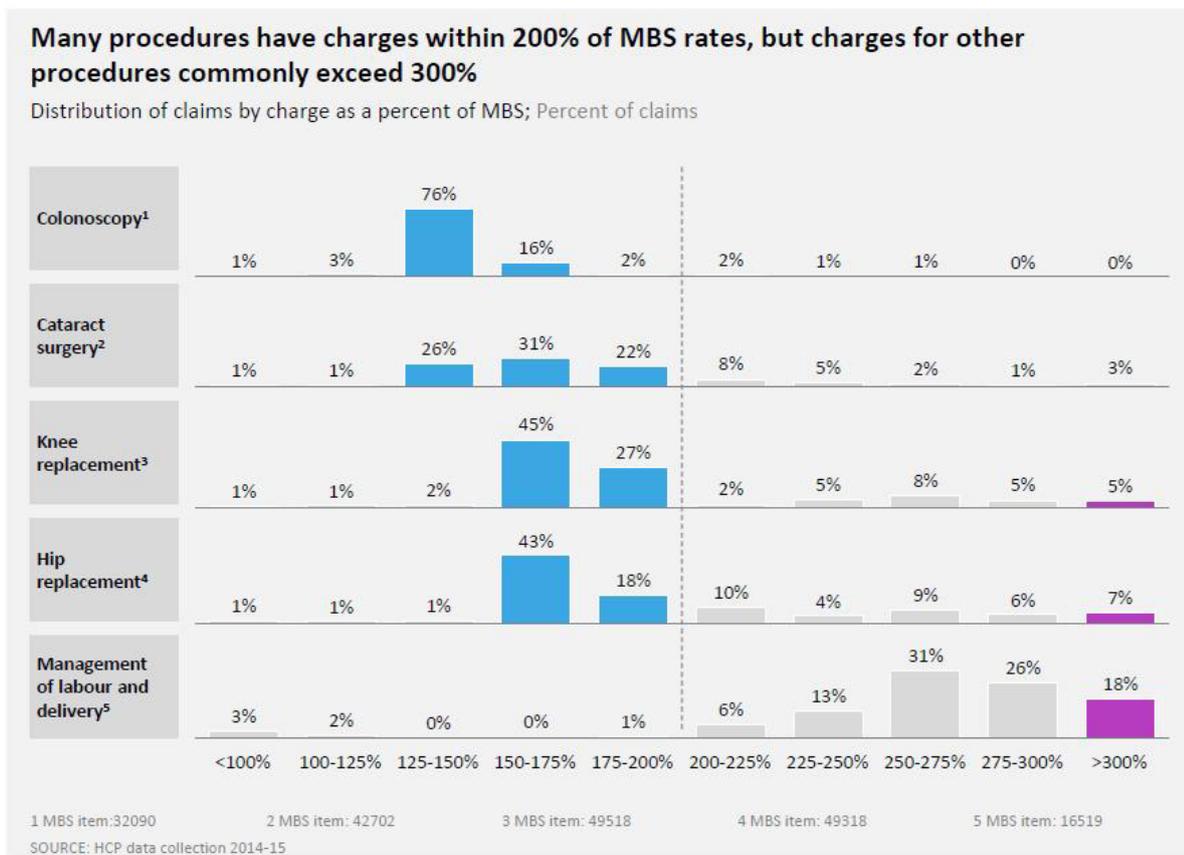


¹ For in-hospital medical services paid for by Private health Insurers in service groups excluding consultations, anaesthetics, diagnostic imaging, pathology and ‘other items’. Does not include all OOP costs associated with single episode

SOURCE: Analysis of APRA (2016) Private Health Insurance Medical Services 2005-2016

For hospital services, the largest area of cost for consumers is the medical gap, comprising over 50% of total ‘out-of-pocket’ hospital costs. Medical gaps are made up mostly of specialist gaps (65%), anaesthetics (23%), diagnostics and pathology (7%) and other medical gaps (5%).

Specialists can often charge over 300% of the Medicare Benefit Schedule rates for some common procedures, and choose whether to enter into 'no-gap' or 'known gap' arrangements.



To enable better choice in the market for specialist healthcare services, consumers require transparency on expected out-of-pocket medical costs and quality, and information on expected costs of a hospital admission.

Specialists generally inform patients about likely out-of-pocket expenses for their services, but over 30% of PHI holders surveyed who went to hospital in the last five years were surprised by the gap that they had to pay for medical treatment. This suggests that informed financial consent (IFC) is not working perfectly, or the additional costs of related medical services are not well communicated. Over a quarter of private hospital patients in 2015 were not informed or given an estimate of what all costs would be before their visit to hospital.

To address this challenge, more information on provider cost and quality is needed at key stages in the consumer journey, to allow for transparency and choice for the consumer. International examples from the US, the Netherlands and the UK suggest there is much to be gained by publishing user-friendly cost and quality information to help consumers and their general practitioner, select providers and navigate the health system.

- The US Center for Medicare and Medicaid Services released data for \$77 billion in payments to over 880 000 providers and 4 000 hospitals from 26 million beneficiaries, empowering consumers to 'shop around' more effectively based on health outcomes and price.
- In 2009, the Dutch government made it mandatory for hospitals to publish quality information. At the same time, the government launched the website www.kiesbeter.nl (translates to 'choose better'). It had more than 5.6 million visitors in 2012 enabling the consumer to compare healthcare providers by various quality metrics.

- In the UK, the NHS publishes information on quality of providers to help consumers make choices, and group specialists and GPs into categories ranging from ‘amongst the best’ to ‘amongst the worse’. The ‘Choices’ website has a very high uptake with over 584 million visits in 2015 making it the most popular healthcare information website in the UK. Over 70% of users claim that they are satisfied with the website, and the use of the website also alters the healthcare-seeking behaviour – especially amongst younger users – leading to approximately £94 million savings per year because of reduced consultations.

Currently consumers receive less than complete information on costs when booking at hospitals, and have limited access to existing platforms and websites that share information on specialist and hospital quality and cost. There are different points along the consumer journey where transparent information can help enhance choice:

- Before visiting the GP;
- When visiting the GP and before specialist referral; and
- At the point of specialist consultation in advance of a procedure.

Greater transparency on cost is needed to enable consumers to identify and select suitable providers, and to support GPs in informing their patients. For example, information on average OOP costs and charges per procedure, including a range of possible expenses, would give consumers a sense of potential charges they could face when undergoing a procedure. In addition to cost transparency, information on the quality of providers would be beneficial to inform consumer choice. In terms of quality, metrics or information would need to be meaningful to consumers. Better information links are needed between health funds, providers and other stakeholders to share cost, treatment outcome and quality information with consumers. Players along the entire supply chain need to be accountable for affordability and transparency, not just insurers.

Recommendation

PHA supports provider fee schedules as a way to give certainty to consumers about out-of-pocket costs. We strongly recommend, if a consumer can demonstrate their health practitioner has not provided informed financial consent in advance of a planned procedure, the ACCC should waive consumers’ obligation to pay.

Better information links are needed between health funds, providers and other stakeholders to share cost and quality information with consumers.

Work undertaken by Medibank with the Royal Australasian College of Surgeons (RACS)¹¹ on variance in surgical out-of-pocket charges, has revealed there is a market operating, it’s just that consumers don’t have access to the information. For example, in States where household incomes are lower and there are large numbers of specialists per health of population like South Australia, gaps tend to be low. In the Australian Capital Territory, the opposite is true and residents pay the highest out-of-pockets in Australia.

PHA member health funds have made considerable investments in directory services like Whitecoat and Healthshare, which aim to provide consumers information about medical specialists, their scope of practice and also whether they participate in ‘no’ or ‘known-gap’ cover with their health fund. As part of the PHI reform process, PHA has been working with government on removing unnecessary regulatory barriers impeding the development of these services.

¹¹ Variation in the costs of surgery: seeking value. David J Hillis, David AK Watters, Lawrie Malisano, Nick Bailey and David Rankin
Med J Aust 2017; 206 (4): 153-154. || doi: 10.5694/mja16.01161

Private health insurers' lack of control over input costs is compounded by the lack of proactive controls for fraud and over-servicing. PHA is strongly supportive of the Government's MBS Review as every dollar of waste and every episode of inappropriate practice threatens the sustainability of private health. A robust mechanism to manage compliance in the MBS program, and to ensure services are provided appropriately will be as important as changes to the MBS schedule of fees in ensuring the sustainability of this program as well as PHI. Enhanced data sharing capability in this regard is needed.

Consistent terminology and transparency within PHI products

Currently there are inconsistencies between health funds in the terminology used to describe what products cover, in particular in how categories of services are described.

In hospital products, this leads to confusion for consumers as to what is included and excluded in their policies. For example, currently the terms 'gastric banding and obesity related services', and 'surgical weight loss procedures' are used to refer to similar areas of coverage, but there is a lack of clarity on what is included in these descriptions.

In addition, exclusions are communicated at different levels of granularity, leaving consumers with an inability to compare coverage across competitor products, e.g., 'back surgery' versus 'spinal fusion'. This lack of standardisation also holds true for general treatment (extras) products in addition to hospital products, e.g., 'prosthesis (non-surgical)' and 'appliances' are used across different health funds to refer to similar categories of items covered.¹²

The above examples demonstrate the variability that exists in current terminology used, leading to consumer-perceived complexity in the PHI product landscape. Of consumers who were less than satisfied with their health insurance purchase process in the last five years, 25% of them stated that the 'terminology used by different health insurance providers was confusing'.¹³

To address this confusion, specific industry-wide definitions are needed to communicate what is included in products. This will help ensure transparency and clarity, and reduce consumer frustration with the private health insurance industry. There is a wide variety of other terminology that could be standardised in the industry, including terms used in policies. Terminology as it applies to both hospital and general product category descriptions is addressed within this section, as a starting point.

PHA has taken an industry leadership position to improve PHI product transparency and consistency of terminology. Our member funds have invested in detailed analysis of the current state of affairs and are willing to do their part to make it easier for consumers to understand PHI policies and find the right level of cover for their healthcare needs. Decisions on how to implement this initiative will need to await the outcomes of the current reform process being undertaken by the Government, as it is likely to result in changes that will impact on transparency measures.

¹² Private Health Insurance Ombudsman (2016, Jan-Mar), *Private Health Insurance Ombudsman Quarterly Bulletin* 78

¹³ Private Healthcare Australia (2016) *PHA Consumer Survey*

CHALLENGES FACING THE HEALTH SECTOR, INCLUDING PRIVATE HEALTH INSURANCE

Although private health insurers are taking a number of steps to contain costs and improve the value proposition for consumers, there remain challenges which are outside of the control of the industry. These are: rising input costs, an inflationary and outdated regulatory environment, and systemic practices which put upward pressure on premiums.

Input costs

The ratio of health expenditure to GDP has remained reasonably stable at 9.8%, which is average for an OECD economy. Over the last decade however, health expenditure has tended to grow faster in real terms than GDP, with an average annual real growth of 5.0% being 2.2 percentage points higher than the 2.8% for GDP. The strain on the health system has been revealed in two ways which impact health fund members; the first is the increasing consumer contribution to the cost of health care through premium increases and rising medical out-of-pocket costs.

A significant driver of premium growth is increases in input costs such as the cost of medical devices, hospital accommodation, and provider fees charged by specialists and allied health providers. Private health insurers have limited control over these input costs which limits their ability to constrain premium increases.

Input costs are increasing unsustainably. Since 2009, average benefit outlays per member have been rising by an average of 6% each year, which is well above average annual wage growth. In 2014-2015, health system input costs (hospital accommodation costs of 7.6%, medical specialist gap costs of 7.1%, medical device costs of 9% and allied health costs of 6.3%) rose by close to 8%, while household incomes rose by just 1.8%.

This is due to a combination of increasing provider costs, increasing technology costs, the ageing profiles of the PHI member base as well as regulatory challenges impacting the market. These healthcare costs unavoidably flow through to policyholders in the form of higher premiums.

Outlays are being driven up by the cost of hospital care, this is related to the increasing market power of both public and private hospitals. Private hospitals have a significant advantage in price negotiations with health funds due to ongoing private provider market consolidation, as well as a price floor in the form of the second tier default benefit. As a result, the cost per private hospital stay has been growing at an average of 4% per year, compared to flat growth for public hospital stays.

Many public hospitals are actively encouraged to charge health funds and generate revenue through public hospital cost shifting, despite the added revenue creating minimal tangible value for PHI members. As a result, the number of PHI members using their insurance in public hospitals has grown at 12% on average over the previous six years.

Regulatory environment

The private health sector is highly regulated, and much of that regulation has been put in place with the best of intentions and serves its purpose. There are, however, a number of regulatory measures that with time have inflated costs and lessened the efficiency and transparency of the sector. A tendency to 'set and forget' means that many regulations have not been reviewed for more than a decade and now operate in a perverse manner to that intended. While these consequences have been unintended, they must be addressed to ensure the longevity of the private health sector.

For example, in an environment where there is almost no regulation on the introduction of new hospital beds, the second tier default benefit is anti-competitive and has an inflationary effect on premiums.

The Federal Government currently regulates the benefits health funds should pay if an implantable medical device or 'prosthesis' is used in a procedure. The effect of 'benefit fixing' has meant that private health fund members now pay between 2-5 times public medical device prices, and those in comparable economies. This is reflected in premium increases.

Legislation currently prevents private health insurance from covering medical services that are provided out-of-hospital and covered by Medicare. This may inhibit insurers from funding up-to-date models of care for chronic conditions which are based out-of-hospital, and out-of-hospital care which may help to avoid unnecessary hospitalisations. In some cases, out-of-hospital care is preferable to treatment within a hospital for clinical reasons. By preventing insurers from funding out-of-hospital care in these cases (which is often more cost effective than in-hospital treatment), the legislation is putting upwards pressure on premiums.

It also creates an obvious perverse incentive for doctors to admit patients to hospital, particularly for short-stay admissions when it isn't clinically required. This is because in doing so, the provider can claim gap cover, and additional revenue if they have an additional financial stake in a short-stay hospital facility. This has fuelled huge growth in hospitalisation of patients previously treated in doctors' rooms and in the community, for everything from excision biopsies to cognitive behavioural therapy, and has inevitably put upward pressure on premiums. It would make much more sense to amend the legislation, permitted health funds to negotiate with providers for appropriate remuneration in an appropriate setting of care.

Australia's regulatory framework should support the operation of a PHI industry that is both dynamic and sustainable. There is some urgency in implementing reform of this sector given the pressure on household budgets. This is not without its challenges as some of the proposed changes will result in 'winners and losers' should they be implemented. It should be noted that there are some powerful vested interests in the health sector that are capable of running scare campaigns should their historical income streams be threatened. The sustainability of private health in the long run however, fully depends on the system operating at maximum efficiency. Health funds are therefore committed to working with government to remove every dollar of wasted expenditure in private health, and every piece of toxic regulation driving up premiums. In return, the PHI sector is actively engaged in a process with government to greatly improve consumer understanding of health fund products and transparency of information on key issues identified by consumers as a major problem, like medical out-of-pocket costs. PHA member funds have already made a significant financial investment as a sector towards implementing the government's consumer transparency election policy measures laid out in 2016.

PHA estimates if the over-regulation of private health insurance is addressed as described in this submission, including reform of the Prostheses List (which has already commenced), health fund members will save just over \$1.5 billion a year on premiums as a result of increased competition and transparency.

PHA'S GOALS FOR REFORM

Affordability

Premium affordability ranks as the highest concern among consumers with and without private health insurance.

Market research has repeatedly shown premium affordability is the main reason deterring people from taking out PHI, and premium increases are the main driver of dropouts and downgrades from existing levels of cover.

This year's industry average premium increase of 4.8%, the lowest in a decade, demonstrated the commitment of health funds to return every dollar in savings from Prostheses Lists reform to members. Health funds would like to do better and this can only be achieved through regulatory reforms targeting reducing waste, improving compliance and increasing transparency.

Health inflation impacts both the private and public health systems, in the last Commonwealth/State hospitals agreement, public hospitals secured a 6.5% annual funding increase. The problem in private health, unlike public hospitals, is that consumers are directly exposed to this price signal.

The reform measures identified in this submission will result in a reduction in input costs, across the three key areas – medical devices, hospitals and health professional costs.

Reform the Prostheses List

There is broad acknowledgement that Prostheses List benefits need to be deflated in line with real market prices for equivalent medical devices.

As this Committee is well aware, the Federal Government currently regulates the benefits health funds pay if an implantable medical device or 'prosthesis' is used in a procedure. The effect of benefit fixing has meant that private health fund members now pay 2-5 times public medical device prices, than those in comparable economies. This is reflected in premium increases.

In May 2017, the Senate Community Affairs Reference Committee inquiry into "Price regulation associated with the Prostheses List Framework" made a series of recommendations which if adopted would deliver significant savings for consumers.

A 2015 report "Costing an Arm and a Leg" determined if Australian public hospital prices are used as a benchmark, \$800 million is being wasted per annum on excess benefits paid for medical devices. The report estimated two thirds of this waste was going straight to Wall St in excess profit for the large multinationals dominating the Australian medical device market. During 2016 Budget negotiations, PHA supported the Federal Government's phased approach to correcting regulations fixing medical device prices and agreed to pass on all savings as a reduction in the 2016-17 premium round. This process should now be fast tracked.

Background

As a result of concern about out-of-pocket costs for medical devices being passed on to patients, early this century the Federal Government took the unusual step of regulating the benefits health funds should pay if an implantable medical device or 'prosthesis' is used in a procedure. This was unusual because device benefits are completely uncoupled from MBS reimbursement for the surgical procedure or the bundled hospital benefits. This does not occur in most other comparable economies.

By 2006, on the eve of the global financial crisis, the Commonwealth Prostheses List (PL) had ballooned into a list of over 10 000 products with minimum fixed benefit levels set by regulation. The majority of these are commodity products like artificial hip and knee implants, which had been in use for many years with minimal variation. There are currently 48 hip implants on the PL, which according to the National Joint Replacement Registry (NJRR) have identical clinical functions and outcomes. Only the top 15% of items on the PL are regularly used, and there is no clear mechanism to remove underperforming or obsolete items from the list.

Other problems with the PL in its current form are as follows:

1. It locks out small to medium enterprises that want to compete on price. The list is subject to a rule that smaller companies must be able to guarantee 25% market share in a particular category if they want to enter the market at a lower price. The effect is highly inflationary and anticompetitive. List suppliers are currently dominated by the large US-based multinationals. Many smaller companies are locked out, and this was the subject of the Applied Medical court case that ran against the Commonwealth in 2015¹⁴.
2. It stifles innovation. With inflated benefits set at global high prices guaranteed for older, commoditised products, there is no incentive for providers to innovate or negotiate the provision of lower cost options.
3. There is no clear evidence-based path to reimbursement for new procedure-based technologies due to fragmentation of the system in Australia, which separates private from public, and device reimbursement from the MBS-funded procedure.

Graeme Samuel AC, who chaired the Health Minister's Review of Private Health Insurance in 2015, has been a vocal opponent of the Commonwealth setting benefits through the PL, and has been an uncompromising advocate for the removal of this dysfunctional process.¹⁵

PHA strongly supports the removal of Federal Government regulation of medical device pricing as a separate measure, over time. In this environment, where utilisation of implantable devices is also increasing rapidly, fixed benefit setting by the Commonwealth has had disastrous unintended consequences, stifling innovation and putting significant upwards pressure on premiums. The taxpayer has also been exposed as a result of regulation tying the procurement of medical devices by the Department of Veterans' Affairs to PL benefits.

Health funds have however needed to compromise and take a pragmatic approach to avoid a shock to the sector that could have resulted in unexpected costs being passed on to patients. As part of a pre-Budget negotiation process within the sector prior to May 2016, the following mechanisms were agreed with the Government to deflate PL benefits in line with real market prices for medical devices.

1. The Prostheses List Advisory Committee (PLAC) would be reappointed with a new membership, with a greater focus on economic health technology assessment and introducing dynamic market pricing to this area.
2. A reference pricing mechanism taking into account Australian public hospital prices and international comparator prices from equivalent economies.

¹⁴ Australian Financial Review 'Applied Medical sues federal government over price of keyhole surgery clip guns' Ben Potter April 27, 2015.

¹⁵ The Australian 'Graeme Samuel urges cuts to price-fixing prostheses list' Pamela Williams November 8, 2016.

3. A price disclosure mechanism similar to the one operating in the subsidised prescription pharmaceutical sector to take account of rebates paid by suppliers to customers against PL benefits.

In addition to the above measures, as a show of good faith Federal Cabinet agreed to a small up-front benefit reduction across four key categories where there is high utilisation, and where the differences between the PL benefits payable by health funds and State Government tender prices are large – these are cardiac devices, hips, knees and intraocular lenses. Health funds agreed to pass on all savings as a reduction in the 2016-17 premium round and a premium increase of 4.8%, the lowest in a decade, was announced by the Health Minister.

Considerable further benefit reductions are expected as the agreed pricing processes are implemented, and further downward pressure on premiums will result. With time it is anticipated the Commonwealth should be able to exit price regulation for medical devices used in the private sector all together.

Recommendation

The reform of Prostheses List benefit setting by the Commonwealth must progress rapidly in 2017-18 with the implementation of reference pricing to State Government tender prices and international reference prices from comparable economies, as well as the introduction of price disclosure. Health funds have agreed to a process to pass on all savings made as a result of this measure back to members. The Commonwealth should have an explicit deadline to exit regulation of medical device benefits in the private health sector.

Encourage competitive contracting: second tier default benefit.

While medical device prices have been excessively inflated in Australia, they account for only a portion of rising input costs. To address affordability of PHI and maintain and enhance participation, the other components of premium inflation - hospital accommodation and health professional costs - must also be addressed.

Private hospitals are a key component in the supply chain for private health, and a robust system of contracting between payor and provider is essential to maintain high quality standards and value for money for consumers. Health funds however cannot address concerns over affordability and deliver lower premiums if hospitals continue to demand upwards of 5% per annum in contracted benefits.

The main impediment to competitive contracting is the second tier default benefit. The second tier default benefit is the level of benefit payable by a health fund for an episode of hospital treatment provided by an eligible private hospital facility with which it does not have a negotiated agreement. The second tier default benefit is 85% of the average charge for the equivalent episode of hospital treatment under that health fund's negotiated agreements with comparable facilities in that State or Territory.¹⁶

Background

The second tier default benefit was introduced in 1998, when the private hospital provider market was fragmented, and the PHI industry was adjusting to federal legislation introduced in 1995, which allowed contracting between health funds and hospital providers. At the time, it was

¹⁶ The average charge for the equivalent episode includes the sum payable under the negotiated agreement and any excess or co-payments payable by members in accordance with the health fund's rules; and excludes charges for prostheses and nursing-home type patients. Where a health fund has less than five negotiated agreements with comparable facilities in a state, then the benefit will be based on all of that health fund's negotiated agreements in that state. Where the second tier default benefit is below the minimum benefit outlined in schedules 1, 2 or 3 of the Private Health Insurance (Benefit Requirements) Rules 2011, the minimum benefit applies.

felt health funds' larger market size allowed them too much negotiating power over private hospitals that were less concentrated in terms of market share. The Federal Government introduced the second tier default benefit with an eye to supporting smaller providers, and re-balancing market dynamics between health funds and private hospital providers.

By 2003, private hospital ownership began to concentrate and the balance of negotiating power shifted back to private hospital providers, with Ramsay Healthcare and Healthscope holding 37% market share at this time. The Federal Government proposed abolishing the second tier default benefit on the following grounds:

- Private hospital providers no longer required the protection of the second tier default benefit since the health fund-provider contracting environment had stabilised as both health funds and private hospital providers had matured in their approaches to commercial negotiation;
- Health funds had strong incentives to enter contracts with private hospitals because their members would move to other health funds if there were a narrow contracted provider network; and
- The second tier default benefit had an undesirable effect of setting a price floor.

The Federal Government's proposal was defeated after intense opposition from vested interest groups, who argued policyholders would be adversely affected by a reduction in choice of hospital providers, particularly with small and regional hospitals. Since this time, the private provider market has further consolidated with the two largest providers (Ramsay and Healthscope) increasing their ownership from 37% to 44% market share.

Between 2003 and 2015, three of the top five largest overall receivers of second tier default benefit payments from health funds were large provider networks, including Ramsay, St Vincent's and Cabrini. Combined they account for 39% of second tier default benefit payments.

Considered today, the three main major concerns about the second tier default benefit regulations are as follows:

- First, it provides too much visibility on pricing data to contracted private hospital providers, which strengthens these providers' negotiating positions. Health funds are obliged to provide private hospital providers with a schedule of second tier default benefit rates. This applies when a provider has been granted second tier eligibility by the Second Tier Advisory Committee (STAC)¹⁷ and is out of contract with the fund. There is no equivalent obligation on private hospital providers to publish or share financial or clinical care data with health funds. This creates information asymmetry between the two negotiating parties;
- Second, the second tier default benefit creates a price floor at 85% of the episodic charge for comparable facilities in the same State. This encourages some hospitals to use the 85% as a "fall back" for negotiations. As the 85% rate is a price floor, rather than a ceiling, in some cases it results in higher out-of-pocket expenses for policyholders. This is because second tier eligible hospitals can either accept the second tier default benefit as full payment from the health fund or can charge out-of-pocket expenses to patients. There is no limit to the patient out-of-pocket that can be charged; and
- Third, it limits the ability of health funds to negotiate to improve hospital quality. Currently when health funds agree to pay under contract a higher charge per episode to private hospital facilities that demonstrate high quality patient outcomes, they indirectly reward facilities with lower quality outcomes that may decide to utilise the second tier default benefit. The higher charge to the high performing facility will increase the health fund's average charge per episode, and thereby increase the second tier default benefit.

¹⁷ This is a committee which is defined by regulation and which consists of three nominees of private hospitals and three nominees of health funds. Under current arrangements it is administered by the Australian Private Hospitals Association (APHA) which is a peak body representing private hospitals.

While there are clearly concerns with the current benefit, it is also acknowledged some smaller and regional facilities do rely on the benefit and would be at risk in circumstances where the benefit was abolished. For example, over 75% of small facilities with less than 50 beds are not aligned with a large provider network, which is defined as a provider group earning sufficient revenue to hold greater than 3% market share. Only 30% of medium, with 50-100 beds, and 15% of large facilities, with over 100 beds, are owned by small provider networks. Outer regional, remote and very remote facilities are mainly outside the large private hospital provider networks and tend to have less negotiating power than providers in more populous areas such as inner regional areas and major cities. For example, 60% of outer regional facilities are not aligned with a large provider network.

In these circumstances, the second tier default benefit supports outer regional facilities and smaller negotiating networks in securing quality outcomes for policyholders.

Recommendation

Health funds believe a more competitive and robust contracting environment can be achieved through review of the second tier legislation, and save members up to \$180 million in premium cost per year in the longer term. This can be achieved through removal of the second tier default benefit for day and overnight hospitals located in metropolitan areas, as defined by the top 20 cities in Australia identified by the Australian Bureau of Statistics (ABS).

While we do not believe there is an issue with regional and rural hospitals, it is an area where opponents of change could manipulate opinion to mount an untruthful scare campaign. As such, we believe that it would be better to limit the change to metropolitan areas where the majority of the problems issues arise.

The negotiating power between health funds and contracted facilities would be rebalanced as large urban provider negotiating networks would no longer be able to use the 85% price floor as a fallback position during negotiations.

For hospitals falling out of a negotiated agreement, direct to consumer charges should not be levied up-front, and should be restricted to 100% of the charge for comparable services in comparable facilities. This is to protect the consumer from excessive out-of-pocket expenses should a hospital fall out of contract for a period of time.

It should be noted it is highly unlikely a major hospital group will fall out of contract with a health fund in the current market. Consumer portability between funds is now effectively seamless, and the risk of a customer exodus strongly disincentivises this outcome.

Stop State Government cost-shifting

Public hospital cost shifting or transferring the costs incurred of public services to health funds in Australia is in the order of \$1 billion dollars per annum. This accounts for about 6% of premiums.

“Cost shifting” is a common term used in the Australian healthcare system. It can be defined as a party transferring the costs of incurred services to another party in order to avoid a cost, which would usually fall to them. Public hospital cost shifting to health funds in Australia is in the order of \$1 billion dollars per annum. This accounts for about 6% of premiums.

Many informed consumers intentionally decide to be private patients in a public hospital. PHI products which offer this option have traditionally been part of private health insurance in what was formerly called the ‘basic’ table. For example, public hospitals play an important role for private patients in rural areas, and there are a number of patients with severe chronic illnesses who need particular specialists who prefer to practice in this setting.

This section refers to the deliberate establishment of procedures and business models by State governments to divert patients presenting to public sector emergency departments and outpatients to private funding options.

Background

For most patients attending a public emergency department, using their private health insurance is not a premeditated choice. In fact, many patients who intended to be treated as a public patient are signed up after they are admitted. The end result is PHI policyholders are now subsidising the costs of public hospitals, despite having already contributed to these through their taxes. Nationally, in FY14-15, the PHI industry provided 2.1% of all public hospital funding.¹⁸

This has been growing at an average rate of 12% every year since 2009, driven by two factors: the number of public hospital stays charged to PHI per consumer, growing at 7.5% per annum, and the increase in PHI membership, growing at 3% per annum. In contrast, the price per stay has been growing marginally at 1% per annum.¹⁹

The chart below illustrates the drivers of public hospital patient growth.

The largest driver of increasing public provider benefit outlays is volume growth



SOURCE: APRA annual reports

Analysis of public hospital patient growth

The 7.5% year-on-year growth in public hospital stays per PHI member is significantly higher than the growth in private hospital stays per PHI member, which is 1.6% per annum.

At a State level, a tacit encouragement of public hospital cost shifting seems to be growing. In recent years, at least two States have set quotas for public hospitals to seek "own-source revenue", which is a combination of PHI, veteran's affairs, and other non-State Government funding.

¹⁸ Australian Institute of Health and Welfare (AIHW) 2015 'Health Expenditure Australia 2013-14'

¹⁹ APRA (2009 and 2015) 'Private Health Insurers Operations Report Data - total outlays to public hospitals'

The impact was most evident in 2011 and 2012; after the Queensland State Government brought in quotas in 2010. Annual growth in public hospital stays for private patients changed from 7% per annum before 2010, to 12% per annum after 2010. Some public hospital organisations are adopting new provision models to capitalise on PHI income. For example, the new Fiona Stanley Hospital in Western Australia and the new Royal Adelaide Hospital both have significantly more single occupancy rooms than traditional public hospitals.²⁰ States are able to charge health funds more for single rooms by issuing regulation by a ‘circular’, which is very difficult for funds not to comply with, without adversely impacting members.

In one case, the Northern Beaches public hospital in NSW is a private hospital where patients may elect to be public patients, which is replacing a public hospital.²¹ The NSW Health Minister says the business model is that 86% of medical patients presenting to the emergency department will be persuaded to use their private health insurance.

Case study: public hospitals have created significant capacity to charge PHI

Several new hospitals have financial pressures and new capability, which may lead to increased cost shifting to PHI patients

	Sydney Northern Beaches Hospital	Fiona Stanley Hospital	Royal Adelaide Hospital
New build	✓	✓	✓
Bed numbers	488	783	800
Single rooms proportion	75%+	75%	100%
Approach to recruitment of patients to use private insurance	Private hospital giving patients choice to elect to become public	Clear message on website and in-person that PHI helps hospital financially	Recruitment of ‘counselors’ to identify patients with private health cover
Drivers of public hospital cost shifting	For-profit hospital operator dependent on filling private beds for operating model	Closing operational financial deficit presently at ~\$150m	Closing financial deficit ~\$400m and cost blow out of new build

SOURCE: Official websites for the respective hospitals

New public/private hospitals bring a new complication: they only use one provider number. As a result, health funds are finding themselves paying full private rates for a patient who was treated in the public portion of the hospital. In addition, patients using their PHI in a public hospital are at risk of potentially triggering out-of-pocket expenses, unlike public patients. The average out-of-pocket expense faced by a private patient treated in a public hospital is \$400 (not including health fund excess payments).

If every State and Territory achieved cost shifting at the same level as NSW, which is 3.2% of all public hospital costs, it would cost an additional \$500 million in outlays annually. This would potentially drive up premiums a further 2.8%. The Federal Government would be impacted with an expected \$75 million due to additional MBS payments, which are triggered once a ‘private’ specialist is appointed to care for the patient.

²⁰ Fiona Stanley Hospital: 83% single occupancy rooms. See Fiona Stanley Hospital 2016 ‘About us’ www.fsh.health.wa.gov.au. Royal Adelaide Hospital has over 700 single occupancy rooms. See SA Health (2016) The New Royal Adelaide Hospital www.sahealth.sa.gov.au.

²¹ Northern Beaches Hospital (2015) ‘Your new Northern Beaches Hospital’ www.nbhsredev.health.nsw.gov.au.

Informed financial consent is a requirement of patients electing to be private patients in the public system. It can be defined as members electing to be private in a public hospital who have been made fully aware and understand the financial implications of their decision. Research conducted by the Australian Bureau of Statistics (ABS) in 2010 states that 11% of patients did not feel adequately informed about the financial decision they were making when electing to be a private patient in a public hospital. This aligns with earlier research by IPSOS in 2006, which stated 10% of patients felt explicitly coerced into signing up as a private patient. This is despite clear consent rules outlined in the National Health Reform Agreement, with anecdotal evidence suggesting hospital staff voicing over the official consent forms in ways explicitly banned by the rules.

Common reports include statements such as "...it really helps fund your local public hospital", "consider it a donation to the hospital" and "...we need it to continue research into your condition". Further to improper informed financial consent, some public hospitals are paying consumers' excesses and offering other financial incentives (e.g. free meals), thereby removing the disincentive to use PHI, put in place by health funds.

The current consent form is insufficiently detailed and does not require the signature of a witness or appropriate staff member. At very least, the form needs to make clear the following:

- Out-of-pocket expenses may occur which would not be payable if the patient does not elect to go private; and also
- Amenities like private rooms are not necessarily guaranteed and are dependent on availability.

Furthermore, informed financial consent should not occur until eligibility is established and it is known whether the health fund cover includes the treatment required.

Another enabler of cost shifting is poor transparency of public hospital invoicing. Often invoices received from public hospitals have minimal detail, with only a name and a length of stay, and total cost. In comparison, itemised invoices from private hospitals usually include each test, medical service, and diagnosis. Public hospitals arguably have the ability to already do this, as they provide detailed invoices to the States under activity based funding models.

Health funds should be able to understand the reason for their members' stays in public hospitals at the same level of detail as currently obtainable for private hospital stays. Although some hospitals supply more information, more than two thirds of invoices randomly sampled by health funds had no more information than patient personal details and length of stay. This low level of detail prevents two important processes from occurring:

1. a review of invoices for accuracy, and
2. a follow up of members by the health funds through their chronic disease management programs.

It is recommended that public hospitals provide health funds with Hospital Casemix Protocol (HCP) data, or admitted patient care National Minimum Data Set data. Reporting DRGs and MBS items on invoices, as well as estimated medical cost versus accommodation cost for the stay, would allow more robust discussion between health funds and public hospitals and would likely assist in driving down unnecessary costs further. The Independent Hospital Pricing Authority (IHPA) is also able to provide support to transparency on care being provided, with input on the data systems and fair pricing.

Recommendation

There are a number of regulatory reform options which could improve the relationship between PHI and public hospitals. Private Healthcare Australia considers the most effective reform would involve maintaining the status quo while removing quotas, with increased monitoring of private patient flows through public hospitals, enhance informed consent processes to protect customers, and greater transparency on care being provided.

This can be done either through the COAG National Health Reform Rules, or through legislation. There should be a Code of Conduct introduced through the COAG process to ensure consumers are treated appropriately, are provided fully informed financial consent and are not approached to elect their status while vulnerable or cognitively impaired. Public hospitals will be required to share an appropriate level of data with health funds, and there will be no regulatory barriers to health funds contracting with Local Hospital Networks to ensure the best outcomes for their members if treated in a public hospital. The practice of hospitals offering public patients financial incentives to use their PHI is inappropriate and should be banned.

This will encourage Commonwealth and State Governments to increase transparency and reduce cost-shifting by highlighting the impact on health fund premiums and out-of-pocket costs for consumers. Public hospital cost-shifting to health funds adds more to premium costs than the average year's premium increase.

The Medicare Benefits Schedule (MBS) Review - stop waste, improve compliance

PHA is strongly supportive of the Government's MBS Review as every dollar of waste and every episode of inappropriate practice threatens the sustainability of private health. However, a robust mechanism to manage compliance in the MBS program, and to ensure services are provided appropriately, will be as important as the changes to the MBS schedule of fees arising from the Review in ensuring sustainability of this program as well as PHI.

Under Australian Government regulations, it is very difficult for health funds to pre-approve claims, and any attempt to do so is strongly resisted by health professional representative groups. The 'trigger' for health fund hospital claims is the MBS claim. While this protects the consumer from unexpected out-of-pockets due to claims not being approved, it means health funds are highly dependent on the appropriate management of the MBS program.

Increasing utilisation of services predominantly drives health system cost increases. A large part of this is related to the ageing of the population and the emergence of chronic diseases as the predominant presenting condition. There is, however, a significant incentive created by the MBS fee-for-service reimbursement system for doctors to drive up procedure and consultation volumes. Information asymmetry between providers and consumers is high in this sector, and as a result, provider-induced demand accounts for a significant proportion of services provided.

A robust mechanism to manage compliance in the MBS program, and to ensure services are provided appropriately, will be as important as the changes to the MBS schedule of fees arising from the Review in ensuring sustainability of this program as well as PHI.

Traditionally MBS integrity has been managed through the Professional Services Review (PSR) process, as well as fraud and compliance activities undertaken by the Department of Human Services.

PSR was established in July 1994 as an Agency within the Health Portfolio to protect the integrity of Medicare and the PBS. Part VAA of the *Health Insurance Act 1973* establishes the agency, sets out its role and powers and the process that it must follow when conducting its work.

Through the performance of its statutory role, PSR protects patients and the community from the risks associated with inappropriate practice, and protects the Commonwealth from having to meet the cost of medical / health services provided as a result of inappropriate practice. Appropriate practice describes healthcare that is both medically necessary and clinically relevant. For example, billing a cosmetic surgery procedure to the MBS and a health fund would be considered inappropriate practice, but the fund is legally prohibited from pre-approving these claims, only the MBS can do so.

In its administration of the Scheme, PSR is responsible for reviewing and examining possible inappropriate practice by practitioners when they provide Medicare services or prescribe government subsidised medicines under the PBS.²²

The main problem with the PSR process is it relies heavily on retrospective pursuit of financial gains by practitioners with the goal of cost recovery. This is cumbersome, involves prolonged legal and administrative processes and is rarely successful. Modern data analytics provides the opportunity to better use data to give health professionals generating MBS claims feedback, thereby giving them the opportunity to proactively modify behaviour and prevent fraud and inappropriate practice occurring in the first place. Health funds have already demonstrated the effectiveness of feedback in reducing inappropriate claims. Health professionals are aware 'someone is watching' and are given data about how they are claiming relative to their peers before punitive action is taken.

In 2016, compliance personnel in the Department of Human Services were merged into a single unit with MBS compliance at the Department of Health. This presents a unique opportunity to commence a preventive data analytic-based payment integrity and compliance regime to leverage and back up the good work on the MBS Review.

Health funds have no wish to change the practice of the overwhelming majority of medical professionals who are practicing both appropriately and ethically. However, a focus on changing the small number of individuals who are not practicing appropriately would yield positive results.

Maintain and enhance participation

Review of Lifetime Health Cover settings and Medicare Levy Surcharge

Australia's ageing population directly impacts the Australian PHI industry as older age groups are more highly represented in PHI than younger age groups and cost significantly more in healthcare than younger groups.

Membership imbalance is not a new problem. In 2000, Lifetime Health Cover (LHC) loadings were introduced to encourage younger people to purchase PHI and address this imbalance.

Under LHC regulations, anyone purchasing PHI for the first time after the age of 30 pays a loading on their premium equal to 2% for each year of age older than 30 (with a maximum loading of 70%). The loading lasts for 10 years. For example, a 40 year-old purchasing PHI for the first time will pay 20% more than the listed premium price for 10 years.

PHA believes it is time to re-examine the LHC policy settings in line with demographic and economic changes that have occurred over the last two decades. We have considered a number of reform options for rebalancing the age profile of consumers in Australia.

²² About the PSR scheme (2016) www.psr.gov.au

One of the most difficult challenges we face in the sector is the cost pressure on younger and healthier people, which is creating headwinds against participation in PHI. Under a community rated system, this causes a risk-pool of higher claimers to develop, which in itself puts upward pressure on premiums. The indexation of the PHI rebate to CPI has greatly exacerbated the affordability pressure and will continue to do so over time.

PHA member funds accept the restoration of the 30% rebate is a challenge in the short run. We therefore propose adjustments to Lifetime Health Cover (LHC) and the Medicare Levy Surcharge (MLS) to update the policy settings to current economic circumstances.

Specifically, our ingoing hypothesis is a premium discount applied to people choosing to join a health fund starting at age 25 could improve participation in this critical demographic.

In addition, we are looking at the impact of adjusting the Medicare Levy at each income threshold so high income earners without PHI contribute more to the cost of the public health system (or are encouraged to take out health insurance); and requiring high income earners to hold both hospital and ancillary cover to avoid the MLS.

PHA is currently researching options to progress this policy reform.

Common terminology, transparency

While market research consistently shows people with private health insurance value the product and want to keep it, the complexity of choosing and using health insurance, while not a first-order issue like affordability, can be daunting. There is also the concern younger people without PHI are increasingly unlikely to take it up due to competing financial priorities, and because they simply don't see the need.

There is no doubt over the last two decades, health fund products of different design have proliferated. This has for the most part been driven by consumer concerns about affordability and desire for cheaper 'bespoke' products, which exclude high cost treatment areas like obstetrics. PHA member funds are aware more can be done to help consumers choose and use their health insurance in this era of increased complexity.

PHA has approached the government initiative of health fund product classification into 'Gold/Silver/Bronze' through the following lens – the system should genuinely simplify consumer choice and not add to complexity, there should be no additional regulatory interference in the design of products, there should be no upward pressure on premiums occurring as a result of the policy, including as a consequence of the implementation process.

PHA supports the current direction of retaining a 'Basic' level of cover as a Complying Health Insurance Product (CHIP) as part of the classification. Basic cover has been a feature of Australia's health care system since at least the 1960s and to remove it is likely to be seen by consumers as limiting their choice of location or treatment options.

In addition, we support the introduction of standard clinical terminology so consumers can compare 'apples with apples' and improved independent mechanisms to assist consumers in navigating the system. The approach to implementation should be 'light touch' and communicated via existing channels like privatehealth.gov.au to avoid prohibitive costs adding to funds' management expenses.

Continue to add value

Out-of-hospital care

Since the advent of Medicare in its current form, health funds have been excluded from funding care provided outside of a hospital. This means legislation specifically prevents private health insurance from covering medical services that are provided out-of-hospital and which are covered by Medicare. These services include GP visits, consultations with specialists (in their rooms) and diagnostic imaging and tests.

In the initial construction of Medicare this made sense but over time two things have occurred which makes this inflexible aspect of the system both inflationary and impractical. First, the emergence of chronic health conditions as the predominant burden of disease, and second the emergence of new technology, particularly in IT & T, which means health services can be safely and effectively delivered in many more care settings than a hospital. Hospitals remain the most expensive setting of care, and are not always the safest care setting for a number of conditions.

PHA recommends the Federal Government review relevant legislation with the objective of permitting health funds to provide funding for services provided out-of-hospital which are either a substitute for hospital care, permit the better integration of care for the elderly and the chronically ill, or which have the potential to prevent avoidable hospital admissions or readmissions. Avoidance of unnecessary hospitalisation is a key factor in keeping premiums down.

Examples of the types of health services that could be better funded as a result include:

- integrated (coordinated) care of people with multiple chronic conditions registered with a GP healthcare home;
- provision of improved health care for people in residential aged care, and the frail aged living at home; and
- improved healthcare options for people in rural and remote Australia.

A number of health funds have made a significant investment in better care of people at risk of complications from chronic disease, with view to preventing avoidable hospital admissions, prolonged length of stay in hospitals and unplanned readmissions. For example, CarePoint, operating in Victoria and WA, is an integrated healthcare pilot supporting both public and private patients battling chronic disease and complex health issues (designed by Medibank and supported by HBF). GPs and allied health professionals are critical to this care model, which helps patients navigate available healthcare and social services. Australian Unity's preventive health arm Remedy Healthcare has recently launched its 'Mindstep' program, which targets people with anxiety and depression who have recently been discharged from hospital, with view to preventing readmission.²³

PHA member funds recognise the key role private hospitals play in the Australian health ecosystem, and while in challenging economic circumstances, all sector participants will need to make compromises, there needs to be something in the PHI Reform agreement for them.

The following elements of the above package will have upside for private hospitals:

1. Measures to improve affordability and participation in private health insurance, 'growing the pie' for private health;
2. Measures to help consumers choose an appropriate level of cover, and a 'low-gap' specialist;
3. Measures to improve access for people on low-premium products to access mental health services.

²³ Remedy Healthcare has spent seven years researching and developing its first in kind mental health program. (November 2015
<http://www.australianunity.com.au/thoughtplus/health-latest/2015/december/remedys-mental-health-first#sthash.4s0RPQMp.dpuf>

In addition, PHA is prepared to support and work with the private hospital sector on improved transparency and consumer protections for private patients treated in public hospitals, particularly those solicited through Emergency Departments.

Removal of the anachronistic red tape preventing health funds from financing out-of-hospital care will enable this type of program to expand and flourish, will enhance the role of primary care in addressing chronic disease and will put downward pressure on premiums.

Out-of-pocket expenses

After premium affordability, out-of-pocket costs are the major area of concern for health fund members. While there are more 'no-gap' services provided than ever before, out-of-pocket costs are rising for those which do attract a gap.

Health fund data shows there is a market for specialist fees; it's just that consumers either don't have access to this information or have great difficulty accessing it. Areas with lower household incomes and more doctors (such as South Australia) have lower gaps, and areas with high household incomes and fewer doctors (such as the ACT) have higher gaps. Health funds have made considerable investments in directory services like Whitecoat (HBF, Bupa, nib) and Healthshare (Medibank, HCF), which aim to provide consumers and their GPs with quick access to information about specialists including scope of practice, location and likely fees and charges.

This work has been progressing but some regulatory barriers have been encountered which should be addressed by Government. These are as follows:

1. Amend section 130 of the *Health Insurance Act 1973* (Cth), to permit health funds to use Medicare Provider Directory Service (PDS) data to maintain a clean and up-to-date database of all Medicare registered providers. Amongst other things the database contains providers' names, addresses and specialties. All funds are provided access to this data strictly only for the purpose of paying claims and are expressly prohibited from using this data to populate a directory;
2. Amend section 133(1)(c) of the *Health Practitioner Regulation National Law Act* (the National Law) and Guidelines which states a person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that uses testimonials or purported testimonials about the service or business. A breach of the National Law may be prosecuted with fines of up to \$10,000 per breach for a body corporate. This has the unintended effect of preventing some customer feedback being provided online. As this is carefully curated on directory sites prior to publication, we feel the status quo is out-of-step with current consumer behaviour and expectations; and
3. Clarify the application of the *Privacy Act* to health professionals who are operating businesses under their own name (in contrast to tradesmen for example who use other business names like 'Bill's Plumbing'.) The privacy laws are designed to protect individuals and not revenue generating entities. This means for health professionals, any data published about the business is subject to the same privacy protections that are provided to consumers under Australian privacy laws. Information such as the number of operations that a particular provider has performed and feedback about that provider from their customers/patients is classified as "sensitive information". Under Australian privacy laws, health funds are not able to publish this data without the provider's permission. It would be in the interests of the consumer if this were to be amended.

Health funds are committed to working with stakeholders and the Parliament to foster greater transparency on medical specialist and allied health quality and out-of-pocket costs, and the industry has received strong support from across the political spectrum for this measure.

PHA is fully committed to a sensible reform plan to improve affordability, participation and value in the private health sector. All of this would be very much in the interest of consumers. Our members understand current community sentiment requires a high degree of accountability and transparency from us as the custodians of members' funds. We have thus committed to returning every dollar saved from PHI reform measures targeting input costs, to members through the premium round. We are also open to working cooperatively with regulators on ensuring appropriate standards of accountability and transparency are defined and met.

CONTAINING COSTS AND IMPROVING VALUE FOR CUSTOMERS

Every aspect of reform health funds are entering into, with and without the support of the Federal Government is aimed at improving PHI for consumers. The impact is across the three key metrics of affordability, participation and value.

In light of the ageing population and increased utilisation of healthcare, affordability can only be achieved in the long-run by careful assessment and management of input costs. These are across three key areas – medical device costs, health professional costs and hospital accommodation costs. This submission has clearly outlined the urgent need to further deflate medical device benefits in line with real market prices. Health funds are also working in co-operation with the Federal Government through the MBS Review Taskforce, and the Australian Commission for Quality and Safety in Healthcare on mechanisms to detect and reduce low-value and wasteful care. These are health interventions, which may still be funded for historical reasons, but where the impact on the patient is at best neutral and at worst positively harmful. All stakeholders agree this area needs continual scrutiny by clinicians and payors, who should collaborate in a system of continuous quality improvement. Already there has been considerable success in some areas of surgical treatment, including spinal surgery for pain, and arthroscopy of the knee, but there is a long way to go.

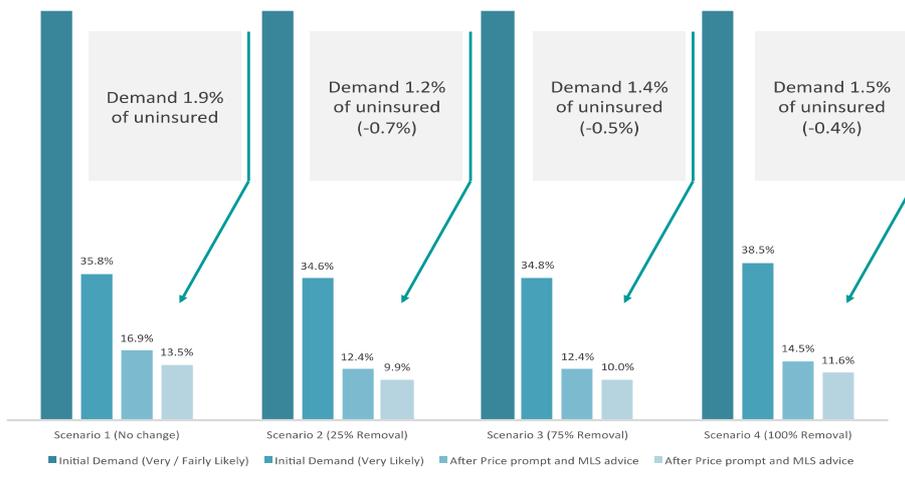
In the area of hospital accommodation costs, regulatory settings must preserve a robust contracting environment to keep downward pressure on costs and positive pressure to maintain a high-quality environment for patients.

It is becoming more urgent to address unnecessary input costs to maintain affordability, as government subsidy to the sector through the PHI rebate is gradually withdrawn, which is increasing financial pressure on consumers.

We have also demonstrated participation in private health insurance is decreasing in younger cohorts, which is creating an increase in premiums for existing members as the risk pool deteriorates to include mainly high claimers.

Consumer market research undertaken in March 2017 indicates there is pent-up demand to join health funds, particularly in younger cohorts, but people with a strong intention to join are being put off by the costs.

New to market intending to purchase
Drop in demand at current and future price points



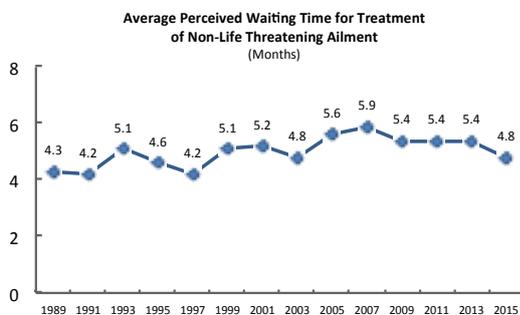
There is a need for policy-makers and health funds to focus attention on participation of people aged under 50. Changing demographics have meant many families are putting off having children until after the age of 30. This removes one of the key triggers for under-30s to take out private health insurance. Once people are over 30, not only do they face the additional cost of the Lifetime Health Cover loading, they find high out-of-pocket charges for obstetrics to manage the pregnancy and ‘booking fees’ put this service further out of reach, and they never take out cover.

Increasingly we are seeing mental health care emerge as the key reason why younger people claim on PHI. Access to dental care while people are looking for a job or a partner is also important, as is the prompt treatment of sporting and recreation related injuries. These are all areas where it can be very difficult to get timely treatment in the public system, however not only do younger people rate their risk of needing these services lower than it is, they often over-estimate their ability to access public hospital services.

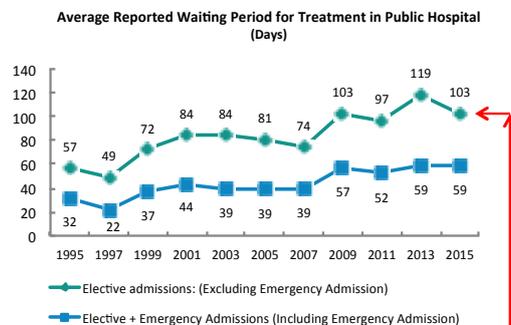


Public hospital waiting times ... perception versus reality

Perception



Reality (Reported)



FACT: Average elective waiting times have more than doubled since turn of century

Section 4.7.2 Question D4 n = 2,741
If you or another member of your family had to go into a public hospital for treatment of an ailment which was not life-threatening, but was a cause of discomfort and pain, how long, if at all do you think you would have to wait to be admitted into a public hospital in your area?

Section 4.7.3 Question A17b(i) n = 2,269
From the time you discovered you required hospital treatment, how long did you have to wait before being admitted to this hospital?

	Top 10 Procedures for Females (25 to 31 years of age)	Number of In-Hospital Treatments funded by PHI	Total Fund Benefits Paid (\$)
1	Mental Health Treatment without Electro convulsion therapy, Sameday	12,128	\$3,784,919
2	Vaginal Delivery, Single Uncomplicated	11,390	\$64,504,231
3	Caesarean Delivery without catastrophic or severe complication and/or comorbidity	8,941	\$72,324,529
4	Other Uterus and Adnexa Procedures for Non-Malignancy, Sameday	5,963	\$7,541,538
5	Vaginal Delivery without catastrophic or severe complication and/or comorbidity	4,908	\$29,968,353
6	Dental Extractions and Restorations	4,763	\$4,437,931
7	Other Female Reproductive System Operating Room Procedures	3,236	\$1,486,119
8	Colonoscopy, Sameday	3,002	\$2,254,388
9	Complex Endoscopy, Sameday	2,970	\$2,427,417
10	Antenatal and Other Obstetric Admissions without catastrophic or severe complication and/or comorbidity	2,805	\$3,992,438

	Top 10 Procedures for Males (25 to 31 years of age)	Number of In-Hospital Treatments funded by PHI	Total Fund Benefits Paid (\$)
1	Dental Extractions and Restorations	3,209	\$3,071,016
2	Mental Health Treatment without Electro convulsion therapy, Sameday	2,855	\$857,232
3	Colonoscopy, Sameday	2,432	\$1,654,194
4	Complex Endoscopy, Sameday	1,570	\$1,255,838
5	Knee Reconstructions, and Revisions of Reconstructions	1,546	\$8,304,684
6	Other Knee Procedures	1,502	\$3,424,149
7	Gastrosocopy, Sameday	1,331	\$654,183
8	Haemodialysis	1,044	\$374,503
9	Other Shoulder Procedures	1,019	\$6,061,339
10	Treatment for Drug Disorders, Sameday	1,007	\$288,486

The review of Lifetime Health Cover, with view to offering a discount to people joining aged between 25 and 30, will in addition to the other proposed measures, help attract younger people into health insurance.

It is however the responsibility of health funds to ensure younger people are fully informed about the availability and access to those services most meaningful to them. This means continuing initiatives to provide access to low-or no out-of-pocket dental and allied health care, and measures to help all consumers choose specialist services based on availability, location, quality and price. The directory websites described in the document above are a very important

consumer transparency initiative championed by health funds that will benefit the whole health system. It is critical the government acts quickly to remove remaining regulatory barriers to their development.

The final challenge is to balance the affordability needs of customers with value. The challenge arises because consumer perceptions of value are not uniform, but vary with financial circumstances, health status and life stage. Contrary to the pervasive myth all consumers want products with a very broad level of coverage, as health inflation has fuelled affordability concerns; consumers have increasingly demanded more bespoke products with relevance to specific life stages. For example, people aged over 45 seeking products which exclude pregnancy and assisted reproductive technology, both of which are very costly to insure, and are often only found in top cover.

The rise of products with exclusions and excesses over the last two decades has occurred in lockstep with increasing complexity and cost of health services. This means it can be challenging for consumers to choose and use their health insurance, which after premium affordability and medical out-of-pocket costs is the third biggest concern people have about private health insurance. The emergence of aggregators and intermediaries has on the surface assisted consumers with choice, however has had the consequence of driving choice predominantly based on price and not health status. The issue that no commercial aggregator website compares all health fund products is also potentially misleading.

PHA member funds have recognised the importance of consumers making a fully informed choice about their health insurance. We are working in co-operation with the Federal Government and industry stakeholders on ways to help consumers choose and use their health insurance. This includes introduction of the gold/silver/bronze classification system, standardised clinical terminology to define exclusions and measures to help consumers navigate the system in an unbiased way to select products that meet their needs. Member funds have already made a significant investment in this process.

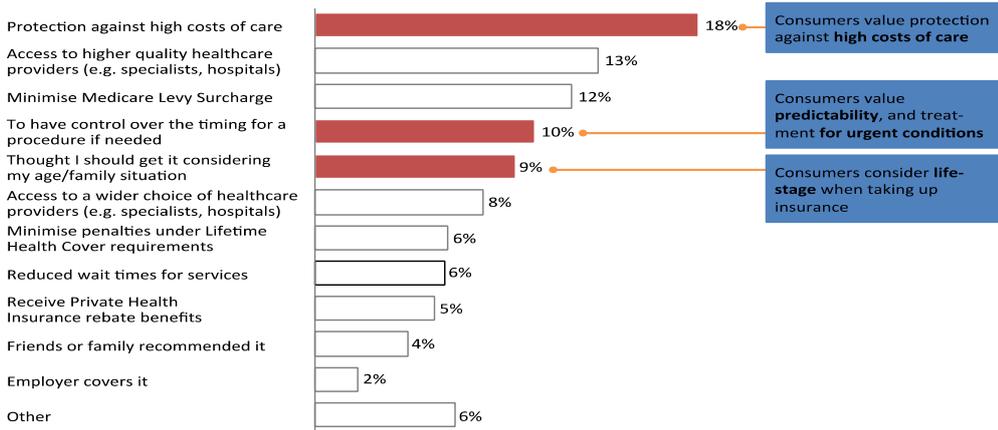
There has been considerable commentary in the media about low-cost policies, giving some the label of 'junk' policies and suggested they should be 'weeded out'. PHA urges caution in taking a heavy-handed approach to low-cost policies.

Since the 1970's there has been a 'Basic Table', which included health funds products covering treatment in a public hospital with choice of doctor and some extras. Historically these products have been predominantly chosen by people in rural and regional Australia who have limited access to private hospitals, but need continuity of specialist care. They have also been used by people on lower incomes with chronic health conditions who are treated by specialists in a public hospital setting, for the same reason. There is a core group of mostly older people in this category who would be severely disadvantaged should they be forced to upgrade to more expensive products they don't need.

Furthermore, it has been alleged there are people who are purchasing low-value products to 'avoid the medicare levy surcharge'. Market research undertaken by PHA in 2016, indicates 12% of consumers surveyed took out PHI for this purpose.

Coverage levels should take into account factors of importance to consumers

What is the main reason you purchased PHI? Percent



SOURCE: PHA Consumer survey 2016, n=2,384

This is however a reflection of the intent of this policy. People on higher incomes who take this option often upgrade to higher value products when their health status changes and they need to claim. They are also making a positive contribution to the risk equalisation pool, which in itself puts downward pressure on premiums. The impact of this should not be discounted.

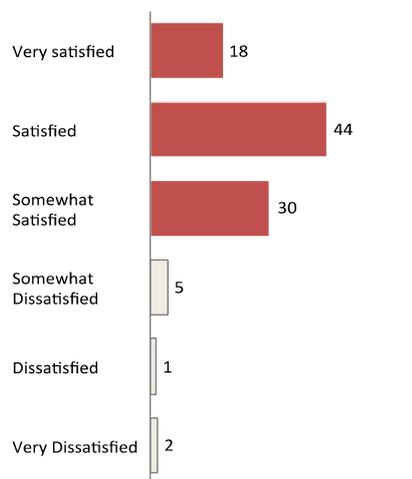
What is most important, is not that there is a range of price points and coverage available, but that consumers fully understand what they are purchasing and make a decision that best meets their financial and health needs.

This is why PHA member funds are supporting increased transparency, and measures to help consumers choose and use their health insurance.

Most people are satisfied with their experience purchasing PHI, but some are confused by product features

How satisfied were you with your experience purchasing private health insurance?

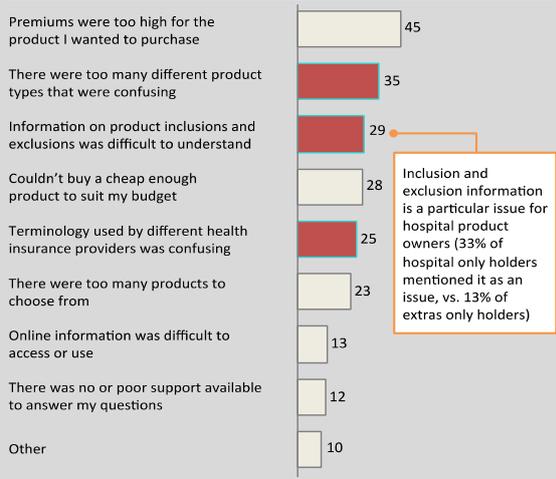
Percent



SOURCE: PHA Consumer survey 2016, n=2,384

Why were you less than satisfied with your experience purchasing private health insurance?

Percent times mentioned by those less than satisfied



Inclusion and exclusion information is a particular issue for hospital product owners (33% of hospital only holders mentioned it as an issue, vs. 13% of extras only holders)

CONCLUSION

Private Healthcare Australia welcomes the Senate inquiry into the value and affordability of private health insurance as this is an issue of huge relevance to the Australian public, whether or not they are members of a health fund. In our submission, we have identified key challenges faced by the sector, as well as practical and achievable policy adjustments that will ensure the sustainability of the Australian health system in to the future. There is no ask for additional government funding, but there needs to be the political will to work proactively with health funds and other private health stakeholders to improve the quality and affordability of the sector for future generations.

The current government has made a worthwhile start with the work of the Private Health Ministerial Advisory Committee (PHMAC) and the MBS Review well underway. Full implementation of the short and long-run reforms we have proposed however, will ensure private health in Australia remains affordable, valuable and sustainable for consumers as the Australian healthcare system confronts the challenges of an ageing population.

The PHI industry is fully committed to a sensible reform plan to improve affordability, participation and value in the private health sector. Health funds have repeatedly committed to returning every dollar saved from PHI reform measures targeting input costs to members through the premium round, as demonstrated in the most recent premium process. This in turn will keep pressure off the public hospital system and benefit all Australians.

In addition to this commitment, we are actively working with government, and investing in ways to help consumers navigate the private health system and manage out-of-pocket medical costs.

ABOUT PRIVATE HEALTHCARE AUSTRALIA

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body that currently has 20 registered health funds throughout Australia, and collectively represents 96% of people covered by private health insurance.

PHA member funds today provide healthcare benefits for over 12.8 million Australians. Private health insurance is provided through organisations registered under the *Private Health Insurance Act 2007*. The financial performance of registered health funds is monitored by the Australian Prudential Regulation Authority (APRA), an independent Australian Government body, to ensure solvency and capital adequacy requirements are met. Other regulators actively monitoring the performance of health funds are the Commonwealth Department of Health and Sport, the Australian Securities and Investment Commission (ASIC), the Australian Competition and Consumer Commission (ACCC) and the Commonwealth Ombudsman.

All members of Private Healthcare Australia are registered as health benefits organisations with the Commonwealth Government and comply with Government standards and regulations on benefits and solvency.