The Senate

Community Affairs References Committee

Value and affordability of private health insurance and out-of-pocket medical costs

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45th Parliament

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TABLE OF CONTENTS

ABBREVIATIONS

AAPD	Australian Association of Paediatric Dentists
ABF	Activity Based Funding
ACCC	Australian Competition and Consumer Commission
ADA	Australian Dental Association
AHHA	Australian Healthcare and Hospitals Association
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ANMF	Australian Nursing and Midwifery Federation
APHA	Australian Private Hospitals Association
APRA	Australian Prudential Regulation Authority
ASX	Australian Stock Exchange
ATSI	Aboriginal and Torres Strait Islander
Code	Private Health Insurance Code of Conduct
committee	Senate Community Affairs References Committee
CPI	Consumer Price Index
Department	Department of Health
DRG	Diagnosis Related Group
EY	Ernst and Young
HHS	Health and Hospital Service
HICAPS	Health Industry Claims and Payments Service
IHPA	Independent Hospital Pricing Authority
Johnson and Johnson	Johnson and Johnson Medical Pty Ltd
LHC	Lifetime Health Cover

LHD	Local Health District
Minister	The Hon. Greg Hunt MP, Minister for Health
MLS	Medicare Levy Surcharge
MTAA	Medical Technology Association of Australia
NASOG	National Association of Specialist Obstetricians and Gynaecologists
NRHA	National Rural Health Alliance
OECD	Organisation for Economic Co-operation and Development
OSR	own source revenue
PHAA	Public Health Association of Australia
PHIIA	Private Health Insurance Intermediaries Association
PHIO	Private Health Insurance Ombudsman
PHMAC	Private Health Ministerial Advisory Committee
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australian College of Physicians
RACS	Royal Australasian College of Surgeons
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Reform Agreement	National Health Reform Agreement
SARRAH	Services for Australian Rural and Remote Allied Health
SHN	Speciality Health Network
WIES	Weighted Inlier Equivalent Separation

LIST OF RECOMMENDATIONS

Recommendation 1

5.11 The committee recommends that the Commonwealth Government undertake an evaluation of the value provided by 'basic' policies as a fourth product category (Gold/Silver/Bronze/Basic). Following that evaluation, the Commonwealth should determine whether consumers are best served by a three-tier or a four-tier product categorisation system.

Recommendation 2

5.18 The committee recommends that the Minister for Health require private health insurers to publish all rebates by policy and item number.

Recommendation 3

5.23 The committee recommends that the Minister for Health instruct the Department of Health to publish the fees of individual medical practitioners in a searchable database.

Recommendation 4

5.26 The committee recommends that the Commonwealth Government ask the appropriate body (such as the Australian National Audit Office, Department of Health, Australian Prudential Regulation Authority, Australian Competition and Consumer Commission or the Private Health Insurance Ombudsman) to report in 12 months on whether the benefits from the Prostheses List reforms are being passed on to consumers.

Recommendation 5

5.29 The committee recommends that the Commonwealth Government provide additional funding to the Private Health Insurance Ombudsman to enable it to widely promote its upgraded website and comparison service to consumers.

Recommendation 6

5.34 The committee recommends that all state and territory governments review policies and practices regarding private patient election to ensure that all patients can provide informed financial consent.

Recommendation 7

5.35 The committee recommends that the Commonwealth Government and state governments ensure that public hospitals provide equality of access for public and private patients based only on clinical need and not on insurance status.

Recommendation 8

5.37 The committee recommends that the issue of private patient adjustments be considered in the context of negotiations on the next National Health Agreement, consistent with the Minister's broader approach.

Recommendation 9

5.41 The committee recommends that the Commonwealth Government consider extending the Broader Health Cover provisions of the *Private Health Insurance Act 2007* on the basis that such services, if offered, do not undermine the universality of Medicare by creating a two-tiered primary health care system, do not inflate costs for the Commonwealth by introducing another payer, are provided on a comprehensive basis and do not delay treatment or lead to greater out-of-pocket costs.

Recommendation 10

5.42 The committee recommends that the Commonwealth Government review current regulations to allow private health insurers to rebate out-of-hospital medical treatment where it is delivered, on referral, in an out-patient, community or home setting.

Recommendation 11

5.44 The committee recommends that private health insurers engage in negotiations with private hospitals and paediatric dentists to urgently resolve the issues surrounding paediatric dentistry.

Recommendation 12

5.47 The committee recommends that the Commonwealth Government amend relevant legislation to prohibit the current practice of differential rebates for the same treatments provided under the same product in the same jurisdiction.

Recommendation 13

5.49 The committee recommends that the Australian Competition and Consumer Commission reconsider whether private health insurers' use of data obtained from the Health Industry Claims and Processing Service is anti-competitive.

5.50 The committee also recommends the Commonwealth Government amend relevant legislation to ensure there is a clear delineation between data obtained from the Health Industry Claims and Processing Service and data used by health insurers competing for services against other non-preferred providers. This should extend to a requirement that such data be maintained strictly and separately and that private health insurers should be prohibited from using data gained through claims processes for commercial gain.

Recommendation 14

5.52 The committee recommends that the Commonwealth Government require intermediaries to disclose any commissions received from private health insurers for the service.

Recommendation 15

5.53 The committee recommends that the Commonwealth Government amend relevant legislation to require all private health insurers disclose executive remuneration and other administrative costs.

Recommendation 16

5.55 The committee recommends that the Minister for Health amend the legislation to require private health insurers to provide adequate written notice of changes to policies and eligibility to allow consumers to consider alternatives, and that this notice clearly communicates changes to the policy that may affect the insured person's coverage, especially where such changes may be detrimental. Where relevant, the notice period should correspond to the eligibility period for any service or treatment affected by the changes.

Recommendation 17

5.60 The committee recommends that the Private Health Insurance Ombudsman advise the Minister for Health in 2019 on additional measures that could be introduced to make private health insurance easier to understand that are in addition to significant reforms being introduced in 2018 and 2019.

Recommendation 18

5.61 The committee recommends that the Australian Competition and Consumer Commission, in consultation with the Private Health Insurance Ombudsman, commence work to establish a new code of conduct that will provide the framework for engagement between private health insurers and healthcare providers.

Recommendation 19

5.62 The committee recommends that the Minister for Health write to the Private Health Insurance Ombudsman to request advice on the disclosure of limitations to treatment type or frequency which may arise from contract arrangements with individual hospitals or providers that impact on members' access to services and out-of-pocket costs.

Chapter 1

Introduction

1.1 Australia operates a mixed public and private healthcare system. Under this system, Australians have the freedom to choose whether they wish to use the public health insurance provided by Medicare or if they wish to be treated privately.

1.2 Since the late 1990s, the Commonwealth Government has encouraged Australians to take out private hospital cover and remove pressure on public hospitals by providing tax and financial incentives.

1.3 In the Senate Community Affairs References Committee's (committee) *Price regulation associated with the Prostheses List Framework* inquiry, the committee received evidence from industry stakeholders that private health insurance was becoming increasingly unaffordable for consumers.[1]

1.4 Submitters to this inquiry confirmed that some consumers are experiencing difficulty to pay private health insurance premiums and/or out-of-pocket costs.[2] In 2015–16, Australians paid $11.4 billion for private hospital policies and $4.5 billion for general treatment policies.[3] Australians also paid $483 million in excesses and co-payments for hospital services and $706 million out-of-pocket for medical services.[4] For general treatment, Australians paid $4.7 billion out-of-pocket.[5] These amounts do not include the substantial contributions of Commonwealth, state and territory governments.[6]

1.5 Private health insurance premiums have become less affordable at the same time that exclusions and co-payments have increased. The number of Australians covered by a policy with a co-payments or exclusions increased from seven per cent in June 2007 to 40 per cent in 2017.[7] The increase in premiums and the increase in the number of exclusions in policies has eroded the value of private health insurance and led some people to drop or downgrade their cover.

Trends in policy coverage

1.6 Graph 1.1 provides a brief overview of the reforms that have influenced individuals to take up private health insurance. As Graph 1.1 demonstrates, Australia

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1 Senate Community Affairs References Committee (committee), *Price regulation associated with the Prostheses List Framework*, May 2017, p. 63.

2 NSW Council of Social Service, *Submission 7*, pp. 12, 22; Consumers Health Forum of Australia, *Submission 17*, pp. 3, 5–6.

3 Department of Health (Department), *Submission 127*, p. 34.

4 *Submission 127*, p. 34.

5 *Submission 127*, p. 34.

6 *Submission 127*, p. 34.

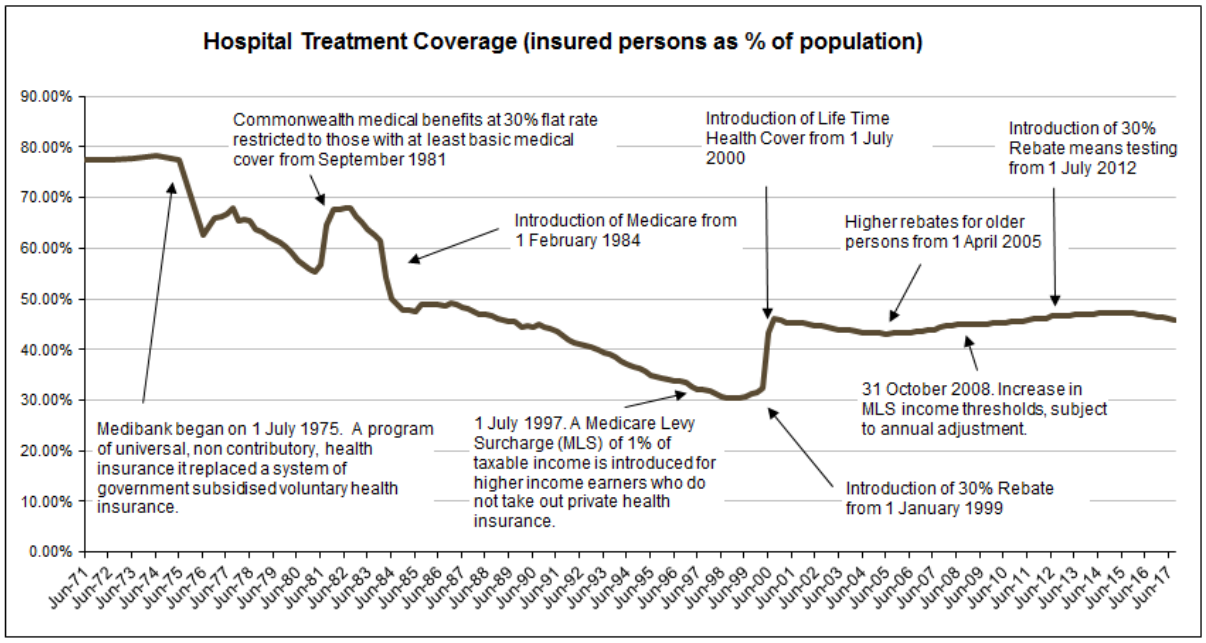
7 Australian Private Hospitals Association (APHA), *Submission 80*, p. 12.

has historically enjoyed high levels of private health coverage which declined until the late 1990s. At that time, the Commonwealth Government introduced three measures to encourage Australians who could afford to do so to take up private health insurance and therefore take pressure off public hospitals.[8]

1.7 In 1997, the Medicare Levy Surcharge (MLS) was introduced as a surcharge tax on high income earners who were not covered by a private hospital policy.[9] In 1999, a 30 per cent private health insurance rebate was introduced.[10] On 1 July 2000, the Lifetime Health Cover (LHC) loading was introduced.[11] The LHC allows a private health insurer to charge a loading of two per cent of the premium per year that the person was not covered by a private hospital policy after the person turns 30. The insurer may continue to charge the loading for ten years.[12]

1.8 Together, these incentives stabilised private health insurance coverage at approximately 50 per cent of the population as Graph 1.1 demonstrates.

Graph 1.1—Hospital treatment coverage as a per cent of population



Source: Australian Prudential Regulation Authority, *Private Health Insurance Membership Trends*, September 2017.

1.9 These incentives and their efficacy in encouraging Australians to maintain levels of coverage is discussed in greater detail in Chapter 3.

8 Catholic Health Australia, *Submission 238*, [p. 10].

9 *Submission 238*, [p. 10].

10 *Submission 238*, [p. 10].

11 Department, *Submission 127*, p. 26.

12 *Submission 127*, p. 24.

Previous inquiries

1.10 A number of previous inquiries have considered aspects of private health insurance.

1.11 In 2007, the Senate Standing Committee on Community Affairs reported on the *Private Health Insurance Bill 2006 [Provisions] and 6 related bills*.[13] The committee recommended the bills be passed with amendment.

1.12 In 2014, the Senate Community Affairs References Committee reported on its inquiry into *Out-of-pocket costs in Australian healthcare*.[14] The report considered private health insurance, but made no specific recommendations.

1.13 In 2015, the Productivity Commission delivered its *Efficiency in Health* report.[15] The Productivity Commission recommended that the Minister for Health conduct a review of private health insurance regulation and that trials be conducted of different private health insurance products.[16]

1.14 In September 2016 the Hon. Sussan Ley MP announced the establishment of the Private Health Ministerial Advisory Committee (PHMAC).[17] The then Minister for Health tasked PHMAC with investigating reforms that would increase competition and provide value for money for consumers.[18] Therefore, the former minister would conduct a review.

1.15 On 13 October 2017, the Minister for Health, the Hon. Greg Hunt MP (Minister) announced the results of the PHMAC review.[19] The reforms announced included developing 'gold', 'silver', 'bronze' and 'basic' categories for classifying private health insurance products, developing standard definitions of medical procedures across products and allowing travel and accommodation benefits to be included in hospital policies to assist consumers living in regional and rural areas.[20] These reforms are discussed in Chapter 5.

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13 Senate Standing Committee on Community Affairs, *Private Health Insurance Bill 2006 [Provisions] and 6 related bills*, February 2007.

14 Committee, *Out-of-pocket costs in Australian healthcare*, August 2014.

15 Productivity Commission, *Efficiency in Health*, Research Paper, April 2015.

16 Productivity Commission, *Efficiency in Health*, Research Paper, April 2015, pp. 70–71.

17 The Hon. Sussan Ley MP, former Minister for Health, 'New Committee to provide recommendation on private health insurance reform', *Media release*, 8 September 2017, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2016-ley056.htm (accessed 6 December 2017).

18 The Hon. Sussan Ley MP, 'New Committee to provide recommendations of private health insurance reform', *Media release*, 8 September 2017.

19 Department, *Submission 127—Attachment 1*, [pp. 1–2].

20 *Submission 127—Attachment 2*, [p. 1].

Role of private health insurance

1.16 The private health insurance industry in Australia is based on a system of 'community rating', which enables all consumers to access private health insurance—regardless of age or likelihood to make a claim—and an insurer cannot refuse to insure an individual.[21] To facilitate the community rated private health insurance model, a risk equalisation mechanism is utilised to pool high-cost claims and distribute them between insurers. This ensures that insurers with a higher risk consumer profile, such as older consumers, are not competitively disadvantaged.

1.17 To keep private health insurance premiums low, insurers need to attract younger and healthier members to balance out the risk profile of older, more costly, members of the existing pool.[22] Attracting younger healthier members places downward pressure on premiums by balancing the risk profile of the pool with lower-risk claimants.[23]

Report structure

1.18 This report is presented in five chapters:

- this first chapter provides a background to the committee's inquiry and an overview of the value and affordability of private health insurance and out-of-pocket medical costs in Australia;
- **Chapter 2** examines the challenges faced by consumers in terms of the affordability and out-of-pocket medical costs associated with private health insurance, including trends in the decline and downgrading of coverage;
- **Chapter 3** examines the economic structures of private health insurance, including factors which increase and constrain premiums;
- **Chapter 4** examines the role of private health insurance in different health contexts, including public hospitals, private and day hospitals, dentistry, allied and primary health care;
- **Chapter 5** concludes the committee's considerations and makes recommendations.

Conduct of the inquiry

1.19 On 29 March 2017, the Senate agreed that on 1 June 2017 it would refer the value and affordability of private health insurance and out-of-pocket medical costs to the committee for inquiry and report, with particular reference to:

(a) private and public hospital costs and the interaction between the private and public hospital systems including private patients in public hospitals and any impact on waiting lists;

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21 Department, *Submission 127*, p. 2.

22 NIB, *Submission 24*, p. 10.

23 *Submission 24*, p. 10.

(b) the effect of co-payments and medical gaps on financial and health outcomes;

(c) private health insurance product design including product exclusions and benefit levels, including rebate consistency and public disclosure requirements;

(d) the use and sharing of membership and related health data;

(e) the take-up rates of private health insurance, including as they relate to the Medicare levy surcharge and Lifetime Health Cover loading;

(f) the relevance and consistency of standards, including those relating to informed financial consent for medical practitioners, private health insurance providers and private hospitals;

(g) medical services delivery methods, including health care in homes and other models;

(h) the role and function of:

(i) medical pricing schedules, including the Medicare Benefits Schedule, the Australian Medical Association fee schedule and private health insurers' fee schedules,

(ii) the Australian Prudential Regulation Authority (APRA) in regulating private health insurers, and

(iii) the Department of Health and the Private Health Insurance Ombudsman in regulating private health insurers and private hospital operators;

(i) the current government incentives for private health;

(j) the operation of relevant legislative and regulatory instruments; and

(k) any other related matter.[24]

1.20 On 16 November 2017, the Senate granted an extension of time for reporting to 15 December 2017.[25] The committee presented two interim reports on 15 December 2017 and 18 December 2017 advising that the committee would present its final report on 19 December 2017.

Submissions

1.21 The inquiry was advertised on the committee's website and the committee wrote to 108 stakeholders inviting them to make submissions.[26]

1.22 The committee invited submissions to be lodged by 28 July 2017.

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24 *Journals of the Senate*, No. 37, 29 March 2017, p. 1220.

25 *Journals of the Senate*, No. 71, 16 November 2017, p. 2252.

26 The committee's inquiry website can be located at: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Privatehealthinsurance (accessed 8 December 2017).

1.23 The committee received 293 submissions. A list of submissions provided to the inquiry is available on the committee's website and at Appendix 1.

Public hearings

1.24 The committee held two public hearings: one in Canberra on 5 July 2017 and one in Sydney on 31 October 2017.

1.25 A list of the witnesses who provided evidence at the public hearings is available at Appendix 2.

Note on references

1.26 Some references to *Committee Hansard* in this report are to the proof transcripts. Page numbers may vary between the proof and official transcripts.

Chapter 2

Consumers

2.1 This chapter considers the difficulties faced by private health insurance consumers in terms of affordability and out-of-pocket costs. This chapter also examines why there has been an increase in the number of individuals dropping or down-grading their private health insurance.

Number and content of policies

2.2 Throughout the inquiry, submitters raised concerns about the complexity of private health insurance products and the lack of information provided by insurers.[1] Many submitters noted that a greater number of available policies, changes to available benefits, difficult to understand terminology and a rise in non-comprehensive policies added to complexity for consumers.[2]

2.3 In June 2015, the Australian Competition and Consumer Commission (ACCC) noted there were approximately 46 500 private health insurance products on offer.[3] At the same time, research has suggested that up to 60 per cent of Australians have low levels of health literacy.[4]

2.4 The Commonwealth Ombudsman and Choice emphasised that health insurance policies are often unnecessarily complex and difficult for consumers to understand.[5] Both submitters noted that this complexity is compounded by private health insurers using different terminology to explain similar concepts. Choice noted that 'complex jargon makes it challenging for consumers when reading, comparing and understanding their policies'.[6] The Commonwealth Ombudsman further stated that the 'information provided by health insurers causes a number of problems for some consumers who consider the policy they received does not match their expectations.'[7] One consumer noted the difficulty in finding appropriate coverage and comparing it to other private health insurance policies:

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1 Australian Healthcare and Hospitals Association (AHHA), *Submission 3*, pp. 9–10; Breast Cancer Network Australia, *Submission 12*, pp. 6–7; Royal Australasian College of Physicians (RACP), *Submission 11*, pp. 3–5; Commonwealth Ombudsman, *Submission 19*, p. 5; Consumers Health Forum of Australia, *Submission 17*, p. 6.

2 Mr John Biviano, Acting Chief Executive Officer, Royal Australasian College of Surgeons (RACS), *Committee Hansard*, 5 July 2017, p. 9; Choice, *Submission 207*, pp. 13–16; Private Healthcare Australia, *Submission 18*, p. 24.

3 Australian Competition and Consumer Commission (ACCC), *Communicating changes to private health insurance benefits: A report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance: For the period 1 July 2014 to 30 June 2015*, p. 35; RACP, *Submission 11*, p. 3.

4 Consumers Health Forum of Australia, *Submission 17*, p. 6.

5 Commonwealth Ombudsman, *Submission 19*, p. 5; Choice, *Submission 207*, p. 13.

6 Choice, *Submission 207*, p. 13.

7 Commonwealth Ombudsman, *Submission 19*, p. 5.

> My wife is a doctor and we have two children. After having decided recently that we would not be having any more children we thought we would investigate if we could obtain a better rate from another fund as the Doctors fund does not let you separate maternity cover. We spent a few weeks doing so but ended up very confused. Trying to find which [policy] is the best for the consumer is very difficult and the government needs to act.[8]

Exclusions, co-payments and changes

2.5 The number of policies with exclusions or co-payments has increased dramatically in recent years.[9] According to the Australian Private Hospitals Association (APHA) citing Australian Prudential Regulation Authority (APRA) data, the number of people covered by exclusionary policies has increased from seven per cent in June 2007 to 40 per cent in 2017.[10]

2.6 The Department of Health (Department) noted that the most commonly excluded services include: heart investigations and surgery, eye surgery, pregnancy and birth related services and hip and knee replacements.[11]

2.7 These exclusions mean that individuals who use the private healthcare system are left with a lower value policy.[12] Day Hospitals Australia noted that the rise in exclusions can lead to unnecessary stress for policy holders when they require care, particularly if exclusions in a policy are not properly explained:

> The failure by health funds to clearly explain the policy holders [sic] cover and the associated product restrictions and exclusion, at the time of purchase, creates enormous stress for the consumer when they require hospital services.[13]

2.8 The committee heard evidence regarding the influence that co-payments and 'gaps' have on driving up medical costs.[14] While some health funds have 'no gap' arrangements with certain providers, these may not be the providers the patient is referred to. A patient diagnosed with breast cancer experienced the financial impact of this gap:

> I queried the gap with the private health fund and they said to me: 'Well you've got the wrong surgeon' and I said: 'Well when you're told you've got breast cancer, you don't say "hold on a minute, I'll go find another surgeon"'. You're sort of overwhelmed by the diagnosis and you want to get

8 Choice, *Submission 207*, p. 13 (brackets in original).

9 RACP, *Submission 11*, p. 3.

10 Australian Private Hospitals Association (APHA), *Submission 80*, p. 12.

11 Department of Health (Department), *Submission 127*, p. 20.

12 AHHA, *Submission 3*, p. 11.

13 Day Hospitals Australia, *Submission 91*, p. 5.

14 AHHA, *Submission 3*, pp. 3–4; Breast Cancer Network Australia, *Submission 12*, pp. 4–5.

> the treatment. I had confidence in him (the surgeon) but not in his bills. It was a lot of money we weren't expecting to pay.[15]

2.9 Another consumer noted the large and unexpected out-of-pocket payment they faced when their policy changed despite holding top cover:

> I had a 15-year policy with Medibank Private which I thought was "Top Cover" but when the daughter needed braces and an operation, no cover. $16,000 out of pocket despite the $3500 per year payments. Policies change and cover degrades we were not aware [sic].[16]

2.10 COTA Australia noted that older people are also susceptible to unexpected out-of-pocket costs:

> A recurring story…is older people having maintained [private health insurance] for decades, only to find when they need to draw on it in later life they cannot realise the benefits because they cannot afford to meet the co-payments or other out-of-pocket costs associated with a procedure or treatment.[17]

2.11 Dr Michael Gannon, President of the Australian Medical Association (AMA), outlined the case of an elderly woman who was recently told by her insurer that her surgery was covered. However, the insurer decided not to pay after the surgery was performed, leaving the woman out of pocket by $7000.[18] Dr Gannon suggested that the insurer may not have paid because evidence of the clinical necessity of the surgery was not provided to the insurer prior to surgery.[19]

2.12 The AMA suggested to the committee that changes to a policy after purchase had the capacity to shake consumer confidence in private health insurance:

> When policies change haphazardly and reduce choice, consumers lose faith that the product provides value for money. Private health insurance provides choice for the patient and without that choice, its value is diminished.[20]

Affordability and rising out-of-pocket costs

2.13 Some submitters raised concerns about rising out-of-pocket costs and the difficulties faced by consumers in accurately estimating these costs before and after they received treatment.[21]

2.14 A 2015 poll on healthcare and insurance in Australia conducted by Ipsos found that Australians were most concerned about the affordability of private health

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15 Breast Cancer Network Australia, *Submission 12*, p. 4 (brackets in original).

16 Consumers Health Forum of Australia, *Submission 17*, p. 11.

17 COTA Australia, *Submission 88*, p. 6.

18 Dr Michael Gannon, President, Australian Medical Association (AMA), *Committee Hansard*, 31 October 2017, p. 32.

19 Dr Gannon, *Committee Hansard*, 31 October 2017, p. 32.

20 AMA, *Submission 58*, p. 9.

21 Consumers Health Forum of Australia, *Submission 17*, p. 9.

insurance.[22] Of those surveyed, 61 per cent of people identified the cost of premiums as the primary reason for allowing their private health insurance to lapse.[23] A further 71 per cent of people without private health insurance reported that the primary reason was that premiums were too high.[24] Further research commissioned by Private Healthcare Australia shows that if trends of low-wage growth and increasing premiums continue, private health insurance will 'potentially become unaffordable for up to one in five current hospital policyholders within the next 5-6 years'.[25]

2.15 Ms Alison Verhoeven, Chief Executive of the Australian Health and Hospitals Association (AHHA) noted that numerous Australians over the age of 50 held concerns that affordability was a barrier to purchasing private health insurance.[26]

2.16 Ms Verhoeven told the committee that the affordability of private health insurance was affecting uptake among the Aboriginal and Torres Strait Islander (ATSI) community and the elderly.[27] Ms Verhoeven referred the committee to the most recent data available, an Australian Institute of Health and Welfare study from 2012–13, that showed that only 20 per cent of ATSI adults had private health insurance and 72 per cent indicated they could not afford private health insurance, or believed it was too expensive.[28]

2.17 Concerns about affordability have led to an increase in the number of members who have downgraded their private health insurance. As the figure below demonstrates, HBF is one company that has experienced an increase in policy downgrades.

22 Private Healthcare Australia, *Submission 18*, p. 11.

23 *Submission 18*, p. 11.

24 *Submission 18*, p. 12.

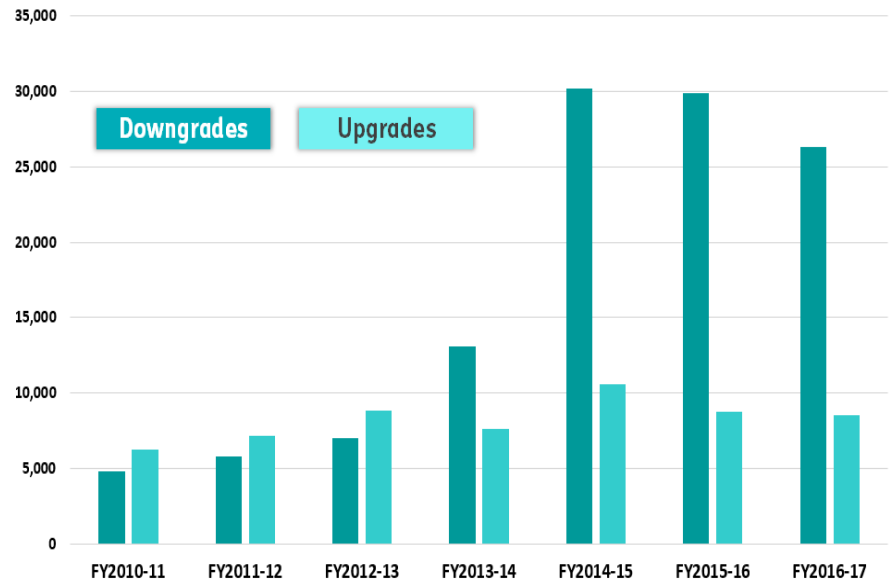
25 *Submission 18*, p. 12.

26 Ms Alison Verhoeven, Chief Executive, AHHA, *Committee Hansard*, 5 July 2017, p. 20.

27 Ms Verhoeven, *Committee Hansard*, 5 July 2017, p. 20.

28 Ms Verhoeven, *Committee Hansard*, 5 July 2017, p. 20.

Graph 2.1—HBF Policy upgrades and downgrades between FY2010–11 and FY2016–17



Source: HBF, *Submission 63*, p. 6.

2.18 HBF also noted a dramatic increase in the number of its members who took out 'less comprehensive products'.[29] In 2009–10, 31 per cent of HBF members chose 'top hospital' coverage.[30] By 2017 the percentage of HBF members who chose 'top hospital' cover had fallen to 14 per cent.[31]

2.19 Submitters expressed concern about rising out-of-pocket costs. In Australia, out-of-pocket costs now account for roughly 20 per cent of healthcare expenditure.[32] According to the AHHA, this figure is higher than other similar countries such as Canada (14 per cent), New Zealand (13 per cent) and the United Kingdom (10 per cent), though similar to the Organisation for Economic Co-operation and Development (OECD) average.[33]

2.20 A similar trend in higher out-of-pocket costs was identified by a number of specialist health organisations. The Australian Federation of AIDS Organisations and the National Association of People with HIV Australia noted concerns about the affordability of HIV medication:

> Each time a medication is dispensed, there is a co-payment – currently $38.80 at the general rate, and $6.30 at the concessional rate. In addition to the costs of HIV medication, many people with HIV pay additional co-payments for treatments associated with other HIV-related medical conditions, for example the control of lipids, diabetes and depression.

29 HBF, *Submission 63*, p. 6.

30 *Submission 63*, p. 6.

31 *Submission 63*, p. 6.

32 Ms Verhoeven, *Committee Hansard*, 5 July 2017, p. 21.

33 Ms Verhoeven, *Committee Hansard*, 5 July 2017, p. 21.

> Research shows that these cumulative costs cause financial stress, and result in some people forgoing treatment, leading to lower medication adherence. The outcomes of this are poorer individual health outcomes and increased onward transmissions, as a result of viral rebound.[34]

2.21 The Australian Dental Prosthetists Association voiced concern that 'dental services generally fall under ancillary or extras cover'.[35] As a result, roughly 10 per cent of insured adults pay all their dental expenses and 76 per cent registered dissatisfaction with the level of rebates received for dental treatment.[36]

2.22 Other issues relating to out-of-pocket costs in dentistry are canvassed in Chapter 4.

2.23 The committee received evidence regarding the scale of fees charged by some specialists.[37] The Royal Australasian College of Surgeons (RACS) drew the committee's attention to the *Surgical Variance Report 2017: General Surgery*.[38] The surgical variance report revealed that there can be significant variations in separation costs, surgeon out-of-pocket costs and out-of-pocket costs for other medical services.[39] Private Healthcare Australia noted that a market exists in specialist fees and it is information that consumers do not have access to.[40]

2.24 RACS acknowledged that some surgeons charged excessive fees and that disclosure of those fees may be one way to address that problem.[41] Dr Stephen Duckett, Director of the Health Program at the Grattan Institute suggested that publishing surgeons' fees would be relatively simple:

> One option, of course, is to say, 'Well, if you want to charge patients you can charge what you like, but there's going to be no rebate if you charge more than 50 per cent above the schedule'—or whatever you like and so force some discipline into the market. The government already collects information about what fees are charged and it would be relatively easy for Medicare to publish the information about fees charged by individual doctors by procedure.[42]

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34 Australian Federation of AIDS Organisations and National Association of People with HIV Australia, *Submission 59*, p. 3.

35 Australian Dental Prosthetists Association, *Submission 77*, [p. 1].

36 *Submission 77*, [p. 1].

37 Mr Biviano, *Committee Hansard*, 5 July 2017, p. 10.

38 Mr Biviano, *Committee Hansard*, 5 July 2017, p. 10; RACS and Medibank Private, *Surgical Variance Report 2017: General Surgery*, p. 2.

39 See for example RACS and Medibank Private, *Surgical Variance Report 2017: General Surgery*, pp. 13–20.

40 Dr Rachel David, Chief Executive Officer, Private Healthcare Australia, *Committee Hansard*, 31 October 2017, p. 48.

41 Mr Biviano, *Committee Hansard*, 5 July 2017, p. 10.

42 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 31 October 2017, p. 18.

2.25 Dr Duckett also suggested that transparency data should not just include fees but a range of outcomes at both the surgeon and hospital level:

> My view is that we should publish the complication rates. We already collect information on that. On every patient discharge from every public and private hospital we collect diagnoses that occurred during the course of admission, whether there was an infection, or a laceration during surgery, and so on. We should publish those rates for hospitals—at the hospital level. Because there is a private contract between the doctor and the patient, we should also publish that information where such a private contract exists. That is, the customer should know in advance what the risk of a complication is with the surgeon from whom they are purchasing their service.[43]

2.26 RACS told the committee that it did not oppose the public disclosure of surgeons fees, but the college did not wish to be the body to publish them:

> We're not opposed; it's just how it's done. We wouldn't be doing it. We're not opposed to an independent agency doing that, as long as they're using the right parameters to judge the fees themselves and how they're presented. Our view is that the best way of managing this is to make sure the consumer has all of the information that they need and also to make sure that they ask the right questions from the very start.[44]

2.27 Submitters commonly raised concerns that increasing out-of-pocket costs are leading to worse health outcomes because individuals are either rejecting or delaying treatment.[45]

2.28 Lynch Syndrome Australia noted that 19 per cent of respondents delayed their surveillance or treatment of Lynch Syndrome due to financials costs. A further eight per cent delayed their cancer treatment for financial reasons.[46]

2.29 The AHHA and the Grattan Institute, among others, highlighted that out-of-pocket costs disproportionately disadvantage those on low incomes.[47]

2.30 On 13 October 2017, The Hon Greg Hunt MP, Minister of Health (Minister) announced that a committee would be established 'to consider best practice models for the transparency of out-of-pocket costs'.[48]

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43 Dr Duckett, *Committee Hansard*, 31 October 2017, p. 15.

44 Mr Biviano, *Committee Hansard*, 5 July 2017, p. 13.

45 AHHA, *Submission 3*, p. 3; Combined Pensioners & Superannuants of NSW, *Submission 15*, p. 9; Haemophilia Foundation Australia, *Submission 50*, p. 7; Cancer Council Australia, *Submission 54*, p. 5.

46 Lynch Syndrome Australia, *Submission 55*, p. 2.

47 Ms Verhoeven, *Committee Hansard*, 5 July 2017, p. 21; AHHA, *Submission 3*, p. 3; Grattan Institute, *Submission 72*, p. 13. See also Combined Pensioners & Superannuants of NSW, *Submission 15*, p. 9.

48 Department, *Submission 127—Attachment 2*, [p. 8].

'Junk' policies

2.31 A number of submitters raised concerns about the use of so-called 'junk' or basic policies. These policies are often cheap and are taken up by people who perceive a lack of value in more expensive private health insurance coverage.[49]

2.32 'Junk' policies include policies which provide coverage for a small number of accidents such as knee reconstructions and investigations but have the majority of services and illnesses excluded or covered in a public hospital. They also often offer private hospital cover for accident and ambulance only.[50]

2.33 Choice identified that often 'junk' or basic policies are taken out by consumers who either:

- want the cheapest policy possible, but do not realise the policy offers limited coverage; or
- who know the policy offers limited coverage, does not intend to use it and take it out solely for tax purposes.[51]

2.34 The Australian Nursing and Midwifery Federation (ANMF) raised concerns about the current tax incentives to encourage consumers to maintain private health insurance and noted a recent ACCC report that found that tax incentives are 'driving consumers to lower-priced policies than they would prefer, with an emphasis on tax rather than health outcomes'.[52]

2.35 Some submitters called for an end to 'junk' policies because they believe that they deliver poor value for consumers.[53] Others called for the withdrawal of the rebate from these 'junk' policies.[54]

2.36 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the National Association of Specialist Obstetricians and Gynaecologists (NASOG) raised concerns about the disproportionate effect these

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49 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), *Submission 51*; Australian Nursing and Midwifery Federation (ANMF), *Submission 70*; Australian Society of Ophthalmologists, *Submission 71*.

50 ANMF, *Submission 70*, [p. 10].

51 Choice, *Submission 207*, p. 33.

52 ANMF, *Submission 70*, [p. 8].

53 Mr Biviano, *Committee Hansard*, 5 July 2017, p. 10; Ms Verhoeven, Committee Hansard, 5 July 2017, p. 22; Mr Michael Roff, Chief Executive Officer, APHA, *Committee Hansard*, 31 October 2017, p. 42; Combined Pensioners and Superannuants Association of NSW, *Submission 15*, pp. 6–7; Consumers Health Forum of Australia, *Submission 17*, pp. 35–36; HBF, *Submission 63*, p. 4; ANMF, *Submission 70*, [pp. 9–10]; Australian Physiotherapy Association, *Submission 74*, p. 3.

54 Choice, *Submission 207*, p. 33; Private Health Insurers Intermediaries Association, *Submission 221*, [pp. 8–9].

junk policies have on women holding private health insurance.[55] RANZCOG argued in their submission:

> These policies may cover small proportions of treatments provided in private hospitals…Because these policies usually do not cover treatments in private hospital for the most important and common needs of women – maternity care, menstrual disorders, gynaecological malignancies, prolapse and incontinence, and private psychiatric facilities in case of a perinatal mental health condition, their value is questionable.[56]

2.37 However, some people do consider that basic policies afford some benefit.[57] The benefit is mostly attributed to contributions made to the risk equalisation pool. This is considered in greater detail in Chapter 3.

Groups who face additional barriers to using private health insurance

2.38 The committee received evidence from groups who considered that they face additional barriers to using their private health insurance. This included people living in rural and regional Australia, people suffering from chronic diseases and those diagnosed with certain illnesses.

Rural and regional consumers

2.39 The committee received substantial evidence from consumers in rural and regional areas. In particular, numerous submitters drew attention to the lack of contracted providers in rural towns.[58] The paucity of private health infrastructure in rural areas can be seen in the figure below.

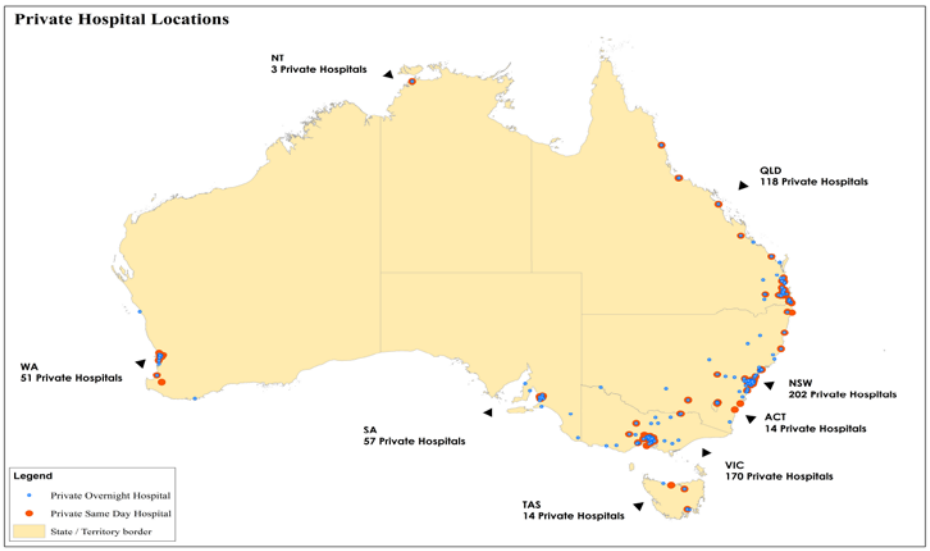
55 RANZCOG, *Submission 51*, p. 5; National Association of Specialist Obstetricians and Gynaecologists (NASOG), *Submission 83*, pp. 3–4.

56 RANZCOG, *Submission 51*, p. 5.

57 Dr David, *Committee Hansard*, 31 October 2017, p. 56; Dr Dwayne Crombie, Managing Director, Private Health Insurance, Bupa Australia, *Committee Hansard*, 31 October 2017, p. 56.

58 ANMF, *Submission 70*, p. 17; National Rural Health Alliance (NRHA), *Submission 48*; Optometry Australia, *Submission 8*; Services for Australian Rural and Remote Allied Health (SARRAH), *Submission 61;* Name withheld, *Submission 128*, p. 3; Australian Physiotherapy Association, *Submission 74.*

Figure 2.1 Locations of private hospitals in Australia



Source: Department, *Submission 127*, p. 6.

2.40 The National Rural Health Alliance (NRHA) noted that 52.3 per cent of individuals living in regional and remote communities do not have private health insurance, compared to 39 per cent in major cities.[59]

2.41 The NRHA argued that private health insurance products need 'to enable better access to services and supports designed specifically to enhance access for rural and remote Australia'.[60] The NRHA's recommendations include an increased range of benefits for non-hospital based services in rural areas, increased access to higher rebates to cover transport and accommodation when forced to travel to receive medical services and progressive reductions based on geographic remoteness to encourage people to take out private health insurance.[61]

2.42 People living in rural areas have also noted their frustration at their inability to access 'preferred providers' and therefore face higher out-of-pocket expenses.[62] In regional areas the scarcity of these providers means that consumers are required to travel long distances if they wish to access one.[63]

2.43 Due to the lack of health facilities in rural areas, patients noted they would often have to travel long distances to receive treatment.[64] As a result of limited access to facilities and lower access to medical specialists compared to urban areas, regional Australians have substantially lower levels of private health membership.[65]

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59 NRHA, *Submission 48*, p. 3.

60 NRHA, *Submission 48*, p. 1.

61 *Submission 48*, p. 1.

62 *Submission 48*, p. 4.

63 *Submission 48*, p. 4.

64 ANMF, *Submission 70*, p. 17.

65 *Submission 70*, p. 17.

2.44 Despite access to fewer medical facilities, individuals who live in rural and remote areas pay the same premium as those living in urban centres. Services for Australian Rural and Remote Allied Health (SARRAH) noted that this is compounded by the additional financial costs faced by those in rural areas who often have to travel greater distances and face additional costs to access adequate healthcare.[66] These issues often lead to rural and regional consumers accessing health services 'less frequently' or relying 'on intermittent outreach services'.[67]

2.45 Numerous submissions have therefore recommended initiatives to improve the value of private health insurance for consumers living in regional and remote locations. The Australian Physiotherapy Association recommended rebates for the non-hospital option to include any transport or accommodation costs to assist rural patients.[68] The ANMF recommended the 'provision of incentives for private practitioners to operate in rural areas' and the 'leveraging of models of care that would enhance access, such as telehealth, remote monitoring and the funding of nurses and allied health professionals to deliver care, closer to people's homes'.[69]

2.46 SARRAH have suggested that private health insurance products 'should be tailored to meet the needs of indigenous and non-indigenous Australians living in rural and remote Australia'.[70] This includes improving access and value through increasing the range of benefits for non-private hospital services and increasing transport and accommodation benefits.

2.47 On 13 October 2017, the Minister announced that insurers would be able to offer accommodation and travel benefits for people in rural and regional areas.[71]

Chronic illnesses

2.48 Other submitters raised concerns about high out-of-pocket expenses for people diagnosed with chronic diseases.[72] Allied Health Professions Australia stated that high costs for this cohort 'reduce the accessibility of services and results in consumers avoiding treatment and increasing their risk of avoidable health issues'.[73]

2.49 Breast Cancer Network Australia told the committee that in 2016 it conducted research into the financial impact of breast cancer. This research showed that women with private health insurance 'typically pay more than twice as much for their breast cancer treatment and care than women without private health insurance'.[74]

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66 SARRAH, *Submission 61*, p. 5.

67 *Submission 61*, p. 5.

68 Australian Physiotherapy Association, *Submission 75*, p. 10.

69 ANMF, *Submission 70*, p. 18.

70 SARRAH, *Submission 61*, p. 5.

71 Department, *Submission 127—Attachment 1*, [p. 1].

72 Allied Health Professions Australia, *Submission 52*.

73 *Submission 52*, p. 4.

74 Breast Cancer Network Australia, *Submission 12*, p. 3.

2.50 The Haemophilia Foundation Australia also undertook an internal survey of individuals diagnosed with the disease. This found that 34 per cent of individuals used the public health care system.[75] The reasons cited for using the public system instead of private healthcare included, management of the bleeding risk and that respondents saw 'limited value in using public health insurance for extras…as the benefits were low and far outweighed by the premium costs'.[76] The majority of respondents said they were debating whether they could afford private health insurance.[77]

2.51 A number of submitters also drew attention to the significant out-of-pocket expenses incurred by individuals diagnosed with particular illnesses. Parkinson's Australia noted that patients can face costs of as much as $50 000 depending on their level of private health insurance coverage.[78]

2.52 Parkinson's Australia told the committee that the high costs associated with treating particular illnesses could be very substantial:

> Parkinson's Australia is aware of people who have had to mortgage their homes or have had to dip into their superannuation to finance their DBS [deep brain stimulation] treatment. There are also many who cannot afford this treatment at all even though it is appropriate for them and is considered cost effective.[79]

2.53 The Royal Australian College of General Practitioners (RACGP) noted that chronic disease management is an area where private health insurance can provide long-term saving to patients.[80] In particular it noted that '[private health insurance] organisations can improve the health of their members and Australians more widely through supporting services not funded through Medicare'.[81] These include chronic disease management, care coordination and general practice modernisation.

2.54 Product design relating to the management of chronic illnesses is considered further in Chapter 4.

Transparency

2.55 Some submitters to the inquiry raised concerns that consumers find it difficult to understand what their health insurance product covers.

2.56 A common recommendation throughout this inquiry has been for the implementation of standardised terminology for health insurance products. The AHHA, for example, recommends a 'mandated simplification and consistency of product information provided across the sector'.[82] It was proposed that this would

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75 Haemophilia Foundation Australia, *Submission 50,* p. 5.

76 *Submission 50,* p. 5.

77 *Submission 50,* p. 6.

78 Parkinson's Australia, *Submission 1,* p. 2.

79 Parkinson's Australia, *Submission 1,* p. 2.

80 Royal Australian College of General Practitioners (RACGP), *Submission 9,* p. 2.

81 *Submission 9,* p. 2.

82 AHHA, *Submission 3,* p. 10.

allow consumers to better compare private health insurance products and increase transparency in the sector.

2.57 The Private Health Insurance Ombudsman (PHIO) provides information for consumers to understand private health insurance policies via the consumer website privatehealth.gov.au.[83] In 2016 this website attracted 1.2 million unique visitors, approximately one-eighth of the roughly 10 million health insurance consumers in Australia.[84] When questioned on these figures, Mr David McGregor, Director of Private Health Insurance for the Commonwealth Ombudsman, said this was not a 'surprising figure'.[85] Mr McGregor also noted that there was currently no allocation in its budget to promote the website.[86]

2.58 A number of submitters suggested that better promotion of the website by both the Commonwealth Government and private health insurers is essential to increase transparency of the industry and to allow consumers to make better informed decisions about the products available to them.[87]

2.59 Promotion of the PHIO-run site is critical because it is one of the only independent comparison websites.[88] Many of the other comparison websites are run by intermediaries, also known as commercial comparison services.[89] 'Intermediary' is a broad term that includes comparators,—such as Compare the Market, iSelect and Choosewell—agents and brokers who provide advice and guidance to consumers about available products.[90] These companies operate on commissions from private health insurers, but are not necessarily transparent about the private health insurers they receive commissions from, which can make it difficult for consumers to know if they are being shown all of their available options.[91]

2.60 On 13 October 2017, the Minister announced a series of reforms including a policy to redevelop the privatehealth.gov.au website to assist consumers in choosing private health insurance products suited to their needs.[92] The website will also see the introduction of a 'minimum data set' to communicate private health insurance product data in an online format.[93]

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83 Ms Doris Gibb, Acting Deputy Commonwealth Ombudsman, *Committee Hansard*, 5 July 2017, p. 1.

84 Mr David McGregor, Director, Private Health Insurance, Commonwealth Ombudsman, *Committee Hansard*, 5 July 2017, p. 1–2.

85 Mr McGregor, *Committee Hansard*, 5 July 2017, p. 2.

86 Mr McGregor, *Committee Hansard*, 5 July 2017, p. 2.

87 AHHA, *Submission 3*, p. 10; Mr Shaun Gath, *Submission 5*, p. 28.

88 Mr McGregor, *Committee Hansard*, 5 July 2017, p. 2. The other independent website is run by the Australian Consumers' Association.

89 Private Health Insurance Intermediaries Association (PHIIA), *Submission 221*, [p. 3].

90 *Submission 221*, [p. 3].

91 National Seniors Australia, *Submission 86*, p. 6.

92 Department, *Submission 127—Attachment 1*, [p. 2].

93 *Submission 127—Attachment 2*, [p. 9].

2.61 The Commonwealth Government has also proposed a new system for categorising private health insurance products. This includes the introduction of categories ('gold', 'silver', 'bronze' and 'basic') which place a minimum standard against each category. This classification is intended to assist consumers to compare and contrast private health insurance products. The Commonwealth Government will seek to introduce a list of standard clinical definitions insurers will be required to apply across all private health insurance documentation.[94]

2.62 Submitters to the inquiry generally welcomed the new classification system, but agreed that consumers needed to be able to clearly understand what they were covered for.[95] Dr Gannon told the committee that:

> With gold, silver, bronze, it is just absolutely important that people understand what they're getting. And if gold means 'everything', silver means 'everything with excesses or co-payments', if you must, and 'bronze' means 'a reduced level of service, but more than just junk', then we can live with that. But what we want is people, your average member of the community, to be able to understand it and to have something in their hands that's actually worth something.[96]

Minimum standard benefits

2.63 Some submitters proposed that a new minimum standard for a complying private health insurance policy be introduced. Currently, the only requirement for a complying health insurance policy is that minimum benefits are provided for psychiatric, rehabilitation and palliative care services.[97]

2.64 The Department explained that these requirements reflect concerns by hospitals and other providers that insurers would not contract for those services.[98]

2.65 NASOG suggested that obstetric services ought to be a mandatory inclusion:

> Australian society has an overriding responsibility to support, and care for, the women of our nation who undertake the great responsibility of our next generation. The inclusion of obstetric cover in the design of all PHI [private health insurance] policies for women of childbearing age is paramount, and should be a standard inclusion.[99]

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94 *Submission 127—Attachment 2*, [p. 5].

95 Mr Ian Burgess, Chief Executive Officer, Medical Technology Association of Australia (MTAA), *Committee Hansard*, 31 October 2017, p. 6; Mr Ian Yates, Chief Executive Officer, COTA Australia, *Committee Hansard*, 31 October 2017, pp. 8, 11; Ms Leanne Wells, Chief Executive Officer, Consumers Health Forum of Australia, *Committee Hansard*, 31 October 2017, p. 12; Dr Gannon, *Committee Hansard*, 31 October 2017, p. 32; Dr David, *Committee Hansard*, 31 October 2017, p. 48.

96 *Committee Hansard*, 31 October 2017, p. 39.

97 AHHA, *Submission 3*, p. 10.

98 Mr Charles Maskell-Knight, Principal Adviser, Department, *Committee Hansard*, 31 October 2017, p. 73.

99 NASOG, *Submission 83*, [p. 3].

2.66 In relation to obstetrics, RANZCOG made the argument that:

> There is evidence that in the Australian community at least half, and probably more, of all pregnancies are unplanned, so couples or women don't have the opportunity to make provision through their cover beforehand. It should not be an issue that they have to wade through thousands of policy types in the hope that they will encounter or be able to select and buy a private health insurance product that covers maternity.[100]

2.67 Other submitters singled out mental health care as a feature to be included in all policies.[101] Dr Duckett advocated for the inclusion of mental health as a minimum requirement on the basis that people are unlikely to anticipate whether they will acquire a mental illness:

> Most people would probably think they're never going to have a mental illness; so they would probably be comfortable about having mental health as an exclusion. But yet we know…that mental illness is something that can affect everybody of every age—mental illness is not something that people like to talk about or people like to think about. But it is a serious illness and we want to make sure that if people have private health insurance they are covered for it because, as I said, it's not like orthopaedics or obstetrics, which have quite different incidents over time. But it's something that can affect everybody.[102]

2.68 However, the Department clarified that the government recently decided not to include comprehensive psychiatric care in basic policies because it would have a dramatic impact on premiums:

> …if you look at the range of basic products that are out there in the market at the moment, and they generally cover those three things that they must cover and then they cover a range of minor surgery…the question then becomes: 'Okay, so what would you want to add to those products to make them more comprehensive?' And this is where the candidate that is often mentioned is one that is providing full cover for psychiatric care rather than restricted cover. As soon as you do that, several things happen. One of them is that all the people who are buying top cover at the moment so that they get access to psychiatric care and who don't want to get anything else much drop out of top cover and move down. As soon as you do that, the extra benefits that have to be paid out of that basic cover go up and that makes premiums go up by 15 per cent. Once that became clear and the advice was provided to the government around this, the government decided that it didn't wish to pursue expanding the scope of those basic things.[103]

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100 Prof Steve Robson, President, RANZCOG, *Committee Hansard*, 31 October 2017, p. 34.

101 Dr Duckett, *Committee Hansard*, 31 October 2017, p. 14; Dr Kym Jenkins, President, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 31 October 2017, p. 34.

102 Dr Duckett, *Committee Hansard*, 31 October 2017, p. 20.

103 Mr Maskell-Knight, *Committee Hansard*, 31 October 2017, p. 71.

Committee view

2.69 The committee recognises that consumers are currently confused by the large number of private health insurance policies that are on offer and that it can be difficult for consumers to understand what they are covered for. The committee also understands that rising premiums, exclusions and out-of-pocket costs are diminishing the value of private health insurance for consumers.

2.70 Whilst a certain onus must be placed on the consumer to understand their level of coverage and the exclusions in their private health insurance policy, the committee is concerned about the rising level of exclusions in private health insurance policies. The committee also considers that consumers who pay for private health coverage should not face unexpected out-of-pocket payments.

2.71 The committee is concerned about reports of individuals using their superannuation savings or mortgaging a house to pay out-of-pocket medical costs. The committee notes the government's announcement relating to accommodation and travel costs for people in rural and regional areas. The committee's conclusion on this announcement is contained in Chapter 5.

2.72 The committee believes that private health insurers should be more transparent about the scope of coverage of their private health insurance policies.

2.73 The committee recognises there are pressures that are placed on private health insurers in setting premiums. Premiums are examined in the next chapter.

Chapter 3

Private health insurance premiums

3.1 This chapter considers the economic structures that increase and constrain private health insurance premiums in Australia.

Factors driving premium increases

3.2 As discussed in the previous chapter, submitters told the committee that some Australians have been dropping or downgrading their private health insurance because of affordability or because they perceive that the product is not value for money.[1]

3.3 However, submitters held differing views about what was causing significant premium increases.

3.4 Submitters told the committee that increases in underlying cost pressures are largely to blame for rising premiums.[2]

3.5 The Australian Healthcare Reform Alliance told the committee that private health insurers were experiencing increased costs in a number of areas, but questioned insurers' ability to control those costs:

> Premiums are rising due to both the growth in consumer demand for services and increased health technology and pharmaceutical costs. Private insurers have little or no capacity to influence either of these factors and so have argued for more control over provider behaviour, in order to reduce inflated costs and low value care.[3]

3.6 The factors that private health insurers say they cannot control include utilisation, medical costs, private patients in public hospitals, management costs and intermediaries.

Utilisation

3.7 Utilisation measures the rate at which insured persons demand hospital services.[4] Some submitters considered that increased utilisation had caused premiums to increase by 50 per cent between 2010 and 2016.[5]

3.8 According to research conducted by the Australian Private Hospitals Association (APHA), the rate at which consumers accessed services increased by

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1 For more discussion of affordability for consumers see Chapter 2.

2 Mr Charles Maskell-Knight, Principal Adviser, Department of Health (Department), *Committee Hansard*, 31 October 2017, p. 72; Private Healthcare Australia, *Submission 18*, p. 25; NIB, *Submission 24*, p. 2; HBF, *Submission 63*, pp. 7–10.

3 Australian Healthcare Reform Alliance, *Submission 67*, [p. 2].

4 Australian Private Hospitals Association (APHA), *Submission 80—Attachment 2*, p. 9.

5 Johnson and Johnson Medical Pty Ltd (Johnson and Johnson), *Submission 62*, p. 3. See also Private Healthcare Australia, *Submission 18*, p. 25; NIB, *Submission 24*, p. 2; HBF, *Submission 63*, p. 7.

20 per cent between 2010 and 2016.[6] In 2010, the rate was 321 hospital episodes per 1000 insured people.[7] In 2016, that rate had steadily increased to 384.8 hospital episodes per 1000 insured people.[8]

Table 3.1—Annual ratio of episodes per 1000 persons insured 2010–16

Year	2010	2011	2012	2013	2014	2015	2016	Change 2010-2016
Utilisation ratio	321.0	328.9	337.4	347.1	365.7	374.8	384.8	63.8

Source: APHA, based on APRA data.

Source: Australian Private Hospitals Association, *Submission 80—Attachment 2*, p. 9.

3.9 The APHA told the committee that the 20 per cent increase in the utilisation rate over this period accounted for 'forty percent [sic] (40.2%) of the growth in benefits paid out over 2010–2016'.[9]

3.10 Private Healthcare Australia explained to the committee that the increase in utilisation could be directly attributed to rising consumer expectations about what the health system ought to deliver:

> 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.[10]

3.11 Other submitters pointed to Australia's ageing population to explain the increase in utilisation.[11] Specifically, older Australians make up a larger proportion of the insured cohort.[12]

3.12 Representatives from the Department of Health (Department) suggested that Australia's ageing population and the ability to safely provide a wider range of medical services to an older cohort was leading to increased utilisation:

> I think the underlying cost pressures driving premiums up are that people are getting older. Doctors and technology companies are inventing more

6 APHA, *Submission 80—Attachment 2*, p. 9.

7 *Submission 80—Attachment 2*, p. 9.

8 *Submission 80—Attachment 2*, p. 9.

9 *Submission 80—Attachment 2*, p. 9.

10 Private Healthcare Australia, *Submission 18*, p. 14.

11 Ms Alison Verhoeven, Chief Executive, Australian Healthcare and Hospitals Association (AHHA), *Committee Hansard*, 5 July 2017, p. 19; Ms Penny Shakespeare, Acting Deputy Secretary, Health Benefits Group, Department, *Committee Hansard*, 31 October 2017, p. 72; Bupa Australia, *Submission 43*, p. 3; Johnson and Johnson, *Submission 62*, p. 4; HBF, *Submission 63*, p. 7; Australian Physiotherapy Association, *Submission 74*, p. 21.

12 APHA, *Submission 80—Attachment 2*, p. 9.

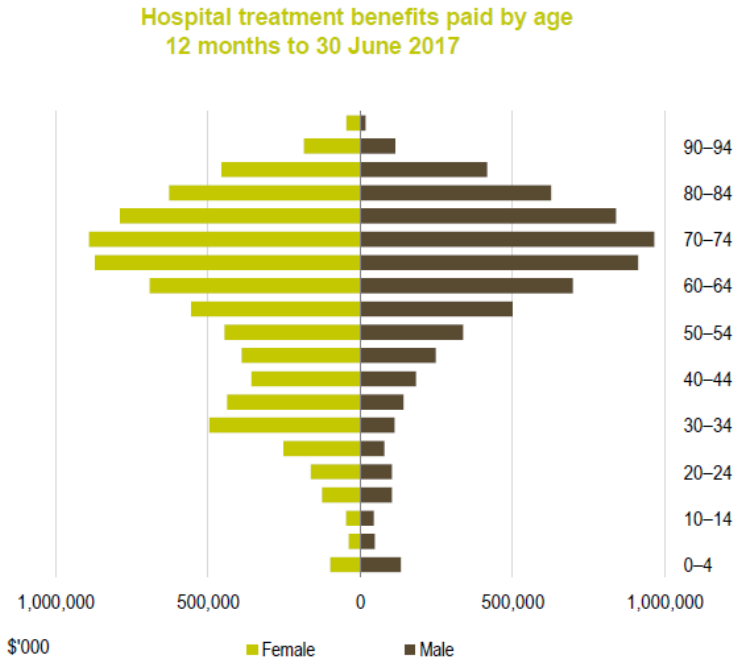
> and more things that can be done to folk, especially as they get older. Anaesthetic technology has now advanced to the point that 80-year-olds can be anaesthetised safely for things that wouldn't have been done 15 years ago.[13]

3.13 The Grattan Institute agreed with the Department's assessment.[14]

3.14 Private Healthcare Australia also explained to the committee that an ageing population has an effect on private health insurers because older Australians are 'more highly represented in PHI [private health insurance] than younger age groups and cost significantly more in healthcare than younger groups'.[15]

3.15 Private Healthcare Australia's observation about the demand and cost of healthcare in older populations is supported by data published by the Australian Prudential Regulation Authority (APRA) that demonstrates that greater hospital benefits are paid to persons in older age groups.

Graph 3.1—Hospital treatment benefits by age



Source: APRA, *Private Health Insurance Quarterly Statistics*, June 2017, p. 6.

Medical costs

3.16 Private Healthcare Australia and its members told the committee that medical costs were also contributing to health inflation and placing pressure on private health insurance premiums.[16]

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13 Mr Maskell-Knight, *Committee Hansard*, 31 October 2017, p. 72.

14 Grattan Institute, *Submission 72*, p. 7.

15 Private Healthcare Australia, *Submission 18*, p. 36.

16 Private Healthcare Australia, *Submission 18*, p. 9.

3.17 Hirmaa, which represents not-for-profit and restricted membership funds, similarly told the committee that the rising cost of medical services was placing pressure on private health insurance premiums:

> We would love premiums to be even lower, but unfortunately insurers have to set premiums in line with the growing cost of medical services.[17]

3.18 The Australian Medical Association (AMA) disagreed that the increased cost of medical services was a substantial contributor to private health insurance premiums, saying:

> Medical expenses are a small proportion of total benefit outlays for private health insurers. Medical expenses have remained static at around 16 per cent since 2007. In fact, administration expenditure by private health insurers is around 10 per cent. So it is costing insurers almost as much to run their business as it is to pay the doctors who treat their customers.[18]

3.19 The APHA also disagreed that medical expenses were significantly impacting premiums. According to APHA's research, once adjusted for inflation, increased medical costs only accounted for 1.1 per cent of the growth in benefits paid to patients.[19] The APHA considered that utilisation, inflation and the number of insured people had a greater effect on premiums.[20]

Private patients in public hospitals

3.20 Another factor that may be placing pressure on premiums is the practice of insured patients being treated privately in public hospitals. The committee heard that consumers are often encouraged to use their private health insurance to 'help the hospital' or to obtain benefits like a private room, their choice of doctor or faster admission to surgery.[21]

3.21 The APHA told the committee that it believes that this practice has contributed significantly to pressure on premiums:

> Private Healthcare Australia has equated that to a six per cent increase in premiums; premiums are six per cent higher than they would otherwise be if that outlay wasn't there.[22]

3.22 Bupa Australia explained that whilst using their private health insurance in a public hospital may not leave the consumer out-of-pocket, consumers are not necessarily informed that using their private health insurance in a public hospital

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17 Mr Matthew Koce, Chief Executive Officer, hirmaa, *Committee Hansard*, 5 July 2017, p. 29.

18 Dr Michael Gannon, President, Australian Medical Association (AMA), *Committee Hansard*, 31 October 2017, p. 31.

19 APHA, *Submission 80—Attachment 2*, p. 8.

20 *Submission 80—Attachment 2*, p. 8.

21 Independent Hospital Pricing Authority (IHPA), *Submission 2*, p. 27; Haemotology Federation of Australia, *Submission 50*, p. 7; Bupa Australia, *Submission 43*, pp. 11–12.

22 Mr Michael Roff, Chief Executive Officer, APHA, *Committee Hansard*, 31 October 2017, p. 44.

contributes to the overall pressure on premiums.[23] This practice will be discussed further in Chapter 4.

Remuneration and management

3.23 Several submitters to this inquiry highlighted that private health insurance companies have moved from being structured as member-owned not-for-profit mutuals to being large corporations.[24] The effect of that change is that profit becomes a substantial consideration for companies.[25]

3.24 Of Australia's 37 private health insurers, 13 operate as for-profit companies.[26] Those for-profit companies have been generating 'substantial' profits in recent years.[27]

3.25 In 2015–16, Australia's 37 private health insurers made $1596 million in profit before tax and $1252 million after tax.[28]

3.26 In 2016–17, Australia's 37 private health insurers made $1822 million before tax and $1396 million after tax.[29]

3.27 Some submitters to the inquiry argued that the need to generate a profit and a return to shareholders has fuelled a rise in premiums. The AMA told the committee:

> The shift to a full-profit industry has created the need to ensure that there are sufficient profits to allow a return to shareholders. This is driving much of the growth in increased premiums.[30]

3.28 Other stakeholders, such as the Medical Technology Association of Australia (MTAA), suggested that private health insurers' rising profits indicated that private health insurers had capacity to reduce premiums further:

> The evidence of private health insurers' increasing profits, increasing cash reserves and increasing CEO salaries suggests that they should do some belt tightening of their own to keep premium growth to a CPI [consumer price index] level.[31]

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23 Bupa Australia, *Submission 43*, p. 11.

24 Dr Gannon, *Committee Hansard*, 31 October 2017, p. 37; Council of Procedural Specialists, *Submission 41*, [p. 1].

25 Dr Gannon, *Committee Hansard*, 31 October 2017, p. 37.

26 Department, *Submission 127*, p. 3.

27 Dr Gannon, *Committee Hansard*, 31 October 2017, p. 37.

28 Australian Prudential Regulation Authority (APRA), 'Financial performance', *Private Health Insurance Operations Report 2015–16*, http://www.apra.gov.au/PHI/Publications/Pages/Operations-of-Private-Health-Insurers-Annual-Report.aspx (accessed 9 November 2017).

29 APRA, 'Financial performance', *Private Health Insurance Operations Report 2016–17*, http://www.apra.gov.au/PHI/Publications/Pages/Operations-of-Private-Health-Insurers-Annual-Report.aspx (accessed 9 November 2017).

30 Dr Gannon, *Committee Hansard*, 31 October 2017, p. 32.

31 Mr Ian Burgess, Chief Executive Officer, Medical Technology Association of Australia (MTAA), *Committee Hansard*, 31 October 2017, p. 2.

3.29 According to APRA, the industry average for management expenses was 8.5 per cent in 2015–16 and 8.8 per cent in 2016–17.[32]

3.30 Private health insurers disagreed that management expenses were contributing to rising premiums.[33] Instead, private health insurers indicated that their management expenses were relatively low compared to other types of insurance.[34]

3.31 Representatives of hirmaa told the committee that:

> My funds operate on very narrow management expense ratios, and that includes salaries for running the fund. There's been no jump-up in MER [management expense ratio] within my funds. It's very narrow, and you don't have that MER for anyone else in the health supply chain. If there were a jump in the MER, the management expense ratio, I would say, yes, you'd have every right to question why there is an increase in the management expense ratio, but there's not.[35]

3.32 Representatives of Bupa Australia similarly indicated that they were committed to keeping their management costs down:

> We have committed internally next year to have our costs grow by no more than one per cent. The only reason those costs are growing is because we face rental costs with landlords and commission costs for some of the things we do for people, like students and so on. There's just no way I can easily get out of some of those costs.[36]

3.33 As the representative from hirmaa noted, management expense ratios are published by APRA but submitters noted that there is currently a difference between the levels of transparency required of insurers depending on whether they are listed on the Australian Stock Exchange (ASX).[37]

3.34 One of those transparency factors is executive remuneration. Currently, only the two ASX listed companies, Medibank Private and NIB, are required to disclose what their senior executives are paid.[38]

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32 APRA, 'Financial performance', *Private Health Insurance Operations Report 2015–16*; APRA, 'Financial performance', *Private Health Insurance Operations Report 2016–17*.

33 Mr Koce, *Committee Hansard*, 5 July 2017, p. 30; Dr Dwayne Crombie, Managing Director, Health Insurance, *Committee Hansard*, 31 October 2017, p. 50; Private Healthcare Australia, Submission 18, p. 6; NIB, *Submission 24*, p. 4; hirmaa, *Submission 75*, p. 7.

34 Private Healthcare Australia, *Submission 18*, p. 7.

35 Mr Koce, *Committee Hansard*, 5 July 2017, p. 31.

36 Dr Crombie, *Committee Hansard*, 5 July 2017, p. 50.

37 Mr Koce, *Committee Hansard*, 5 July 2017, p. 32; Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 31 October 2017, p. 18; Mr Shaun Gath, *Submission 5*, p. 14.

38 Mr Koce, *Committee Hansard*, 5 July 2017, p. 32.

3.35 Some submitters, such as Dr Stephen Duckett, Director of the Health Program at the Grattan Institute, considered that all private health insurers ought to disclose these amounts:

> My view is that we should have requirements on health insurance funds in the same way we have requirements on listed companies about disclosure and about transparency of how they're spending the money.[39]

3.36 Some of the private health insurers the committee spoke to did not consider that revealing executive remuneration would be a problem, but wanted it to be consistent across the industry. Representatives of Bupa Australia told the committee that:

> We don't have a problem if it's done for the industry. People could reasonably argue that where public money is being spent—as long as there is consistency involving suppliers, medical device companies, even industry associations and all the rest of it—it should be a matter for the public record.[40]

3.37 Dr Rachel David, Chief Executive Officer of Private Healthcare Australia, the peak body representing private health insurers, agreed that executive remuneration ought to be disclosed in more areas of healthcare:

> What you'd need to do is ensure that in the hospitals—whether they be church, charitable or publicly listed—their senior executives do the same; and I also believe quite strongly medical specialists and dental practices as well.[41]

3.38 Whilst not all submitters agreed that the disclosure of remuneration ought to necessarily extend to individual medical practitioners, Private Healthcare Australia suggested that its members would not oppose greater transparency:

> Should our elected representatives or our regulators agree it's in the community interest for a heightened level of disclosure to occur, we certainly will not oppose that. We will comply with anything along those lines that is required of us.[42]

Intermediaries

3.39 In Chapter 2, the committee considered the role of the privatehealth.gov.au website in helping consumers select a policy. In that chapter, the committee noted that the privatehealth.gov.au website was one of the only independent comparison websites and that many other websites operate on a fee-for-placement basis. On a fee-for-placement website, the private health insurer pays a fee or commission to the website when an individual takes out a private health insurance policy after using the

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39 *Committee Hansard*, 31 October 2017, p. 18.

40 Dr Crombie, *Committee Hansard*, 31 October 2017, pp. 51–52.

41 *Committee Hansard*, 31 October 2017, p. 52.

42 Dr Rachel David, Chief Executive Officer, Private Healthcare Australia, *Committee Hansard*, 31 October 2017, p. 51.

intermediary's website.[43] Bupa Australia and other submitters suggested that commissions paid to intermediaries to facilitate consumers switching private health insurers may also be contributing to rising premiums.[44]

3.40 The Private Health Insurance Intermediaries Association (PHIIA) told the committee that the mission of its members was to increase market competition and improve consumer outcomes.[45]

3.41 However, Bupa Australia told the committee that the commissions claimed by intermediaries were large and did not assist consumers:

> Comparators claim as much as 40 per cent of the first year's premium as their commission for informing people of their choice. This fee doesn't go to buying health services, it must be absorbed, and inevitably leads to higher premiums. This causes further pressure on premiums each year.[46]

3.42 Bupa Australia suggested that removing commissions to intermediaries would reduce pressure on private health insurance premiums:

> Eliminating commissions that would have otherwise been paid to on-line brokers, who currently capitalise on this gap, would flow through to lower premiums for all customers.[47]

3.43 PHIIA however rejected suggestions that commissions paid to comparison websites were increasing pressure on premiums:

> In reality the comparators are just another sales channel, such as TV, Facebook, Google etc., among various marketing costs. In many instances, the cost of member acquisition via comparison sites is more cost-effective – particularly for smaller funds – than undertaking their own marketing activities and sales channels.[48]

Constraining factors

3.44 While all the factors mentioned in the previous section play a part in increasing premiums, a combination of regulation, incentives and market factors act to constrain rising premiums.

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43 Choice, *Comparing the comparators*, https://www.choice.com.au/money/insurance/insurance-advice/articles/insurance-comparison-sites (accessed 30 November 2017).

44 Bupa Australia, *Submission 43*, p. 19.

45 Private Health Insurance Intermediaries Association (PHIIA), *Submission 221*, [p. 2].

46 Bupa Australia, *Submission 43*, p. 19.

47 *Submission 43*, p. 20.

48 PHIIA, *Submission 221*, [p. 4].

Regulation

3.45 The Commonwealth Government encourages people to take up private health insurance to relieve pressure on state public hospitals and to 'provide consumers with a greater choice of care options'.[49]

3.46 To ensure that patients with a high risk profile are not charged prohibitive private health insurance premiums and insurers are not discouraged from insuring high risk consumers, Australia's private health insurance market is based on the principles of community rating and risk equalisation.

Community rating and risk equalisation

3.47 Community rating is the principle that private health insurers cannot discriminate between consumers seeking coverage on the basis of their health, age or likelihood to claim.[50]

3.48 Community rating guarantees that anyone who wants to take out private health insurance has access to it.[51] In its *Efficiency in Health* report, the Productivity Commission noted that 'community rating and other price regulations effectively act to cross-subsidise private health insurance premiums'.[52] The Department clarified that:

> Community rating prohibits insurers from discriminating on the basis of past or likely future health or risk factors such as age, pre-existing condition, gender, race or lifestyle in the premiums that they charge. Although community rating means that people who are older or sicker do not have to pay higher premiums commensurate with their risk, it also means that younger and healthier people pay more than they otherwise would.[53]

3.49 Community rating is supported by a system of risk equalisation. In its submission, the Department explained the rationale for risk equalisation in the private health insurance market:

> Risk equalisation attempts to adjust for the risk of adverse selection. It is designed to spread the burden of high cost claims across all insurers, helping to keep them all financially viable…These arrangements are designed to ensure that insurers (and policy holders with those insurers) with higher numbers of older members or high users are not financially disadvantaged compared with those insurers with a younger or healthier membership.[54]

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49 Department, *Submission 127*, p. 1.

50 *Private Health Insurance Act 2007* (Cth), s. 55-5; Department, *Submission 127*, p. 2.

51 Department, *Submission 127*, p. 2; Explanatory Memorandum, Private Health Insurance Bill 2006, cl. 55-1.

52 Productivity Commission, *Efficiency in Health*, April 2015, p. 68.

53 Department, *Submission 127*, p. 2.

54 Department, *Submission 127*, p. 2.

3.50 Submitters to this inquiry were almost unanimous in their agreement that community rating and risk equalisation are important to the effective operation of the existing private health insurance regime.[55]

Private health insurance rebate

3.51 Two other elements of the existing regulatory regime are designed to help to control the price of private health insurance premiums: the premiums reduction scheme—commonly known as the private health insurance rebate—and the Minister for Health's approval of premiums.

3.52 The private health insurance rebate was introduced from 1 January 1999 as one of three government incentives to encourage people to take out private health insurance cover during the late 1990s and early 2000s.[56]

3.53 Today, the existing structure of the rebate is based on the age and income of the beneficiary/beneficiaries of the private health insurance policy.[57] Since 2014, the rebate has also been reduced by up to one percent per year.[58]

3.54 Some submitters considered the rebate to be an inefficient use of public money.[59] For these submitters, the inefficiency stemmed from the fact that a plurality of private health insurers lacked the efficiency of scale of a universal health system.[60]

3.55 The Grattan Institute questioned the value of the rebate and stated that other factors, such as the lifetime health cover loading, had a much more significant effect on participation than the introduction of the rebate.[61]

3.56 The Grattan Institute also noted that changes to the rebate for older and wealthier Australians in 2005 and 2014 did not appear to change their participation rate in private health insurance.[62] Therefore, the Grattan Institute advocated for gradual curtailment of the rebate.[63]

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55 See for example: Ms Leanne Wells, Chief Executive Officer, Consumers Health Forum of Australia, *Committee Hansard*, 31 October 2017, pp. 7, 10; Dr Gannon, *Committee Hansard*, 31 October 2017, p. 32; Dr Crombie, *Committee Hansard*, 31 October 2017, p. 50; AHHA, *Submission 3*, p. 16; Australian Association of Practice Management, *Submission 16*, p. 4; Consumers Health Forum of Australia, *Submission 17*, p. 4. For submitters that considered that some amendment could be required see: Mr Shaun Gath, *Submission 5*, pp. 15–17; Private Healthcare Australia, *Submission 18*, p. 10.

56 Department, *Submission 127*, p. 24.

57 *Private Health Insurance Act 2007* (Cth), s. 22-15.

58 *Private Health Insurance Act 2007* (Cth), s. 22-15.

59 Public Health Association of Australia (PHAA), *Submission 49*, p. 4; Consumers Health Forum of Australia, *Submission 17*, p. 52; Australian Health Care Reform Alliance, *Submission 67*, [pp. 2–3]; Grattan Institute, *Submission 72*, p. 5.

60 Consumers Health Forum of Australia, *Submission 17*, pp. 6–7; PHAA, *Submission 49*, p. 4.

61 Grattan Institute, *Submission 72*, p. 18.

62 *Submission 72*, p. 19.

63 *Submission 72*, p. 25.

3.57 Some private health insurers expressed concern about the impact of the annual reduction in the rebate: representatives of hirmaa called for a price floor to be set to ensure that the rebate does not drop below 25 per cent.[64] Private health insurers want a price floor to be established as the diminishing rebate is compounding the affordability problem caused by rising premiums:

> …the Australian government rebate is no longer at 30 per cent; it is in the 25 per cent zone and it is dropping by a per cent every year, and it is means-tested. That means that only those who really deserve it receive the rebate and it is dropping by a per cent a year. So, if a health fund puts up premiums by four per cent, you can add another per cent through the Australian government rebate dropping as well, and that is causing a lot of cost pressures.[65]

Minister's approval of premiums

3.58 The Minister for Health (Minister) is required to approve private health insurance premium increases, unless there is an overriding public interest reason not to do so.[66]

3.59 Mr Shaun Gath, the former head of the Private Health Insurance Administration Council, suggested that the law was drafted to reflect a compromise:

> There is little doubt that their purpose was to reflect *a compromise*, namely that insurers could reasonably *expect* that their application would be approved (the Minister "must" approve …) subject only to some quite exceptional event where a decision to approve would actually be "contrary to the public interest". In practice, however, ministers of both political persuasions continued to regard themselves as primarily responsible for an approval process where intense micro-scrutiny was applied to the applications (often with little transparency) with a view to approving the lowest increase prudentially acceptable.[67]

3.60 Dr Duckett explained that it seemed to be contrary to private health insurers' interests to propose higher than needed fee increases, which led him to conclude that price may not be the most important factor for private health insurers:

> When Minister Ley, I think it was, knocked them back…they came back with lower proposals, which suggests that there was padding in their initial proposal. That suggests they don't care about fee increases, because they have a whole lot of other structures which stop people dropping out as much.[68]

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64 Mr Koce, *Committee Hansard*, 5 July 2017, p. 28. The base tier rebate for under 65-year-olds is currently 25.934 per cent.

65 Mr Koce, *Committee Hansard*, 5 July 2017, p. 28.

66 *Private Health Insurance Act 2007* (Cth), s. 66-10(3).

67 Mr Shaun Gath, *Submission 5*, p. 18 (emphasis in original).

68 Dr Duckett, *Committee Hansard*, 31 October 2017, p. 17.

Medicare levy surcharge and Lifetime health cover

3.61 Other structures that encourage individuals to maintain coverage are the Medicare Levy Surcharge (MLS) and the Lifetime Health Cover (LHC) loading.

3.62 The MLS is a tax applied to persons who earn over a threshold amount and do not hold private hospital insurance.[69] Between 2014–15 and 2017–18 the MLS was calculated in accordance with the table below.[70]

Table 3.2—MLS income thresholds 2014–15 to 2017–18

Singles **Families**[44]	**≤$90,000** **≤$180,000**	**$90,001-105,000** **$180,001-210,000**	**$105,001-140,000** **$210,001-280,000**	**≥$140,001** **≥$280,001**
	Base Tier	**Tier 1**	**Tier 2**	**Tier 3**
	0.0%	1.0%	1.25%	1.5%

Source: Department, *Submission 127*, p. 24.

3.63 The Department explained that the LHC was an incentive that was introduced on 1 July 2000 to 'encourage people to take out hospital insurance earlier in life, and to maintain their cover throughout their life'.[71]

3.64 It works by applying an extra two per cent loading to their private hospital insurance premium for each year after the age of 30 that the person did not hold an appropriate level of cover and allows the insurer to charge the person the premium plus the loading for the next ten years.[72]

3.65 Together, the LHC loading and the MLS are intended to encourage younger, healthier people to enter the private health insurance risk pool earlier than they otherwise might.

3.66 According to Private Healthcare Australia the MLS and the LHC provide stability to Australia's private health insurance market:

> Market research estimates these measures together, underpin 75% of demand for PHI [private health insurance], and successfully stabilised uptake of private health insurance at its current level of approximately 50% of the population.[73]

3.67 Consumer surveys also confirmed that the MLS and the LHC were important factors in individuals' decision to maintain coverage. A survey by Choice found that 34 per cent of respondents considered avoiding paying the MLS to be a key reason to take out private health insurance while another 24 per cent of respondents considered avoiding LHC loading to be a key reason.[74] Among households earning over

69 Department, *Submission 127*, p. 24.

70 *Submission 127*, p. 24.

71 *Submission 127*, p. 26.

72 *Submission 127*, p. 26; *Private Health Insurance Act 2007* (Cth), ss. 31-1, 34-10.

73 Private Healthcare Australia, *Submission 18*, p. 16.

74 Choice, *Submission 207*, p. 9.

$150 000, 55 per cent cited avoiding the MLS as a key reason for taking out private health insurance.[75]

Market factors

3.68 As noted above, an older insured cohort that is more likely to claim will put upward pressure on premiums. Therefore, to reduce pressure on premiums, private health insurers, collectively, need to attract younger, healthier people to join the insured pool who are less likely to make a claim.[76]

3.69 Some submitters raised concerns that a failure to attract younger people to take up private health insurance may lead to a 'death spiral':

> An important consideration regarding the incentive policy is the age structure of the insurance pool it generates. Generally speaking, in order to maintain a sound risk structure and affordable premiums, low risk insurees are required to balance out the high risk insurees. An imbalance in the insurance pool toward high risk individuals will drive the premiums up which may cause more low risk persons to drop out, leading to further premium increases. This process is known as the insurance market 'death spiral'.[77]

3.70 While participation numbers are down, APRA disagrees that the insurance market is headed for a 'death spiral'.[78] However, some private health insurers suggested that the existing incentives—the rebate, LHC and the MLS—are not sufficient to encourage younger, healthier people take out private health insurance:

> Current sticks and carrots, including the Medicare Levy Surcharge, Lifetime Health Cover and even the PHI [private health insurance] Rebates, don't do enough to make the product sufficiently attractive to healthy under 30s. It is this group that is essential to deepening the community rated risk pool and therefore keeping premium growth down.[79]

'Reverse' Lifetime health cover

3.71 Some private health insurers suggested that the government implement a 'reverse' LHC to provide a financial incentive for people under 30 to take out private health insurance.[80]

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75 *Submission 207*, p. 10.

76 Private Healthcare Australia, *Submission 18*, p. 37; NIB, *Submission 24*, p. 2; Bupa Australia, *Submission 43*, p. 25.

77 Dr Marcin Sowa, Dr Joshua Byrnes and Prof Paul Scuffham, *Submission 106*, p. 7. See also Mr Koce, *Committee Hansard*, 5 July 2017, p. 28.

78 Mr Louis Serret, Acting Executive General Manager, Specialised Institutions Division, Australian Prudential Regulation Authority, *Committee Hansard*, 31 October 2017, p. 65.

79 NIB, *Submission 24*, p. 2. See also Bupa Australia, *Submission 43*, pp. 25–26.

80 NIB, *Submission 24*, p. 2; Bupa Australia, *Submission 43*, pp. 25–26.

3.72 On 13 October 2017, the Minister announced that the insurers would be allowed to discount premiums for people who take out private health insurance between the ages of 18 and 29.[81]

3.73 Under the plan, a discount of up to 10 per cent could be applied to premiums until the person turns 40 when the discount would start to be phased out.[82]

3.74 The Department confirmed that the purpose of this plan was to lower premiums.[83]

3.75 However, some submitters raised concerns that an additional incentive may not be sufficient for young people to take out private health insurance.[84] Dr Duckett explained to the committee that even under the recently announced plan he would not advise his daughter to take out private health insurance:

> …it's not good value for money. She's 22, relatively healthy, and until she turns 30 there's no particular reason for her to take out health insurance at all. As the health insurers know, and as the government knows, the whole point of the deductions is to encourage people into health insurance who will not use their health insurance. That's the whole point of it.[85]

Junk/basic policies

3.76 The low value that junk/basic policies provide to consumers was considered in Chapter 2. However, submitters to the inquiry explained that the benefit of these policies is that their policyholders contribute to the risk equalisation pool and place downward pressure on premiums:

> They all contribute to the risk equalisation pool and, therefore, the total pool of funds available to members, thereby keeping overall premiums stable.[86]

3.77 The Department agreed that one reason junk/basic policies are allowed to continue is because they play a role in placing downward pressure on premiums.[87] Some submitters also observed that people may see some value in a policy that allows them to be treated as a private patient in a public hospital or allows them to contribute to the risk equalisation pool.[88]

3.78 The Department agreed that some people do see value in the product:

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81 Department, *Submission 127—Attachment 1*, [p. 1].

82 *Submission 127—Attachment 1*, [p. 1].

83 *Submission 127—Attachment 2*, [p. 11].

84 Dr Duckett, *Committee Hansard*, 31 October 2017, p. 14.

85 Dr Duckett, *Committee Hansard*, 31 October 2017, p. 16.

86 Dr David, *Committee Hansard*, 31 October 2017, p. 56.

87 Mr Maskell-Knight, *Committee Hansard*, 31 October 2017, p. 70.

88 Dr David, *Committee Hansard*, 31 October 2017, p. 58; Dr Crombie, *Committee Hansard*, 31 October 2017, p. 58.

> …there are a greater or lesser number of people who do see value in those products. They do offer cover for some things. You can question whether you get your money back. Most people with health insurance don't get their money back in the short run, but that's what insurance is.[89]

Prostheses

3.79 Some submitters also raised concerns about the price of prostheses increasing pressure on private health insurance premiums.[90]

3.80 The term 'prosthesis' specifically refers to a surgically implantable device, such as a cardiac pacemaker or an intraocular lens in a cataract surgery.[91]

3.81 Earlier this year, the Community Affairs References Committee completed an inquiry into *Price regulation associated with the Prostheses List Framework*.[92] The inquiry examined the impact of benefit-setting on the price of prostheses available and used for privately insured patients.

3.82 Submitters to both inquiries noted that prostheses benefits amount to approximately 14 per cent of hospital rebate expenditure for private health insurers.[93] The committee also heard evidence that the different prices were being charged for prostheses in public and private hospitals and that the differential between the price paid in public and private hospitals was having a substantial impact on premiums.[94]

3.83 In its inquiry into *Price regulation associated with the Prostheses List Framework*, the committee made 16 recommendations including that the 'the nature and costs of services associated with a medical device on the Prostheses List be disclosed separately to the cost of the device'.[95]

3.84 Prior to the conclusion of the committee's inquiry, the Commonwealth Government announced and implemented an initial review and reduced the benefits for certain groups of items on the Prostheses List, signalling that this would represent an initial saving of $86 million and $500 million over 6 years.[96]

3.85 The government's response to the inquiry report agreed to ensure that there is greater transparency in relation to decisions and benefit setting by the Prostheses List

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89 Mr Maskell-Knight, *Committee Hansard*, 31 October 2017, p. 72.

90 Mr Koce, *Committee Hansard*, 5 July 2017, p. 30.

91 Community Affairs References Committee (Committee), *Price regulation associated with the Prostheses List Framework*, May 2017, pp. 3–4.

92 Committee, *Price regulation associated with the Prostheses List Framework*, May 2017.

93 Mr Burgess, *Committee Hansard*, 31 October 2017, p. 3; Department, *Submission 127—Attachment 2*, [p. 13].

94 Mr Koce, *Committee Hansard*, 5 July 2017, p. 30.

95 Committee, *Price regulation associated with the Prostheses List Framework*, May 2017, p. 63 (Recommendation 16).

96 The Hon. Sussan Ley MP, Minister for Health and Aged Care, 'Turnbull Government to ease pressure on private health insurance premiums', *Media release*, 19 October 2016.

Advisory Committee, and to continue the process of refining the number, range and benefit level of items available on the Prostheses List.[97]

3.86 On 13 October 2017, the Minister announced that a round of benefit reductions would commence on 1 February 2018 to save private health insurers $188 million in 2018.[98] Combined with further benefit reductions in subsequent years, the government announced that:

> Total estimated savings to private health insurers over the next four premium years (2018 to 2021) are more than a billion dollars.[99]

3.87 This agreement with the MTAA, who represent device manufacturers, is designed to place downward pressure on premiums. The Minister announced that:

> Private health insurers have publicly stated that every $200 million in prostheses benefits reductions will decrease private health insurance premiums by one per cent.[100]

3.88 To ensure that the Prostheses List savings were passed on, the MTAA suggested that the Australian National Audit Office should audit the books of all private health insurers:

> MTAA would like to propose that private health insurers be required to open up their books to the Australian National Audit Office, to verify that they are passing on all of these savings, and to publish revenue and claims payout ratios. This would be entirely appropriate for an industry in receipt of $6 billion in taxpayer funds. We would encourage the committee to consider this as a recommendation that should be enshrined in legislation. A simple amendment to the Private Health Insurance Act should be able to facilitate this.[101]

3.89 Dr Duckett also suggested that an audit would be possible:

> I think the Auditor-General has follow-the-dollar powers, and may be able to initiate an audit of that kind. It would possibly be impossible to tell what the impact of the prostheses changes are going to be. If I were a health insurance fund I'd say, 'Yes, we made all those savings and we've ploughed them back because our fees aren't increasing next year as much.'[102]

3.90 The private health insurers did not oppose the suggestion of an audit:

> In the premium round you have to be very specific about the claims on medical devices, how they've decreased, get the actuaries to do the

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97 Australian Government, *Australian Government response to the Senate Community Affairs References Committee report: Pricing regulation associated with the Prostheses List framework*, September 2017, [p. 4] (tabled 14 September 2017).

98 Department, *Submission 127—Attachment 2*, [p. 13].

99 *Submission 127—Attachment 2*, [p. 13].

100 *Submission 127—Attachment 2*, [p. 13].

101 Mr Burgess, *Committee Hansard*, 31 October 2017, p. 2.

102 Dr Duckett, *Committee Hansard*, 31 October 2017, p. 17.

> modelling, put it in the premium and ensure they have been passed on. If that was found not to be sufficient, and it was suggested by the government that the ANAO's involvement would add something, we would open our books and show them. There is absolutely nothing to hide. We were the ones who put this issue on the table—that we would pass on all the savings in the prostheses list negotiation. We were the ones who put our hands up and said that we would do it. There is nothing to hide.[103]

3.91 However, APRA was less certain that an audit would be a significant benefit as it considered that it would be clear if additional funds were being held by the private health insurers:

> In terms of whether they have passed on savings, I think we again understand that, if you look at the numbers over the last 10 years, the MERs [management expense ratios], the amount of benefit payments made each year happen to have remained relatively the same over that period. So it would suggest that, if the costs are going up and premiums are going up, there are no excess profits being held within the institutions, given that the benefit payments have stayed around 85 to 86 per cent, the MERs have been at the same per cent and the net margin has been at 4½ or thereabouts…I personally don't think there's a lot to be gained.[104]

Will premiums go down?

3.92 Despite the government's recent announcement, no submitter to the inquiry expected that health insurance premiums were likely to drop in the short term as costs will continue to rise.[105]

3.93 The Department summarised the position of many of the submitters:

> [Private health insurance premiums] will not go up as fast as they otherwise would have done.[106]

3.94 Instead, submitters suggested that upward pressure would continue to be placed on private health insurance premiums. APRA noted that over the longer term rising premiums had the potential to be a significant issue:

> We've identified [the private health insurance business model] as an emerging risk. We see it as a long-term challenge for the industry. With the participation rates coming down amongst the younger cohort, it's going to put pressure on pricing and, of course, that's a long-term structural issue that the industry needs to face. Our role, obviously, is to understand how the industry is actually going to cope with that to ensure that it remains sustainable going forward.[107]

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103 Dr David, *Committee Hansard*, 31 October 2017, p. 53. See also Dr Crombie, *Committee Hansard*, 31 October 2017, p. 53.

104 Mr Serret, *Committee Hansard*, 31 October 2017, p. 64.

105 Mr Serret, *Committee Hansard*, 31 October 2017, p. 65.

106 Mr Maskell-Knight, *Committee Hansard*, 31 October 2017, p. 72.

107 Mr Serret, *Committee Hansard*, 31 October 2017, pp. 64–65.

Committee view

3.95 The committee acknowledges that there are a number of factors that are increasing underlying costs for private health insurers including utilisation, an ageing demographic, intermediaries, prostheses costs and operating margins.

3.96 The committee considers that the existing principles of community rating and risk equalisation are key to ensuring equity in Australia's private health insurance market and supports their continuation.

3.97 The committee notes the reforms announced by the government on 13 October this year. The committee's comments on these reforms are included in Chapter 5.

3.98 The committee also notes the substantial profits that private health insurers are recording which to a certain extent undermines their argument that underlying costs are driving up premiums.

Chapter 4

Using private health insurance

4.1 This chapter will consider the use of private health insurance in a range of different settings, including in public hospitals, out-of-hospital care and in dentistry.

Public hospitals

4.2 A number of submitters to the inquiry were concerned that current arrangements allow policy holders to be treated as private patients in a public hospital.[1]

4.3 The National Health Reform Agreement (Reform Agreement) allows a patient to elect to be treated as a private patient in a public hospital.[2]

4.4 The Independent Hospital Pricing Authority (IHPA), one of the bodies created by the Reform Agreement, commissioned professional services firm Ernst and Young (EY) to write a report on the utilisation of private patients in public hospitals.[3] The IHPA provided the committee with a copy of the EY report that noted that more people are choosing to be treated as private patients in public hospitals.[4] The rate of increase has varied across Australia as the below table shows.

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1 National Rural Health Alliance (NRHA), *Submission 48*, p. 6; HBF, *Submission 63*, p. 10; Royal Australasian College of Surgeons, *Submission 69*, [p. 3]; Australian Nursing and Midwifery Federation (ANMF), *Submission 70*, [p. 5]; Day Hospitals Australia, *Submission 91*, p. 3; Ramsay Healthcare, *Submission 190*, [p. 3].

2 Amanda Biggs, *Private Health Insurance: a quick guide*, 4 August 2017, p. 2 http://parlinfo.aph.gov.au/parlInfo/download/library/prspub/5434084/upload_binary/5434084.pdf (accessed 27 November 2017).

3 Independent Hospital Pricing Authority (IHPA), *Submission 2*, p. i.

4 *Submission 2*, pp. 9–10.

Table 4.1 - Proportion of public hospital separations funded by private health insurance by State and Territory 2008-09 to 2014-15

Year	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	National
2008–09	15.8%	8.9%	4.0%	6.9%	8.4%	13.2%	6.5%	0.7%	9.7%
2009–10	17.1%	9.7%	4.5%	6.6%	8.2%	15.0%	6.6%	0.5%	10.4%
2010–11	17.2%	9.8%	5.7%	5.9%	7.4%	15.1%	6.8%	0.6%	10.5%
2011–12	17.2%	10.5%	8.3%	5.6%	7.2%	16.7%	7.4%	0.6%	11.1%
2012–13	19.0%	12.9%	10.6%	6.1%	7.6%	17.7%	9.2%	0.7%	13.0%
2013–14	20.0%	13.3%	11.7%	7.5%	8.2%	18.4%	10.3%	0.8%	13.9%
2014–15	20.7%	13.3%	12.1%	7.7%	8.1%	18.3%	10.8%	1.4%	14.1%
Growth in proportion between 2008–09 and 2014–15	4.9 percentage points	4.4 percentage points	8.1 percentage points	0.8 percentage points	-0.3 percentage points	5.1 percentage points	4.3 percentage points	0.7 percentage points	4.4 percentage points

Source: IHPA, *Submission 2*, p. 10.

4.5 The EY report investigated whether a change in the hospital funding model—from block funding to Activity Based Funding (ABF)—was driving the increase in the number of patients electing to be treated privately.[5] The report concluded that ABF was not a significant driver of the increase, but that intentional policy settings adopted by state governments are attracting larger numbers of private patients.[6]

4.6 IHPA told the committee that the Commonwealth provides ABF to the states in accordance with the Reform Agreement.[7] However, public hospitals may have a financial incentive to attract private patients depending on whether the funding model adopted by the state or territory accounts for the revenue generated by private patients:

> …funding provided to State and Territory governments per National Weighted Activity Unit (NWAU) is discounted for private patients through the implementation of a Private Patient Adjustment to account for additional revenue for private patients from Private Health Insurers… and other Commonwealth sources.
>
> Without making allowances for additional funding for private patients through private patient adjustments, there would be financial incentives for State and Territory governments, LHNs [Local Hospital Networks] and

5 IHPA, *Submission 2*, p. 29.

6 *Submission 2*, p. 29.

7 *Submission 2*, p. 5.

public hospitals to increase the number of patients admitted as private patients to public hospitals to generate additional funding.[8]

4.7 The below table briefly explains that there is a financial incentive in some jurisdictions to treat private patients in public hospitals.

Table 4.2—Incentives to attract private patients

State	Private patient adjustments	Incentive
NSW	Local Health Districts (LHDs) and Specialty Health Networks (SHNs) were set private patient targets.[9] Where private patient targets are exceeded, the LHD / SHN retained the associated own source revenue (OSR) and where targets were not met LHDs / SHNs experienced a decline in funding.[10]	Yes
QLD	Only 36 QLD public hospitals were funded using ABF (87 block-funded). There were no private patient adjustments because the Health and Hospital Service (HHS) contributed some OSR. When the HHS was above its target for private patients, it retained the surplus funds. QLD Health advised the IHPA that these funds were used to mitigate the financial impact of unrecovered revenue.[11]	Yes
TAS	The Tasmanian ABF model provided funding to health organisations on a gross basis with revenue targets.[12] The Tasmanian model made no adjustment for private patient accommodation or service adjustments.[13] Therefore, there was an incentive to recruit more private patients because there was no deduction to account for the additional revenue received from private patients.[14]	Yes
VIC	Victoria used a Weighted Inlier Equivalent Separation (WIES) funding model.[15] The WIES model had a 24 per cent discount for private patients.[16] Across some	May be a residual incentive

8 IHPA, *Submission 2*, p. 8.

9 *Submission 2*, p. 13.

10 *Submission 2*, p. 13.

11 *Submission 2*, p. 16.

12 *Submission 2*, p. 23.

13 *Submission 2*, p. 23.

14 *Submission 2*, p. 23

15 *Submission 2*, p. 14.

16 *Submission 2*, p. 15.

	Diagnosis Related Groups (DRGs) the Victorian model did not adequately adjust and there may have been an incentive to target private patients with particular conditions where additional revenue had not been fully incorporated into the discounted WIES price.[17]	
WA	The WA ABF model did not apply any private patient adjustments and so the same amount was received from the state government for public and private patients.[18] The IHPA model provided a private patient discount to offset the revenue states and territories received from alternate sources.[19] However, there may have been an incentive to target private patients if the provider considered it could obtain additional revenue from the Commonwealth or the private health insurer.[20]	May be a residual incentive
SA	SA adopted the National ABF model for acute care but not sub-acute or non-acute care, including the private patient accommodation and service adjustments.[21] The Local Health Networks that provided sub-acute and non-acute care received the same amount from the state government regardless of whether the patient was a private or a public patient.[22] However, they may have had an incentive to target private patients if the provider considered it could obtain additional revenue from the Commonwealth or the private health insurer.[23]	May be a residual incentive
ACT	Hospitals in the ACT received the same amount regardless of whether the patient was public or private because it implemented the full ABF model including the adjustments.[24]	No
NT	There was insufficient information publicly available to determine whether there were price differences between public and private patients.[25]	Unknown

17 IHPA, *Submission 2*, p. 15.

18 *Submission 2*, p. 19.

19 *Submission 2*, p. 19.

20 *Submission 2*, p. 19.

21 *Submission 2*, p. 20.

22 *Submission 2*, p. 21.

23 *Submission* 2, p. 21.

24 *Submission 2*, p. 24.

25 *Submission 2*, p. 25.

4.8 The committee received evidence that some hospitals or health services have hired specific staff, often known as a Private Patient Officer (or similar), to encourage consumers to be treated as private patients in a public hospital.[26] One way hospitals or health services have promoted the use of private health insurance in a public hospital is to tell patients that using their private health insurance will assist the hospital.[27]

4.9 The Haemotology Federation of Australia conducted an 'online community survey' to assist in preparation of its submission to the inquiry.[28] Based on that survey, Haemotology Federation of Australia advised the committee that:

> Although [respondents] were largely required to attend public hospitals due to their bleeding disorder, some respondents described being asked to be admitted as a private patient. Many were happy to do this as they felt it was a contribution to the public health system, and some also preferred this where it gave them the possibility of a single room and choice of doctor, and covered telephone and newspapers.[29]

4.10 Some submitters raised concerns that some institutions apply pressure to policy holders to get them to use their private health insurance.[30]

4.11 The Consumers' Health Forum of Australia told the committee that some policy holders are being coerced or are being asked to elect whether to use their private health insurance in circumstances of severe stress. The Consumers' Health Forum of Australia provided the following example from a patient who responded to one of its private health insurance surveys:

> I had a minor operation at a Private Hospital. Pneumonia from op... Ended up in casualty at a major hospital for 14 hours on a trolley as there was no bed. Serious pain, no relief. A bed became available and I was asked am I "Private or Public"? No explanation. I said private and I just got bills as a result.[31]

4.12 Bupa Australia also told the committee that it had received anecdotal evidence from policy holders that some public hospitals had pressured patients into using their private health insurance:

> Current behaviour by many public hospitals sees many Bupa members receiving a bedside visit after a procedure or letters two or three months after an event pressuring them to declare their private cover and we believe

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26 IHPA, *Submission 2*, p. 27. The report provides job advertisements for roles in NSW and Tasmania.

27 *Submission 2*, p. 28.

28 Haemotology Federation of Australia, *Submission 50*, p. 1.

29 *Submission 50*, p. 7.

30 Consumers' Health Forum of Australia, *Submission 17*, p. 7; Bupa Australia, *Submission 43*, pp. 11–12.

31 *Submission 17*, p. 8 (capitalisation in original).

> this is unquestionably inappropriate and contrary to the intent of private patient declaration.[32]

4.13 Accordingly, Bupa Australia recommended to the committee that policy holders should only be able to elect to use their private health insurance for pre-booked admissions and only if the patient signs a form that is submitted to the insurer at least 24 hours before admission to hospital.[33]

Waiting times

4.14 The committee received evidence that many people believe they will gain access to surgery more quickly if they are admitted to a public hospital as a private patient.[34]

4.15 Choice conducted a survey of 1027 consumers about their reasons for purchasing private health insurance in April 2017.[35] The respondents to Choice's survey found that 43 per cent of respondents and 56 per cent of respondents over the age of 56 considered 'avoiding public hospital waiting lists' as one of the key reasons for purchasing private health insurance.[36]

4.16 The Consumers' Health Forum of Australia received a similar indication from consumers:

> [Consumers' Health Forum of Australia's] work with consumers has found that one of the main reasons they value having PHI [private health insurance] which they can use in a public hospital is that it allows them to 'jump the queue' for elective surgery and obtain it in a period they are satisfied with, instead of the extremely long waiting lists that they perceive come with relying on the public system.[37]

4.17 The Department of Health (Department) provided the committee with a copy of Clause 4 of the Reform Agreement which provides:

> States will provide health and emergency services through the public hospital system, based on the following Medicare principles:
>
> a. eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided by hospitals;
>
> b. access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and

32 Bupa Australia, *Submission 43*, pp. 11–12.

33 *Submission 43*, p. 12.

34 Choice, *Submission 207*, p. 10; Consumers' Health Forum of Australia, *Submission 17*, p. 7.

35 *Submission 207*, p. 8.

36 *Submission 207*, pp. 10–11.

37 Consumers' Health Forum of Australia, *Submission 17*, p. 7.

c. arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.[38]

4.18 The Department explained to the committee that this means that:

> …providing that access to services for public patients is on the basis of clinical need and within a clinically appropriate period, the NHRA [National Health Reform Agreement] does not prevent public hospitals from treating private patients before public patients.[39]

4.19 Mr Charles Maskell-Knight, the Department's Principal Adviser, Health Systems Policy Division, was more explicit, suggesting hospitals may positively discriminate in favour of privately insured patients:

> **Mr Maskell-Knight**: There's a misconception that the Medicare principles require access to services within public hospitals to be based on clinical need, and that was the case from 1984 until 1998. In 1998 the then state and healthcare agreements were changed and the relevant principle was that public patients should receive care on the basis of clinical need within clinically appropriate periods.
>
> **Senator DI NATALE**: What does that mean for private patients?
>
> **Mr Maskell-Knight**: That hospitals may differentiate in favour of them.[40]

4.20 Earlier this year the Australian Institute of Health and Welfare (AIHW) released its *Admitted patient care 2015–16: Australian hospital statistics* report.[41] One of the key findings from that report related to the difference in the median waiting times between public and private patients:

> Overall, Public patients had a median waiting time of 42 days, compared with 20 days for hospitalisations with a funding source of Private health insurance.[42]

4.21 Some submitters were very concerned by the prospect that privately insured patients may be receiving preferential treatment on the basis of their insurance status.[43]

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38 Department of Health (Department), *Submission 127*, p. 10.

39 Department, *Submission 127*, p. 10 (emphasis added).

40 Mr Charles Maskell-Knight, Principal Adviser, Department, *Committee Hansard*, 31 October 2017, p. 68.

41 Australian Institute of Health and Welfare (AIHW), *Submission 68*, p. 3.

42 *Submission 68*, p. 4 (capitalisation in original).

43 Council of Procedural Specialists, *Submission 41*, [p. 6]; Australian Salaried Medical Officers' Federation, *Submission 53*, [p. 2]; Grattan Institute, *Submission 72*, p. 24; hirmma, *Submission 75*, p. 22; Australian Private Hospitals Association (APHA), *Submission 80*, p. 7; National Seniors, *Submission 86*, p. 2; COTA Australia, *Submission 88*, pp. 5–6; Catholic Health Australia, *Submission 238*, p. iii.

4.22 The AIHW noted that there may be some legitimate reasons for differences in the timeframes for private and public patients:

> …there may be differences between public patients and patients funded by other sources, in the conditions treated and in the urgency categories assigned, that may account for some variation in waiting times.[44]

4.23 The Australian Health and Hospitals Association (AHHA) noted that the AIHW data did not take account of acuity or case mix, both of which would impact on waiting times.[45] In relation to the AIHW data, the Queensland Government told the committee that:

> It is important to note that published results do not separate the different urgency categories patients are placed into, which consist of different clinically recommended treatment times (treatment within 30, 90 and 365 days for Category 1, 2 and 3, respectively).[46]

4.24 Consumers' Health Forum of Australia agreed that the AIHW data may require further investigation:

> …the data from which these conclusions are drawn are not necessarily robust and there may be clinical reasons for this apparent trend. There needs to be a recommitment by all stakeholders to the principle of treatment in the public system being based on clinical need. This should be supported by enhanced monitoring and data collection to allow for more investigation before major policy decisions are made in this area.[47]

4.25 In December 2017, the AIHW released a more comprehensive report—*Private health insurance patients in Australian hospitals, 2006–07 to 2015–16*—to address the issues identified in the *Admitted patient care 2015–16: Australian hospital statistics* report.[48] The AIHW *Private health insurance patients in Australian hospitals, 2006–07 to 2015–16* report identified that:

> Private health insurance patients were more likely to be assigned to clinical urgency category 1 (admission within 30 days) compared with public patients and other patients (39%, 27% and 23%, respectively).
>
> Among surgical specialties, the largest differences in the proportion assigned to clinical urgency category 1 were for Neurosurgery (50% for

44 *Submission 68*, p. 4.

45 Australian Healthcare and Hospitals Association (AHHA), *Submission 3*, p. 8.

46 Queensland Government, *Submission 85*, [p. 5].

47 Consumers' Health Forum of Australia, *Submission 17*, p. 7.

48 AIHW, *Private health insurance patients in Australian hospitals, 2006–07 to 2015–16*, 6 December 2017, https://www.aihw.gov.au/reports/hospitals/private-health-insurance-patients-hospitals/contents/table-of-contents (accessed 6 December 2017).

> private health insurance patients, 30% for public patients, and 32% for other patients).[49]

4.26 As an example, the AIHW examined data for total knee reconstructions. The data revealed that patients with private health insurance had shorter median waiting times than public patients:

> For *Total knee replacement*, 50% of private health insurance patients were admitted within 76 days for their surgery, compared with 203 days for public patients and 54 days for other patients.[50]

4.27 Whilst some submitters called for an end to policies that would allow patients to be treated as a private patient in a public hospital, other submitters warned that ending such policies could have unintended consequences. The Queensland Government told the committee:

> A possible unintentional outcome of restrictions on private patient practices could be that hospitals might have difficulty attracting and retaining medical practitioners, leading to increased difficulty meeting growing health service demand.[51]

Committee view

4.28 The committee is concerned about the trend in the number of people electing to be treated as private patients in a public hospital. The committee has concerns that state and territory governments are implementing policies that encourage hospitals and health networks to attract private patients.

4.29 The committee notes the AIHW findings that confirm that median waiting times for private patients are shorter than for public patients, but longer than for 'other' patients.

4.30 The committee was also concerned by the evidence of consumer groups that some people feel pressured to elect to be treated as a private patient. The committee maintains that the decision on whether to be treated as a private patient ought to be made by the patient with full knowledge of the financial and associated consequences.

Hospitals and out-of-hospital care

4.31 The committee received evidence that current regulation prevents private health insurers from being able to constructively engage with insured consumers to manage their risks.[52]

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49 AIHW, *Private health insurance patients in Australian hospitals, 2006–07 to 2015–16*, 6 December 2017, p. ix. The classification 'other' was assigned to patients whose separation was self-funded or funded other than by private health insurance or public election. Some examples include funding by the Department of Veterans' Affairs or Department of Defence, part of a worker's compensation or third party motor vehicle claim.

50 AIHW, *Private health insurance patients in Australian hospitals, 2006–07 to 2015–16*, 6 December 2017, p. x (italics and capitalisation in original).

51 Queensland Government, *Submission 85*, [p. 4].

52 Private Healthcare Australia, *Submission 18*, p. 26.

4.32 Private Healthcare Australia told the committee that:

> 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.[53]

4.33 Private Healthcare Australia also told the committee that as a result of these legislative restrictions people may be unnecessarily hospitalised:

> 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 [sic] health funds to negotiate with providers for appropriate remuneration in an appropriate setting of care.[54]

4.34 As noted in Chapter 2, the Royal Australian College of General Practitioners (RACGP) have also acknowledged that private health insurers may have a role to play in helping to keep Australians healthy:

> PHI [private health insurance] organisations can improve the health of their members and Australians more widely through supporting services not funded through Medicare such as:
>
> - chronic disease management – providing additional services for patients with complex and chronic disease
> - care coordination and team care – supporting patients to access nurse services, additional allied health visits and programs to assist patients transitioning between primary and tertiary healthcare, including preadmission or post-operative care
> - general practice modernisation – supporting patients to access telehealth consultations and services with their regular GP [general practitioner]; supporting the use of newer technologies…[55]

4.35 The private health insurance industry has indicated that this is an area that it would like to move into. Private Healthcare Australia told the committee:

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53 *Submission 18*, p. 26.

54 Private Healthcare Australia, *Submission 18*, p. 26.

55 Royal Australian College of General Practitioners (RACGP), *Submission 9*, p. 2.

> Out-of-hospital, we can't contribute. The costs of people treating their cancer out-of-hospital, we can't contribute. Mental health treatment out-of-hospital…the current regulatory system means we cannot easily contribute to patient out-of-hospital costs in the situations where that would avoid hospitalisation. That is something in the modern world we think needs to change. It's also currently acting as a perverse incentive encouraging unnecessary admissions to hospital in some key treatment areas.[56]

4.36 The AHHA suggested that private health insurers ought to be able to contribute to out-of-hospital care in certain circumstances:

> The AHHA recommends that where medical services are provided on referral from the hospital in an outpatient, community or home setting, that these services be eligible for cover through private health insurance.[57]

4.37 NIB also suggested that extending the Broader Health Cover provisions may help to attract more young people and keep premiums low.[58]

4.38 The Department, however, told the committee that private health insurers have been able to provide some of these services since April 2007.[59] The Department indicated that private health insurers could already offer Chronic Disease Management Programs and hospital-substitute treatment, including chemotherapy or a dialysis in a patient's own home or a community clinic.[60]

4.39 The Grattan Institute was supportive of providing private health insurers some greater latitude to determine what products they offer:

> The most recent Australian study I've seen suggests that home-based rehab is just as useful as in-patient rehab. We need to give the private health insurance funds more ability to manage what they are paying for. At the moment they are highly constrained by regulation. If there's going to be more transparency, and more demands made on them, they ought to have a right to more flexibility in what they do.[61]

4.40 However, the RACGP considered that the committee should be cautious in extending the reach of private health insurers into primary care.[62] The RACGP warned that some of the risks may include the duplication and fragmentation of care—

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56 Dr Rachel David, Chief Executive Officer, Private Healthcare Australia, *Committee Hansard*, 31 October 2017, p. 48.

57 AHHA, *Submission 3*, p. 13.

58 NIB, *Submission 24*, p. 2.

59 Department, *Submission 127*, p. 27.

60 *Submission 127*, p. 27.

61 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 31 October 2017, p. 15.

62 RACGP, *Submission 9*, p. 2.

potentially involving 'preferred GP [general practitioner] providers'—removal of general practitioners' clinical independence or access on the basis of insured status.[63]

Case study: dentistry

4.41 The committee received a significant number of submissions from dental practitioners, or individuals who work in the dental industry, about the effect that private health insurance has had on private dentistry.[64] The committee received some similar submissions from optometrists and physiotherapists.[65] The committee considers that dentistry provides a useful a case study through which to examine the role of private health insurance in the provision of primary health care.

Contracted dentists

4.42 The committee heard that some dentists have entered into contracts with private health insurers to charge agreed fees to the private health insurer's policy holders.[66] In return, the private health insurer markets the dental practice and provides better rebates to the private health insurer's policy holders when they visit that clinic.[67] Private health insurers often refer to these contracted dentists as 'preferred providers' or 'member's choice' providers.[68]

4.43 The most common concern raised by dental practitioners was that private health insurers provided different rebates to insured consumers based on whether their dentist had a contract with the consumer's private health insurer.[69]

4.44 Dental practitioners submitted that it was unfair to consumers who had paid for extras policies to receive lower rebates because they decided to use their private health insurance to visit a non-contracted dentist.[70] These submitters argued that consumers who purchase the same extras policy from the same insurer ought to receive the same rebate regardless of which dentist the consumer decides to visit.[71]

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63 *Submission 9*, pp. 2–3.

64 See for example Name withheld, *Submission 92*, [pp. 1–4]; Name withheld, *Submission 124*, [pp. 1–2]; Name withheld, *Submission 256*, [p. 1–4].

65 See for example Australian Physiotherapy Association, *Submission 74*, p. 10; Optometry Australia, *Submission 8*, pp. 3–4.

66 See for example Name withheld, *Submission 168*, [p. 2]; Name withheld, *Submission 275*, [p. 2].

67 See for example Name withheld, *Submission 128*, [p. 2]; Name withheld, *Submission 210*, [p. 1].

68 See for example Name withheld, *Submission 100*, [p. 1]; Name withheld, *Submission 241*, [p. 1].

69 See for example Name withheld, *Submission 97*, [p. 2]; Name withheld, *Submission 280*, [p. 1].

70 See for example Name withheld, *Submission 103*, [p. 1]; Name withheld, *Submission 98*, [p. 1]; Name withheld, *Submission 137*, [p. 1].

71 See for example Name withheld, *Submission 254*, [p. 1]; Name withheld, *Submission 229*, [p. 1].

4.45 The Australian Dental Association (ADA) told the committee that in some cases, the rebates private health insurers paid to consumers that visited non-contracted dentists were so low that dentists who charged substantially lower rates struggled to compete against contracted providers:

> You will see from these examples that the issue is not with the fee charged, but rather the rebate paid. In the first two scenarios the fee for the porcelain crown is less at an independent, non-contracted dentist. However, the rebate provided by the fund is significantly higher when the patient is treated by a contracted dentist. This results in a substantial difference in the patient's out-of-pockets cost, which has little or nothing to do with the fee charged by the dentist.[72]

4.46 The ADA and many dental practitioner submitters considered that consumers would be better empowered to make decisions about where to use their private health insurance if insurers were required to pay the same rebate to insured consumers regardless of which dentist they visited.[73] Accordingly, the ADA and the dental practitioners called for an end to the practice of applying differential rebates depending on whether the dentist was contracted or not.[74]

4.47 In response to a question on notice, Bupa Australia disputed the suggestion that a consumer who visited a cheaper dentist could end up with larger out-of-pocket costs because of the rebate provided by the private health insurer.[75] However, the ADA provided the committee with further documents to substantiate its claim.[76]

4.48 Submitters advised the committee that clients who called their private health insurer have often been provided with incorrect information. One concern was that clients were sometimes told that the reason they received a low rebate was because the dentist 'charged too much'.[77]

4.49 Specialist dentists, such as orthodontists and endontists, told the committee that private health insurers were providing advice to insured consumers that, instead of going to see the dental specialists recommended by their dentist, they should visit a 'preferred provider' dentist.[78]

4.50 One endontist told the committee:

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72 Dr Sachs, *Committee Hansard*, 31 October 2017, p. 21; ADA, *Rebate Disparity Case Study*, [p. 1] (tabled 31 October 2017).

73 Dr Sachs, *Committee Hansard*, 31 October 2017, p. 21. See for example Name withheld, *Submission 155*, [pp. 3–4].

74 ADA, *Submission 222*, p. 6. See also for example Name withheld, *Submission 145*, [p. 5]; Name withheld, *Submission 242*, [p. 1]; Name withheld, *Submission 276*, [p. 1].

75 Bupa Australia, answer to questions on notice, 31 October 2017 (received 17 November 2017).

76 ADA, *Information responding to statements made in submissions, submissions responses and answers to questions on notice*, [p. 1], received 28November 2017.

77 See for example Name withheld, *Submission 141*, [p. 1]; Name withheld, *Submission 214*, [p. 1]; Name withheld, *Submission 270*, [p. 1].

78 Name withheld, *Submission 119*, p. 1; Name withheld, *Submission 211*, [p. 1].

> …most of my patients are seeking relief from pain or discomfort caused by either trauma or infection. They are seeking that treatment through a registered specialist because they have been referred by their general dental practitioner to achieve the best possible outcome for their long-term health. Most have complex management needs. However, my patients report at least weekly that they are disappointed and frustrated by the fact that, on inquiry about rebates, health funds actively endeavour to redirect them to health fund preferred providers, or health fund clinics, where no specialist care is available. The justification for this is that the preferred providers or health fund clinics provide better rebates (despite the fact it is not specialist care).[79]

4.51 Many other specialists expressed similar views and considered the advice of the private health insurer's staff to be clinical in nature and therefore inappropriate.[80]

4.52 Another concern that dental practitioners raised with the committee was that new dentists are unable to join the 'preferred provider' schemes.[81] The inability to become a preferred provider meant that they were unable to ensure that their clients received higher rebates. In some cases, this meant that independent dentists lost clients who were under financial pressure.[82]

Anti-competitive practices

4.53 The dental practitioner submitters to the inquiry considered that the 'preferred provider' schemes, and a number of other practices engaged in by the private health insurers, are anti-competitive.[83]

4.54 One of the concerns that the dental practitioners raised was that private health insurers have started a process of vertical integration where private health insurers now own some contracted dental clinics.[84]

4.55 Many dental practitioners considered that owning clinics was a conflict of interest because the private health insurer, with whom they were now in competition, was able to unilaterally determine the rebate that insured consumers would get if they visited a non-contracted dentist.[85]

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79 Name withheld, *Submission 211*, [p. 1].

80 See for example Name withheld, *Submission 253*, [p. 1]; Name withheld, *Submission 259*, [p. 1].

81 See for example Name withheld, *Submission 102*, [p. 1]; Name withheld, *Submission 200*, [p. 2].

82 See for example Name withheld, *Submission 130*, [p. 1]; Name withheld, *Submission 149*, [p. 1].

83 See for example Name withheld, *Submission 179*, [p. 1]; Name withheld, *Submission 186*, [p. 2]; Name withheld, *Submission 227*, [p. 1].

84 See for example Name withheld, *Submission 111*, [p. 2]; Name withheld, *Submission 223*, [p. 1]; Name withheld, *Submission 246*, [p. 2].

85 See for example Name withheld, *Submission 275*, [p. 2]; Name withheld, *Submission 194*, [p. 2].

4.56 In addition, submitters told the committee that private health insurers were actively steering or redirecting policy holders toward contracted dentists where they could obtain a better rebate.[86] This steering could take the form of a letter or phone call to a client after a visit to an independent dentist advising them that they should visit a 'preferred provider'.[87]

4.57 Bupa Australia rejected the suggestion that it redirected insured consumers from independent dentists to contracted dentists:

> There are a lot of things said about us 'directing' people—we don't. We promote that there is a range of benefits people can access via their products. Every consumer has the same choice in their product.[88]

4.58 Dental industry submitters were also concerned that the private health insurers could compete against them with full knowledge of what practitioners' fees are and what rebates patients are receiving. Private health insurers obtain this information through a billing system called the Health Industry Claims and Payment Service (HICAPS).[89]

4.59 Dental practitioners told the committee that through HICAPS:

> The PHI's [sic] have access to all of the information processed by the HICAPS machine in every dental surgery. This means that they can monitor a dentists [sic] fees, the type of work, client base size and composition, and obviously if any of their own customers are patients to that dentist. This puts the dentist at an extreme disadvantage.[90]

4.60 Since 1999 the Australian Competition and Consumer Commission (ACCC) has produced 18 reports for the Senate about the anti-competitive practices of private

86 See for example Name withheld, *Submission 143*, [p. 2]; Name withheld, *Submission 264*, [p. 1]; Name withheld, *Submission 166*, [p. 2].

87 See for example Name withheld, *Submission 131*, [p. 3]; Name withheld, *Submission 152*, [p. 3].

88 Mr Adam Longshaw, Director, Health and Benefits, Bupa Australia, *Committee Hansard*, 31 October 2017, p. 54.

89 See for example Name withheld, *Submission 112*, [p. 2]; Name withheld, *Submission 143*, p. 3; Name withheld, *Submission 165*, [p. 2].

90 Name withheld, *Submission 111*, [p. 3].

health insurers.[91] The ACCC has been asked to consider if 'preferred provider' schemes are anti-competitive on a number of occasions.[92]

Management of services

4.61 Both 'preferred provider' dental practitioners and independent practitioners raised concerns in relation to attempts by private health insurers to influence the treatment of patients by refusing to pay for particular item combinations to be charged together or by imposing restrictions on benefits.[93]

4.62 One submitter explained to the committee:

> For example, you are not allowed to have a comprehensive dental examination and a dental crown on the same day…I once had a patient present with a broken tooth so I undertook a comprehensive examination and performed a crown for the tooth on the same day to fix the problem. But the patient received no rebate for the crown. The patient obviously was very upset. The patient left to discuss it with the PHI [private health insurer's] office, and so I received a call by the PHI representative. I was told that to do a crown on the same day as the comprehensive exam was not a reasonable treatment and violated their rules... So I was told that perhaps I should not charge the patient for the dental examination. That way the patient can receive the full rebate for the crown. They were asking me to remove a legitimate code and were trying to manipulate my clinical operations by suggesting that my treatment was not reasonable! That is not their decision to make as the insurer.[94]

4.63 Another submitter explained that they had a similar experience with private health insurers placing restrictions on performing clinically necessary dental work:

> Some health funds restrict or do not pay on item numbers related to crowns (611, 613, 615 or 618) when an item of removing a crown has been performed on the same day (655). It is common practice that if a crown needs replacement due to decay or breakages, then the crown is removed, the tooth repaired and a crown commenced for a new crown on the same day to avoid further harm and exposure of the tooth. Patients I have treated

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91 See for example Australian Competition and Consumer Commission (ACCC), *Report to the Australian Senate: On anti-competitive and other practices by health insurers and providers in relation to private health insurance for the period 1 July 2015 to 30 June 2016*, 17 July 2017, https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2015-16 (accessed 4 December 2017) (Report to the Senate 2015–16). See also *Journals of the Senate*, No. 27, 25 March 1999, p. 626.

92 See for example ACCC, Report to the Senate 2015-16, pp. 28–29; ACCC, *Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance for the period 1 July 2010 to 30 June 2011*, 6 June 2012, pp. 30–33, https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2010-11 (accessed 4 December 2017).

93 See for example Name withheld, *Submission 96*, [p. 2]; Name withheld, *Submission 99*, [p. 1]; Name withheld, *Submission 234*, [p. 2].

94 Name withheld, *Submission 205*, [p. 5].

> have been left paying higher out of pocket costs and financially worse off than expected because the health fund has not been clear in their rebates on these items when associated with other items.[95]

4.64 The dental practitioners explained that they used to be able to accurately predict patients out-of-pocket costs because private health insurers used to publish guides to their rebates:

> Many years ago, the Health Funds used to publish their rebates in a booklet. This was of benefit to their customers and to their Dentists because we were able to let our patients know how much they might receive as a rebate from their Health Fund and what the gap payment may be. The Health Funds stopped publishing these rebate booklets because we were able to show our patients (ie their customers) that the rebates had not increased, or increased only slightly, over the years and also we were able to show comparisons of rebate amounts between various Health Funds. The Health Funds claimed that they stopped publishing their rebates because they were "commercial in confidence". The current situation is that when we present a treatment plan to our patients, we give them our fees as well as the item numbers involved so that they can contact their PHI [private health insurer] to see how much they may get back as a rebate. In some cases, when the patient has contacted their PHI to make this enquiry, they have been told that our fees are high, or in some cases, that the patient would receive more rebate if they went to one of the PHI's "preferred providers".[96]

Hospital contracting in paediatric dentistry

4.65 The committee heard evidence that some forms of surgery are financially unviable for private hospitals because private health insurers provide them with very low rebates.[97]

4.66 The committee heard evidence from paediatric dentists that they have been excluded from private hospitals and day surgeries because the hospitals receive low rebates from private health insurers:

> The rebate provided by private health insurers to private hospitals for in-hospital paediatric dental surgery is so low it is not financially viable for private hospitals to accommodate paediatric dentistry in their facilities. As a result, patient access to care is becoming increasingly restricted due to hospitals and other facilities excluding paediatric dentistry.[98]

4.67 The Australian Association of Paediatric Dentists (AAPD) noted that the unwillingness of the private health insurers to negotiate contracts meant that facilities that accommodate paediatric dentists are forced to rely on second tier default benefits.[99] Second tier default benefits are a safety net for small hospitals that do not

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95 Name withheld, *Submission 154*, [p. 2].

96 Name withheld, *Submission 219*, [pp. 1–2] (capitalisation in original).

97 Australian Association of Paediatric Dentists (AAPD), *Submission 25*, p. 3.

98 Dr Daniel Ford, Treasurer, AAPD, *Committee Hansard*, 31 October 2017, p. 22.

99 AAPD, *Submission 25*, p. 3.

have agreements with private health insurers, which is approximately 85 per cent of the average rate for a particular service.[100]

4.68 The AAPD told the committee that the second tier default benefits were inadequate:

> Given that the full rebate is inadequate, the amount paid under 2nd Tier benefits is grossly inadequate to cover the cost of providing the services and the patient must be charged a fee over and above the 2nd Tier rate. This results in reduced access to care and financial hardship.[101]

4.69 That financial hardship is compounded because the Child Dental Benefits Schedule prevents children from being eligible to receive benefits if they received treatment under general anaesthetic.[102]

4.70 The AAPD noted that a survey of its members indicated that fewer facilities were accommodating paediatric dentists:

> …our members have reported; the closure of facilities due to unsustainability financially, a reduced number of operating sessions, unreliable ad hoc time only, changes in sessions to accommodate a more profitable surgeon, time restraints on cases and denial of access despite being accredited for many years at a facility.[103]

4.71 The Australian and New Zealand Society of Paediatric Dentistry also reported that its members have had operating rights restricted in favour of surgeons performing more profitable surgeries.[104]

Committee view

4.72 The committee acknowledges that private health insurers may be able to play a greater role in the management of chronic conditions and out-of-hospital care. The committee accepts that it is desirable, where possible, to avoid unnecessary hospitalisation and that providing private health insurers with some greater latitude to offer these services may be beneficial. However, the committee is mindful of the concerns raised by the RACGP about duplication and fragmentation of care.

4.73 The committee acknowledges the concerns of dental practitioners and, in particular, the financial pressure that can be applied to their businesses by private health insurers. The committee is concerned by some of the practices raised above, such as the active redirection of patients and the restriction on the payment of certain item numbers.

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100 *Submission 25*, p. 3.

101 *Submission 25*, p. 3 (capitalisation in original).

102 *Submission 25*, p. 4.

103 AAPD, *Submission 25*, p. 3.

104 Australian and New Zealand Society of Paediatric Dentistry, *Submission 42*, [p. 5].

4.74 The committee is also concerned about the exclusion of paediatric dentists from operating theatres in private hospitals and day surgeries and its effect on children who are in need of specialist dental services.

4.75 Until the issues raised in this chapter are resolved the committee would be concerned about the further extension of private health insurance to out-of-hospital care.

Chapter 5

Conclusions

5.1 Private health insurance is complicated and the committee acknowledges that it is difficult to achieve a balance between offering more comprehensive products and maintaining affordable premiums for consumers.

5.2 In this inquiry, the committee received evidence from consumers who are finding private health insurance increasingly unaffordable. Meanwhile, private health insurers told the committee that they had little ability to control the costs in their supply chains.

5.3 Submitters—consumers, private health insurers, device manufacturers and dental practitioners—called on the committee to increase transparency, both in private health insurance and across the health industry more generally. As discussed in greater detail below, transparency may assist consumers to be better informed about purchasing and using their private health insurance.

Government's 2017 reforms

5.4 On 13 October 2017 the Minister for Health, the Hon. Greg Hunt MP (Minister), announced a series of reforms to private health insurance including:

- a new 'gold', 'silver', 'bronze' and 'basic' system of categorising policies;
- improving access to mental health services;
- permitting travel and accommodation benefits for Australians living in rural and regional areas to be offered under a hospital policy;
- increasing the powers of the Private Health Insurance Ombudsman (PHIO) to allow for inspections and audits;
- establishing a committee to consider out-of-pocket costs;
- allowing private health insurers to offer a 'reverse' lifetime health cover discount;
- further Prostheses List benefit reductions;
- an agreement with the Medical Technology Association of Australia (MTAA) to reduce the costs of prostheses;
- increasing maximum excess levels;
- removing coverage for some natural therapies;
- streamlining second tier administrative reforms; and
- discussing options relating to private patients in public hospitals as part of the next National Health Agreement.[1]

1 Department of Health, *Submission 127—Attachment 2*.

5.5 The committee commends some of the proposed changes. For example, as discussed in Chapter 2, the committee received evidence that it was very difficult for consumers in rural and regional areas to access private healthcare services. The committee notes, in particular, evidence from the National Rural Health Alliance who called for reform in this area. The committee considers that including travel and accommodation benefits in hospital policies, and thereby allowing the costs to be shared through the risk equalisation pool, is beneficial for consumers.

5.6 The committee approaches some of the other announced changes with caution. In Chapter 2, the committee noted the difficulty faced by consumers in understanding what their private health insurance policy covers them for and the challenges faced by consumers when their coverage is different than what they thought it was. Increasing the maximum excess that consumers must pay before receiving coverage may compound this problem. The committee notes the Government's stated commitment to consult on implementation in the first half of 2018.

5.7 In Chapter 2 the committee noted that many submitters were broadly supportive of a categorisation system that would assist consumers. The committee considers that the classification of 'gold', 'silver', 'bronze' and 'basic' may assist consumers depending upon what is included in each category and how well the categories are able to be understood.

5.8 The committee also noted that hirmaa, Private Healthcare Australia and private health insurers outlined that lower cost policies were used by many Australians who valued the more limited coverage where they met members' personal circumstances and that lower cost products played a role in rural and regional Australia.

5.9 However, the committee notes the concerns raised by submitters, such as the Australian Nursing and Midwifery Federation, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the National Association of Specialist Obstetricians and Gynaecologists about 'junk' or 'basic' policies, which they considered should be discontinued because they provide low value to consumers. The committee also notes that this was the Government's view before the last election, when the then Minister for Health, the Hon. Sussan Ley MP, committed to 'weed out junk policies by ensuring consumers have access to a product with a mandated minimum level of cover'.[2]

5.10 In Chapter 3, the committee considered evidence from the Department of Health (Department), and others, that 'junk' or 'basic' policies make a substantial contribution to risk equalisation and decrease pressure on premiums.

2 The Hon. Sussan Ley MP, former Minister for Health, 'Coalition's plan to ensure private health insurance delivers value for money', http://sussanley.com/coalitions-plan-to-ensure-plan-to-ensure-private-health-insurance-delivers-value-for-money/ (accessed 15 December 2017).

Recommendation 1

5.11 The committee recommends that the Commonwealth Government undertake an evaluation of the value provided by 'basic' policies as a fourth product category (Gold/Silver/Bronze/Basic). Following that evaluation, the Commonwealth should determine whether consumers are best served by a three-tier or a four-tier product categorisation system.

5.12 In Chapter 2, the committee noted that submitters raised concerns about access to mental health services and whether comprehensive psychiatric services should be made a mandatory inclusion in private health insurance policies. However, the committee also noted the Department's advice that making comprehensive psychiatric services a requirement for a complying health insurance product would have the effect of increasing premiums by 15 per cent.

5.13 The Minister has announced that patients with limited mental health cover will be able to upgrade once without serving a waiting period. The committee considers that the Minister's announcement is a good first step, though the committee notes that significant further detail is required from the Minister.

5.14 The committee received evidence that private health insurance is becoming increasingly unaffordable for many Australians. The committee notes Private Healthcare Australia's evidence that private health insurance may become unaffordable for one in five Australians in the next six years and the evidence of the Australian Healthcare and Hospitals Association that Australians pay 20 per cent of their healthcare costs out-of-pocket, more than any comparable Organisation for Economic Co-operation and Development (OECD) country.[3]

5.15 The committee notes that the Minister has announced that he will convene a committee to consider how to achieve transparency in out-of-pocket costs. However, this committee has already heard some evidence regarding transparency measures that can be taken immediately to assist consumers.

5.16 Evidence received by this committee suggests that dentistry is one area that requires attention. Dentists and practice managers informed the committee that they were unable to advise clients what their out-of-pocket costs would be because they did not know what rebate the private health insurer would provide. Instead, consumers are required to phone private health insurers to attempt to seek advice on what they might be covered for.

5.17 Dentists advised the committee that private health insurers have previously published guides to their rebates. The committee considers that requiring private health insurers to publish comprehensible guides to their rebates would be of assistance to consumers and other health practitioners.

3 Private Healthcare Australia, *Submission 18*, p. 12; Ms Alison Verhoeven, Chief Executive, Australian Healthcare and Hospitals Association, *Committee Hansard*, 5 July 2017, p. 20.

Recommendation 2

5.18 The committee recommends that the Minister for Health require private health insurers to publish all rebates by policy and item number.

5.19 Another area that the committee considers warrants examination is the fees charged by medical specialists. The committee received evidence that some surgeons, and other specialists, charge excessive fees. The committee also heard evidence that the Royal Australasian College of Surgeons would accept the public disclosure of surgeons' fees, and that it would be a relatively simple task to publish fees in order to enable consumers to better understand their out-of-pocket costs and make an informed decision.

5.20 Public disclosure of fees would introduce more discipline to the market, and would empower consumers to request a referral from their general practitioner to a preferred specialist that they can afford.

5.21 Ideally, fees would be published in a searchable database which would also include the type and volume of procedures performed, and risk-adjusted complication and error rates, to enable consumers to also weigh the relative skill of their surgeon/medical practitioner.

5.22 Some submitters recommended the implementation of an online searchable tool that patients and private health insurers could use to obtain an estimate of professional fees. The committee believes that such a scheme is worthy of further consideration.

Recommendation 3

5.23 The committee recommends that the Minister for Health instruct the Department of Health to publish the fees of individual medical practitioners in a searchable database.

5.24 The committee notes the Prostheses List reforms announced by the Minister and the agreement with the MTAA to constrain the cost of implantable devices. As discussed in Chapter 3, Prostheses List costs have been contributing to rising premiums and the committee commends efforts to reduce the benefits paid in this area.

5.25 The committee notes the MTAA's recommendation that the accounts of each private health insurer be audited by the Australian National Audit Office to ensure that savings from the Prostheses List reforms are passed on to consumers. Private health insurers did not oppose the recommendation for an audit. The committee considers that it is important to ensure that savings from these reforms are applied to making premiums more affordable for consumers.

Recommendation 4

5.26 The committee recommends that the Commonwealth Government ask the appropriate body (such as the Australian National Audit Office, Department of Health, Australian Prudential Regulation Authority, Australian Competition and Consumer Commission or the Private Health Insurance Ombudsman) to

report in 12 months on whether the benefits from the Prostheses List reforms are being passed on to consumers.

5.27 As part of the private health insurance reforms announced on 13 October, the Government announced that the PHIO's website would be upgraded to make it easier for consumers to compare insurance products.

5.28 The independent website privatehealth.gov.au provides consumers with objective comparator information on private health insurance policies. However, the PHIO has currently has no budget to promote the website with the result that awareness appears limited, with only about one in eight consumers using the service in 2016.

Recommendation 5

5.29 The committee recommends that the Commonwealth Government provide additional funding to the Private Health Insurance Ombudsman to enable it to widely promote its upgraded website and comparison service to consumers.

5.30 Submitters raised concerns with the committee about privately funded patients being treated in public hospitals. The committee notes the increase in the number of patients electing to be treated privately in public hospitals, though also notes that this has always been a feature of Australia's mixed public-private system. The committee was also concerned that some state governments appear to have adopted policies with the intention of attracting private patients, though notes that states feel this is necessary in the context of Commonwealth hospital cuts.

5.31 The committee received anecdotal evidence that some consumers were being asked to make an election about whether to use their private health insurance under some stress. The committee considers that all consumers should be able to make an election with full knowledge of the financial and other consequences and free of pressure or duress.

5.32 The committee notes the Department's perspective that public hospitals may treat private patients ahead of public patients, provided public patients are treated within a clinically appropriate period.

5.33 The latest Australian Institute of Health and Welfare report concludes that patients with private health insurance were more likely to be assigned a higher clinical urgency rating for a similar procedure than a public patient. The committee is concerned by this practice and notes that the Minister intends to raise the matter as part of the next National Health Agreement. The committee agrees that this matter ought to be given high priority by the Minister, the Department and by state and territory governments.

Recommendation 6

5.34 The committee recommends that all state and territory governments review policies and practices regarding private patient election to ensure that all patients can provide informed financial consent.

Recommendation 7

5.35 The committee recommends that the Commonwealth Government and state governments ensure that public hospitals provide equality of access for public and private patients based only on clinical need and not on insurance status.

5.36 In Chapter 4, the committee considered whether state and territory activity based funding models sufficiently adjust to account for privately funded hospital separations. The committee received evidence indicating that some state and territory policies do have such an incentive, particularly where states and territories retain revenue resulting from exceeding private patient targets. The committee was concerned that such financial incentives appear to be leading to an increase in privately funded public hospital separations.

Recommendation 8

5.37 The committee recommends that the issue of private patient adjustments be considered in the context of negotiations on the next National Health Agreement, consistent with the Minister's broader approach.

Other concerns raised with the committee

5.38 The committee received evidence that private health insurers may be able to make a greater contribution to out-of-hospital care. The committee notes that private health insurers are already able to contribute under the Broader Health Cover provisions of the *Private Health Insurance Act 2007*, but recognises that private health insurers would like to cover a wider range of out-of-hospital procedures.

5.39 The committee understands that unnecessary hospitalisation should be avoided where possible and that there is limited clinical evidence that hospital based rehabilitation is superior to rehabilitation provided in a patient's home. Equally, the committee understands that introducing another payer into out-of-hospital care risks undermining the universality of Medicare and inflating costs for both consumers and the Commonwealth.

5.40 The committee is concerned that private health insurers will place limitations on benefits in an attempt to keep costs down. As noted in Chapter 4, private health insurers have placed restrictions on benefits that may be claimed and that this delivers poor outcomes for patients who either incur greater out-of-pocket costs or are forced to delay treatment.

Recommendation 9

5.41 The committee recommends that the Commonwealth Government consider extending the Broader Health Cover provisions of the *Private Health Insurance Act 2007* on the basis that such services, if offered, do not undermine the universality of Medicare by creating a two-tiered primary health care system, do not inflate costs for the Commonwealth by introducing another payer, are provided on a comprehensive basis and do not delay treatment or lead to greater out-of-pocket costs.

Recommendation 10

5.42 The committee recommends that the Commonwealth Government review current regulations to allow private health insurers to rebate out-of-hospital medical treatment where it is delivered, on referral, in an out-patient, community or home setting.

5.43 The committee was very concerned to learn that many children are unable to have serious dental issues addressed because private health insurers will not provide adequate rebates to private hospitals and day surgeries. The committee received evidence that private hospitals are revoking the admitting rights of paediatric dentists and adding children requiring serious dental work to public waiting lists. The committee urges all parties to work together to resolve these issues in the interests of paediatric dental patients.

Recommendation 11

5.44 The committee recommends that private health insurers engage in negotiations with private hospitals and paediatric dentists to urgently resolve the issues surrounding paediatric dentistry.

5.45 The committee also received significant evidence from dental practitioners about the effect 'preferred provider' schemes were having on independent dentistry. In particular, dental practitioners raised concerns that consumers are disadvantaged and received lower rebates because they visited a non-preferred dental practitioner.

5.46 The committee is concerned by evidence received from dental practitioners regarding the impact of 'preferred provider' schemes. Dental practitioners raised concerns that they believed that some practices of the private health insurers were anti-competitive. The committee considers that reforms should be implemented that specify that, where two consumers in the same jurisdiction pay the same private health insurance premium, they should be entitled to the same rebate for the same clinical service.

Recommendation 12

5.47 The committee recommends that the Commonwealth Government amend relevant legislation to prohibit the current practice of differential rebates for the same treatments provided under the same product in the same jurisdiction.

5.48 The committee received evidence from the Australian Competition and Consumer Commission (ACCC) that it had previously considered 'preferred provider' schemes and found that they were not anti-competitive. However, the committee understands that those findings were made on the basis that dentists were able to join those schemes. The committee has questions as to whether private health insurers' use of data obtained from Health Industry Claims and Payments Service (HICAPS) terminals could be used inappropriately when offering competing dental services. The committee asks the ACCC to consider the issue, especially in light of the Productivity Commission report on *Data Availability and Use*, where it was noted that the use and

sharing of membership data exemplify 'the advantage that access to vast quantities of data could offer by way of market power'.[4]

Recommendation 13

5.49 The committee recommends that the Australian Competition and Consumer Commission reconsider whether private health insurers' use of data obtained from the Health Industry Claims and Processing Service is anti-competitive.

5.50 The committee also recommends the Commonwealth Government amend relevant legislation to ensure there is a clear delineation between data obtained from the Health Industry Claims and Processing Service and data used by health insurers competing for services against other non-preferred providers. This should extend to a requirement that such data be maintained strictly and separately and that private health insurers should be prohibited from using data gained through claims processes for commercial gain.

5.51 In Chapter 3, the committee considered the role of intermediaries in policy selection and switching between private health insurers. The committee received evidence that consumers are unaware of the commissions paid to intermediaries. The committee considers that consumers should be made aware of commissions paid to intermediaries by private health insurers.

Recommendation 14

5.52 The committee recommends that the Commonwealth Government require intermediaries to disclose any commissions received from private health insurers for the service.

Recommendation 15

5.53 The committee recommends that the Commonwealth Government amend relevant legislation to require all private health insurers disclose executive remuneration and other administrative costs.

5.54 Many private health insurance products have waiting eligibility periods of up to 12 months. Ideally, notice to consumers about changes to their insurance product should align with relevant waiting periods for any treatment affected by the change, so that consumers are not disadvantaged should they choose to change their cover as a result.

Recommendation 16

5.55 The committee recommends that the Minister for Health amend the legislation to require private health insurers to provide adequate written notice of changes to policies and eligibility to allow consumers to consider alternatives, and that this notice clearly communicates changes to the policy that may affect the insured person's coverage, especially where such changes may be

4 See Australian Dental Association (ADA), *Submission 222*, pp. 42–43.

detrimental. Where relevant, the notice period should correspond to the eligibility period for any service or treatment affected by the changes.

5.56 The Private Health Insurance Code of Conduct (Code) is designed to promote 'informed relationships between private health insurers, consumers and intermediaries'.[5] It covers four main areas of conduct in private health insurance, including that consumers receive the correct information from appropriately trained staff, ensuring that consumers are aware of dispute resolution procedures, and ensuring policy documentation contains all the information consumers require to make a fully informed decision.

5.57 It is important to note the Code is voluntary and, as such, does not have the force of legislation. A breach of the Code does not give rise to any legal right or liability. Further, the quality of information that is provided in the Code is not necessarily user-friendly or helpful to consumers.

5.58 As highlighted by the Australian Dental Association (ADA), whilst it is a legislative requirement that new policy holders are given a Standard Information Statement and details about what their policy covers and how benefits provided under it are worked out, this does not always occur in practice. The end result is a lack of informed financial consent for consumers and little scope for redress.[6]

5.59 Evidence provided to the committee also highlighted that there is very little regulation and oversight of the interactions between private health insurers and providers. In its submission, the ADA recommended that the ACCC, in consultation with the PHIO, encourage private health insurers to work with healthcare providers to develop a code of conduct to promote ethical co-operative relationships between funds and health providers.[7]

Recommendation 17

5.60 The committee recommends that the Private Health Insurance Ombudsman advise the Minister for Health in 2019 on additional measures that could be introduced to make private health insurance easier to understand that are in addition to significant reforms being introduced in 2018 and 2019.

Recommendation 18

5.61 The committee recommends that the Australian Competition and Consumer Commission, in consultation with the Private Health Insurance Ombudsman, commence work to establish a new code of conduct that will provide the framework for engagement between private health insurers and healthcare providers.

5 ADA, *Submission 222*, p. 49.

6 *Submission 222*, pp. 28–30.

7 *Submission 222*, p. 49.

Recommendation 19

5.62 The committee recommends that the Minister for Health write to the Private Health Insurance Ombudsman to request advice on the disclosure of limitations to treatment type or frequency which may arise from contract arrangements with individual hospitals or providers that impact on members' access to services and out-of-pocket costs.

Senator Rachel Siewert

Chair

Government Senators' Additional Comments

1.1 Coalition Senators believe that private health insurance is both an essential and valuable part of a mixed healthcare system.

1.2 The public and private nature of the healthcare system is important and worth preserving.

1.3 Reforms announced in October 2017 by the Minister for Health, represent a fundamental commitment to this public and private mix. They are designed to strengthen our healthcare system.

1.4 The changes include:

- Allowing insurers to discount hospital insurance premiums for 18 to 29 year olds by up to 10 per cent. The discount will phase out after people turn 40.
- People with hospital insurance that does not offer full cover for mental health treatment will be able to upgrade their cover and access mental health services without a waiting period on a once-off basis.
- Insurers will be able to offer travel and accommodation benefits for people in regional and rural areas that need to travel for treatment.
- Reducing the price of implanted medical devices from 1 February next year.
- Increase the maximum excess consumers can choose under their health insurance policies for the first time since 2001.
- Simplify private health insurance by requiring insurers to categorise products as gold/silver/bronze/basic, and use standardised definitions for treatments.
- Increasing the resourcing and powers of the Private Health Insurance Ombudsman to ensure consumer complaints are resolved clearly and quickly.
- The establishment of expert committees to look at out-of-pocket costs and other matters impacting consumers.

1.5 This combination of reforms makes some of the recommendations of the majority report incorrectly targeted.

1.6 Whilst Coalition Senators are broadly supportive of the majority report, we believe the following alternate recommendations would present a more measured policy response to the issues raised.

1.7 In particular, the Coalition Senators do not recommend additional legislative changes beyond those initiated through the comprehensive package of measures announced by the Minister for Health in October 2017 as part of the private health insurance reform package.

Recommendation 2

1.8 The committee recommends that the Minister for Health instruct the out-of-pocket costs committee to consider requiring private health insurers to publish all rebates by policy and item number.

Recommendation 3

1.9 The committee recommends that the Minister for Health instruct the out-of-pocket costs committee to consider the merit of publishing the fees of individual medical practitioners.

Recommendation 13

1.10 The Committee recommends that the Commonwealth Government ask the Private Health Insurance Ombudsman whether the practice of differential rebating exists and is having a detrimental impact on consumers overall. If so, to recommend options—including legislative changes—to mitigate impact on consumers.

Recommendation 17

1.11 The Committee recommends that the Commonwealth Government ask the Private Health Insurance Ombudsman whether legislating requirements of 'adequate written notice' to insurance policy changes is needed and will benefit consumers overall. If so, to propose options—including legislative changes—that may benefit consumers.

Conclusion

1.12 It is essential for the health of our country that we continue to maintain a strong and competitive private health insurance market and continue to improve outcomes for patients. We believe that the recently announced reforms will help to achieve that.

1.13 Additional legislative change not based on evidence could have unforeseen consequences that may be detrimental to consumers and to our healthcare system.

Senator Slade Brockman **Senator Jonathan Duniam**

APPENDIX 1

Submissions and additional information received by the Committee

Submissions

1 Parkinson's Australia

2 Independent Hospital Pricing Authority

3 Australian Healthcare and Hospitals Association

4 Synstrat Group

5 Mr Shaun Gath

6 Dr Kang Kim

7 NSW Council of Social Service (plus an attachment)

8 Optometry Australia

9 Royal Australian College of General Practitioners

10 HCF

11 Royal Australasian College of Physicians

12 Breast Cancer Network Australia

13 Medibank

14 Exercise & Sports Science Australia

15 Combined Pensioners & Superannuants Association

16 Australian Association of Practice Management

17 Consumers Health Forum of Australia

18 Private Healthcare Australia

19 Commonwealth Ombudsman

20 Toothpaste Dental

21 Mr Peter Carroll

22 Name Withheld

23 Dr Gavin Lenz

24 nib health funds limited

25 Australasian Academy of Paediatric Dentistry

26 Australian Society of Orthodontists

27 Confidential

28 Dr Laura Latis and Dr Valery Truhin

29 Confidential

30 Mr Richard Cook

31 Ms Chitra Rao

32 Name Withheld

33 Mr Mark Nathan

34 Dr Ross Bastiaan

35 Ms Meryl Angove

36 Dr Jonathon Munro

37 Dr Claire Wilson

38 Dr Kyung Kim

39 Mrs Darina Nirmalann

40 Dr Pantea Makhmalbaf

41 Council of Procedural Specialists

42 Australian and New Zealand Society of Paediatric Dentistry

43 Bupa

44 Carers NSW

45 Dietitians Association of Australia

46 CUA Health

47 Rural Doctors Association of Australia

48 National Rural Health Alliance

49 Public Health Association of Australia

50 Haemophilia Foundation Australia

51 Royal Australian and New Zealand College of Obstetricans and Gynaecologists

52 Allied Health Professions Australia

53 Australian Salaried Medical Officers' Federation

54 Cancer Council Australia

55 Lynch Syndrome Australia

56 Australian Psychological Society

57 Royal Australian and New Zealand College of Psychiatrists

58 Australian Medical Association

59 Australian Federation of AIDS Organisations and National Association of People with HIV Australia

60 Health Care Consumers Assocation

61 Services for Australian Rural and Remote Allied Health

62 Johnson & Johnson Medical Pty Ltd

63 HBF Health Ltd

64 Pharmacy Guild of Australia

65 Doctors Reform Society

66 Australian and New Zealand Academy of Periodontists

67 Australian Healthcare Reform Alliance

68 Australian Institute of Health and Welfare

69 Royal Australasian College of Surgeons

70 Australian Nursing and Midwifery Federation

71 Australian Society of Ophthalmologists

72 Grattan Institute

73 Australian Prudential Regulation Authority

74 Australian Physiotherapy Association

75 hirmaa

76 Australian Society of Anaesthetists

77 Australian Dental Prosthetists Association Ltd

78 Association of Independent Retirees

79 Medical Technology Association of Australia

80 Australian Private Hospitals Association (plus three attachments)

81 Australian Diagnostic Imaging Association

82 Wounds Australia

83 National Association of Specialist Obstetricians & Gynaecologists

84 People with Disabilities (WA)

85 Queensland Government

86 National Seniors Australia

87 Action Economics

88 COTA Australia

89 Alcon

90 Professor Phillip Clarke & Xinyang Hua

91 Day Hospitals Australia

92 Name Withheld

93 Name Withheld

94 Name Withheld

95 Name Withheld

96 Name Withheld

97 Name Withheld

98 Name Withheld

99 Name Withheld

100 Name Withheld

101 Name Withheld

102 Name Withheld

103 Name Withheld

104 Name Withheld

105 Name Withheld

106 Dr Marcin Sowa, Dr Joshua Byrnes & Professor Paul Scuffham (plus an attachment)

107 Name Withheld

108 Name Withheld

109 Name Withheld

110 Name Withheld

111 Name Withheld

112 Name Withheld

113 Name Withheld

114 Confidential

115 Confidential

116 Confidential

117 Confidential

118 Confidential

119 Name Withheld

120 Council of Presidents of Medical Colleges

121 Confidential

122 Name Withheld

123 Confidential

124 Name Withheld

125 Name Withheld

126 Name Withheld

127 Department of Health (plus two attachments)

128 Name Withheld

129 Name Withheld

130 Name Withheld

131 Name Withheld

132 Name Withheld

133 Confidential

134 Name Withheld

135 Name Withheld

136 Name Withheld

137 Name Withheld

138 Name Withheld

139 Name Withheld

140 Name Withheld

141 Name Withheld

142 Name Withheld

143 Name Withheld

144 Name Withheld

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157 Name Withheld

158 Name Withheld

159 Name Withheld

160 Name Withheld

161 Name Withheld

162 Confidential

163 Name Withheld

164 Name Withheld

165 Name Withheld

166 Name Withheld

167 Confidential

168 Name Withheld

169 Name Withheld

170 Name Withheld (plus three attachments)

171 Confidential

172 Confidential

173 Name Withheld

174 Confidential

175 Name Withheld

176 Name Withheld

177 Painaustralia

178 Name Withheld

179 Name Withheld

180 Name Withheld

181 Confidential

182 Name Withheld

183 Name Withheld

184 Name Withheld

185 Confidential

186 Name Withheld

187 Name Withheld

188 Name Withheld

189 Biotronik Australia Pty Ltd

190 Ramsay Health Care

191 Confidential

192 Name Withheld

193 Name Withheld

194 Name Withheld

195 Name Withheld

196 Confidential

197 Name Withheld

198 Confidential

199 Name Withheld

200 Name Withheld

201 Confidential

202 Name Withheld

203 Name Withheld

204 Confidential

205 Name Withheld

206 Name Withheld

207 Choice (plus an attachment)

208 Name Withheld

209 Name Withheld

210 Name Withheld

211 Name Withheld

212 Name Withheld

213 Name Withheld

214 Name Withheld

215 Name Withheld

216 Name Withheld (plus an attachment)

217 Queensland Consumers Association

218 Name Withheld

219 Name Withheld

220 Mr Gordon Gregory

221 Private Health Insurance Intermediaries Association

222 Australian Dental Association
Adverse comment response from Whitecoat

223 Name Withheld

224 Name Withheld

225 Name Withheld

226 Name Withheld

227 Name Withheld

228 Name Withheld

229 Name Withheld

230 Name Withheld

231 Name Withheld

232 Name Withheld

233 Name Withheld

234 Name Withheld

235 Name Withheld

236 Confidential

237 Palliative Care Australia Incorporated

238 Catholic Health Australia

239 Name Withheld

240 Name Withheld

241 Name Withheld

242 Name Withheld

243 Name Withheld

244 Name Withheld

245 Name Withheld

246 Name Withheld

247 Confidential

248 Name Withheld

249 Occupational Therapy Australia Limited

250 Name Withheld

251 Name Withheld

252 Name Withheld

253 Name Withheld

254 Name Withheld

255 Name Withheld

256 Name Withheld

257 Name Withheld

258 The Australasian Academy of Dento-Facial Aesthetics (AADFA)

259 Name Withheld

260 Confidential

261 Confidential

262 Confidential

263 Name Withheld

264 Name Withheld

265 Ms Donna McGrath

266 Name Withheld

267 Name Withheld (plus an attachment)

268 Name Withheld

269 Name Withheld

270 Name Withheld

271 Name Withheld

272 Name Withheld

273 Name Withheld

274 Name Withheld (plus an attachment)

275 Name Withheld

276 Name Withheld

277 Name Withheld

278 Name Withheld

279 Name Withheld

280 Name Withheld

281 Name Withheld

282 Name Withheld

283 Name Withheld

284 Mr David Maguire

285 Name Withheld

286 Name Withheld

287 Mr Keith Bettany

288 Name Withheld

289 Name Withheld

290 Confidential

291 Name Withheld

292 Confidential

293 Name Withheld

Additional Information

1 National Rural Health Alliance's opening statement from 31 October 2017 public hearing, from National Rural Health Alliance, received 13 November 2017

2 Information responding to statements made in submissions, submission responses and answers to questions on notice, from Australian Dental Association, received 28 November 2017

Answers to Questions on Notice

1 Answers to Questions taken on Notice during 5 July public hearing, received from Australian Healthcare and Hospitals Association, 19 July 2017

2 Answers to Questions taken on Notice during 5 July public hearing, received from hirmaa, 17 August 2017

3 Answers to Questions taken on Notice during 5 July public hearing, received from Medibank, 18 August 2017

4 Answers to Questions taken on Notice during 5 July public hearing, received from Royal Australasian College of Surgeons, 18 August 2017

5 Answers to Questions taken on Notice during 5 July public hearing, received from Commonwealth Ombudsman, 18 August 2017

6 Answers to Questions taken on Notice during 31 October public hearing, received from Royal Australian and New Zealand College of Psychiatrists, 16 November 2017

7 Answers to Questions taken on Notice during 31 October public hearing, received from HCF, 16 November 2017

8 Answers to Questions taken on Notice during 31 October public hearing, received from Australian Private Hospitals Association, 17 November 2017

9 Answers to Questions taken on Notice during 31 October public hearing, received from Australian Dental Association, 17 November 2017

10 Answers to Questions taken on Notice during 31 October public hearing and written Questions on Notice, received from Australian Competition and Consumer Commission, 17 November 2017

11 Answers to Questions taken on Notice during 31 October public hearing and written Questions on Notice, received from Bupa, 17 November 2017

12 Answers to Questions taken on Notice during 31 October public hearing and written Questions on Notice, received from Department of Health, 27 November 2017

13 Answers to written Questions on Notice, received from Grattan Institute, 11 November 2017

14 Answers to written Questions on Notice, received from Private Healthcare Australia, 16 November 2017

15 Answers to written Questions on Notice, received from Consumers Health Forum of Australia, 17 November 2017

16 Answers to written Questions on Notice, received from Australian Medical Association, 20 November 2017

17 Answers to written Questions on Notice, received from Medical Technology Association of Australia, 20 November 2017

18 Answers to written Questions on Notice, received from Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 7 December 2017

Tabled Documents

1 Medibank - Our Value to Customers and the Health System, tabled by Medibank Private, at Canberra public hearing, 5 July 2017

2 Rebate Disparity Case Study, tabled by Australian Dental Association, at Sydney public hearing, 31 October 2017

3 Average income per operating list ($) for Australian Private Day Surgery, tabled by Australasian Academy of Paediatric Dentistry, at Sydney public hearing, 31 October 2017

Correspondence

1 Information, from Australian Taxation Office, received 28 July 2017

2 Information, from Business Council of Co-operatives and Mutuals, received 28 July 2017

3 Information, from Prostheses List Advisory Committee, received 2 August 2017

APPENDIX 2

Public hearings

Wednesday, 5 July 2017

Parliament House, Canberra

Witnesses

Commonwealth Ombudsman
GIBB, Ms Doris, Acting Deputy Commonwealth Ombudsman
McGREGOR, Mr David, Director, Private Health Insurance

Royal Australasian College of Surgeons
BIVIANO, Mr John, Acting Chief Executive Officer

Australian Healthcare and Hospitals Association
VERHOEVEN, Ms Alison, Chief Executive
PARTEL, Mr Krister, Advocacy Director

hirmaa
KOCE, Mr Matthew, Chief Executive Officer

Medibank Private Ltd
WILSON, Mr Andrew, Group Executive, Healthcare and Strategy
VENETICO, Ms Franca, Director, Customer Experience Transformation

Tuesday, 31 October 2017

Portside Centre, Sydney

Witnesses

Medical Technology Association of Australia
BURGESS, Mr Ian, Chief Executive Officer
KUNCA, Ms Andrea, Director, Access, Policy, Procurement and Innovation

Consumers Health Forum of Australia
WELLS, Ms Leanne, Chief Executive Officer
RANDALL, Ms Rebecca, Policy and Research Officer

National Rural Health Alliance
DENNEHY, Mr John Patrick, Deputy Chair
DIAMOND, Mr Mark, Interim Chief Executive Officer

COTA Australia
YATES, Mr Ian, Chief Executive

Grattan Institute
DUCKETT, Dr Stephen, Director, Health Program

Australian Dental Association
SACHS, Dr P Hugo, Federal President
MITSCH, Mr Damian, Chief Executive Officer

Australasian Academy of Paediatric Dentistry
FORD, Dr Daniel, Treasurer
SHEAHAN, Dr John, Member

Australian Association of Practice Management
LEACH, Ms Gillian, Chief Executive Officer
BAYNIE, Mrs Catherine, Director and National President

Australian Medical Association
GANNON, Dr Michael, President
TRIMMER, Ms Anne, Secretary General
TOY, Mr Luke, Director, Medical Practice

Royal Australian and New Zealand College of Psychiatrists
JENKINS, Dr Kym, President

Royal Australian and New Zealand College of Obstetricians and Gynaecologists
ROBSON, Professor Stephen, President
KILLEN, Ms Alana, Chief Executive Officer

Catholic Health Australia
PANZERA, Ms Annette, Director, Health Policy
RYAN, Mrs Cathryn, Group Manager, Health Funds, St John of God Health Care Inc.

Australian Private Hospitals Association
ROFF, Mr Michael, Chief Executive Officer
CHEETHAM, Ms Lucy, Director, Policy and Research

Private Healthcare Australia
DAVID, Dr Rachel, Chief Executive Officer

Bupa Australia

CROMBIE, Dr Dwayne, Managing Director, Health Insurance
LONGSHAW, Mr Adam, Director, Health and Benefits

Hospitals Contribution Fund of Australia Ltd

JACK, Ms Sheena, Chief Executive Officer

Australian Prudential Regulation Authority

SERRET, Mr Louis, Acting Executive General Manager, Specialised Institutions Division
FERMOR, Mr Michael, Senior Manager, Specialised Institutions Division

Australian Competition and Consumer Commission

GREGSON, Mr Scott, Executive General Manager, Enforcement Division
SALISBURY, Mr David, General Manager, Consumer and Small Business Strategies

Department of Health

SHAKESPEARE, Ms Penny, Acting Deputy Secretary, Health Benefits Group
MASKELL-KNIGHT, Mr Charles, Principal Adviser, Health Systems Policy Division