

# Medibank Submission

**Submission to the Australian Labor Party's Discussion  
Paper on the Proposed Productivity Commission Inquiry  
into the Private Health Sector**

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## Executive Summary

Medibank welcomes the opportunity to inform the terms of reference for a Productivity Commission inquiry into the private health sector.

It is imperative that a Productivity Commission review results in meaningful and wide-ranging reforms that address the cost drivers in the healthcare system.

A Productivity Commission review that concentrates on private health insurance in isolation from the broader private healthcare system will be fundamentally flawed and incapable of examining the issues and reforms necessary for sustainably lower premium increases in the long-term.

The Productivity Commission has recommended a wide-ranging review of Australia's health system on many occasions over the past 20 years. A comprehensive review of the private healthcare system should now be conducted.

Medibank's submission provides responses to each of the questions raised in the Discussion Paper on the Proposed Productivity Commission Inquiry into the Private Health Sector. Our submission may be provided by a future Labor Government to the Productivity Commission following the establishment of an inquiry. Our submission may also be made public and Medibank encourages wide public and industry debate on the sustainability of health costs. Medibank may also make additional submissions to the Productivity Commission once an inquiry and public consultation process are formally underway.

Medibank supports the broad questions posed in the discussion paper, but proposes that the Productivity Commission be also directed to have regard to:

- A Labor Government's objective to keep private health insurance premium increases at two per cent per annum.
- The financial sustainability of private healthcare and private health insurance.
- The demand and financial pressures on the private and public health systems.

Crucially, any Productivity Commission inquiry must result in positive reforms for consumers, which is the only way premiums can be sustainably low without detrimental outcomes to both the public and private health systems.

### Key Considerations for the Productivity Commission

Address out-of-pocket costs for consumers.

Recognise the value private health insurance delivers for consumers, taxpayers and Australia's health system.

Promote greater cost, price and quality transparency in the health system.

Tackle unnecessary costs, such as prostheses prices, low value care and MBS payment integrity.

Promote alternative models of care, particularly for chronic disease.

Private health insurance is a critical element of Australia's healthcare system. Australia's health system is strong precisely because it is a mixed system that relies on both public and private providers.

Given the world-leading outcomes of Australia's mixed health system,<sup>1</sup> any changes should be considered with caution to avoid unintended consequences that could erode a system that, on balance, operates well and in the interest of all Australians.

All Australians benefit from private health insurance as it takes pressure off the public health system, provides greater consumer choice, and reduces costs for taxpayers. Private health insurance funds two in every five hospital admissions in Australia – admissions that would otherwise be borne by an already pressured public health system.

Far from being a saving, adverse changes to private health insurance incentives – such as eroding the rebate – will add costs to the Commonwealth over time, diminish competition in the health system, undermine consumer choice, and place greater demands

on the public system, leading to longer wait times for patients and deteriorating health outcomes.

Given private health insurance pays over \$20 billion in benefits to consumers, this means that for every \$1 spent on the rebate, around \$3 does not have to be spent in the public system. Without the rebate a typical family with teenage children with hospital and extras cover receiving the standard rebate of 25 per cent would pay around \$1,500 a year more for their health insurance, which is an onerous burden on families. Medibank is committed to improving the value of health insurance for Australians and to strengthening our health system.

## About Medibank

Medibank is one of Australia's largest providers of private health insurance, with 40 years' experience delivering better health to Australians. We look after the health cover needs of 3.7 million Australians through our Medibank and ahm brands and deliver a range of programs to support health and wellbeing in the community.

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

### Our Business

Headquartered in Melbourne, Medibank has corporate offices in Canberra, Brisbane, Perth, Sydney, and Wollongong. We have more than 80 retail stores across Australia, with over 20 in regional areas, employ over 4,100 people, and handle more than 40,000 phone inquiries a week.

For the 2017-18 financial year, Medibank recorded a net profit of \$445 million (down one per cent from the previous year) and paid over \$183 million in tax. Around 270,000 Australians own shares in Medibank.

In addition to private health insurance, Medibank provides healthcare to 60,000+ permanent and 20,000+ reservist uniformed Australian Defence Force personnel, employs 1,500 clinicians across Australia, delivers 800,000 nurse advice calls for Australians and 70,000 GP tele-consultations per year as part of the more than 1.8 million interactions a year we deliver through our telehealth services, delivers the beyondblue support service, and provides telephone and online counselling services for those experiencing sexual assault or domestic and family violence through 1800RESPECT.

Medibank is focussed on delivering health services, not just health insurance, with our CareComplete program supporting more than 21,000 people with chronic disease in partnership with State Governments.

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

### Medibank's Commitment to Deliver Value for Our Customers

Medibank has a fundamental stake in the health and wellbeing of our 3.7 million customers. We spent \$5.3 billion on our customers' healthcare in 2018, covering more than 1.3 million hospital admissions, nearly 24 million ancillary services like dental and optical, and more than half a million surgeries.

Medibank knows that affordability of private health insurance is a real issue for many Australians. That is why our premium increase for 2019 is the lowest in 18 years. We are working hard to deliver greater value to our customers and to address the affordability challenges that the private healthcare industry faces. Some of our recent initiatives to bring greater value for our customers include:

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

### Supporting the Community

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

## The Value of Private Health Insurance

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

The majority of Australians – 13.56 million people, representing 55 per cent of all Australians – hold an insurance policy covering them for hospital and/or extras cover.<sup>2</sup>

Nearly half of the Australians with private health insurance have disposable incomes under \$50,000 per year.<sup>3</sup>

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

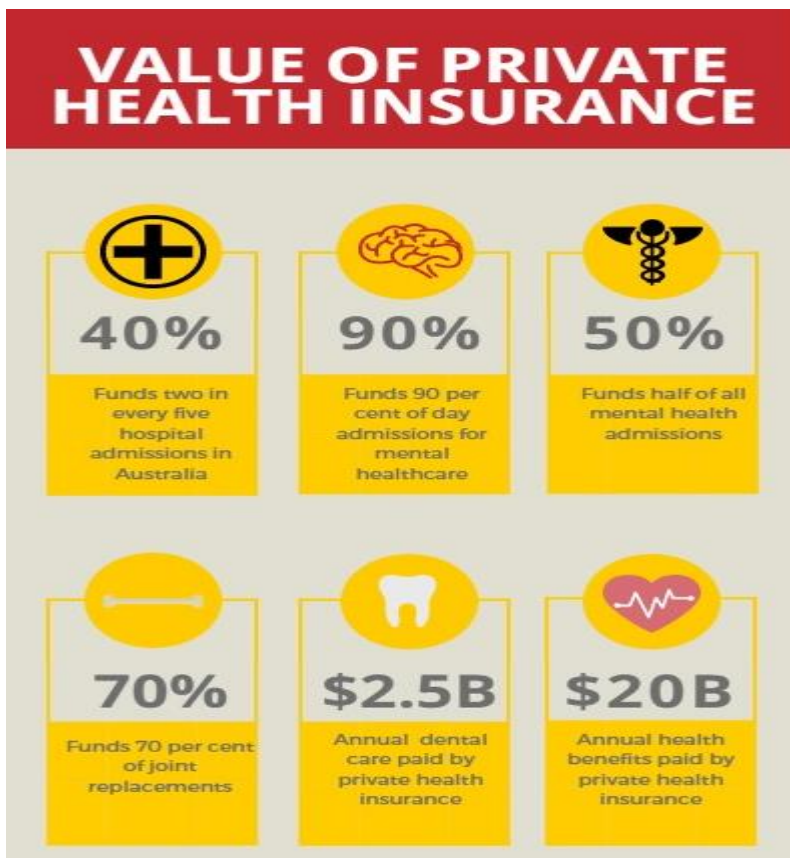
### Taking Pressure off the Public Health System

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

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

“The Government has reduced the pressure on the public hospital system by supporting individuals to purchase private health insurance.”<sup>4</sup>

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



Around 90 per cent of day admissions for mental healthcare, 50 per cent of all mental health admissions, 70 per cent of joint replacements, 60 per cent of chemotherapy, and 88 per cent of retinal procedures take place in the private health sector.<sup>5</sup>

The majority of elective surgeries (around 67 per cent) in Australia are performed in private hospitals, which reduces waiting times for elective surgery and lowers demand for hospital beds in the public system.<sup>6</sup>

More than \$2.5 billion in dental care is paid for by private health insurance, more than the Commonwealth pays for dental care. Around 90 per cent of dental health services provided to low and middle income earners are subsidised by private health insurance.<sup>7</sup>

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

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

As the Commonwealth Government states:

“The proportion of Australians with some form of private health insurance is now around 56 per cent, providing a high level of access to private health services and taking pressure off the public system.”<sup>8</sup>

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

“If consumers withdraw from the private sector, demand for these services will move to the public sector, which under current capacity, will not meet the additional need or only at a higher cost to governments.”<sup>9</sup>

Similarly, the Pharmacy Guild observes that:

“The reason that the Federal Government encourages and subsidises private health insurance is that patients accessing care through private hospitals reduce the overall demand on the public hospital system. The Government should focus its investment in private health insurance on reducing the burden on public hospitals, by encouraging patients to utilise the private hospital system and related services that are cost-effective in reducing hospitalisation and preventable use of the wider public health system.”<sup>10</sup>

The Queensland Government notes that:

“...suspending rebate thresholds for private health insurance could increase demand for public hospital[s].”<sup>11</sup>

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

“...increasing due, in part, to a larger proportion of the population not having private health insurance.”<sup>12</sup>

And Western Australia’s Auditor-General notes that:

“...the State’s public health system is subject to increasing demand pressures...[but] this pressure has been alleviated to some extent by improved efficiencies in same day surgery and bed management as well as by more people having their surgery performed at private hospitals following the introduction of the 30 per cent health insurance rebate.”<sup>13</sup>

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

## **Providing Greater Consumer Choice**

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

As the Productivity Commission observes:

“Private health insurance allows consumers to insure for a level of service above that which governments would usually provide through universal health care arrangements. While any Australian can seek ‘free’ treatment in a public hospital, those with private hospital cover can choose to be treated as a private patient, and typically have shorter waiting times for elective surgery and greater choice of doctor.”<sup>14</sup>

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

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

As the Commonwealth Department of Health states:

“Australia’s mixed and balanced model of private and public health insurance is integral to the provision of universal access to high quality affordable health care services for all Australians. People have a choice about whether to use the public or private systems. The decision to purchase private health insurance is a personal choice. People who cannot afford private health insurance or who do not wish to take out private health insurance for any other reason, continue to have the right to access free treatment in public hospitals.

Private health insurance has many benefits such as providing access to private in-hospital services. Private health insurance members can be treated in a private or public hospital as a private patient. This means that depending on the circumstances, they can choose the doctor that treats them, the hospital they are treated in and at a time that suits them.

Private health insurance also provides cover for non-MBS services such as physiotherapy, dental and podiatry services, and some aids and appliances. Many people rely on private health insurance to access services they would otherwise be unable to afford.”<sup>15</sup>

Choice has clear benefits for consumers – and 84 per cent of Australians with private health insurance value the product and want to keep it – and also for Australia’s health system.<sup>16</sup>

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

As the Australian Medical Association states:

“Private health insurance offers Australians greater choice in their doctors and their treatment and may offer shorter waiting times for some services.”<sup>17</sup>

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

As the Productivity Commission states:

“...the accessibility of private hospital services improved with the increased take-up of private hospital insurance.”<sup>18</sup>

This consequence is important given the Australian Medical Association recently found that the median waiting times for elective surgery increased to 37 days in public hospitals.<sup>19</sup> The finding of the Australian Medical Association is consistent with that of the Australian Institute of Health and Welfare, which found that in 2015-16:

“The median waiting time for public hospital elective surgery was 38 days overall—42 days for public patients and 20 days for patients who used private health insurance to fund all or part of their admission.”<sup>20</sup>

There is already significant waiting times in public hospitals for many procedures – waiting times that will only increase if patients transfer from private health insurance to the public system.<sup>21</sup>

The Australian Medical Association also notes:

“Elective surgery waiting list data hide the actual times that patients are waiting to be treated in the public hospital system. The time that patients wait - from when they are referred by their general practitioner to actually seeing a specialist for assessment - is not counted. It is only after patients have seen the specialist that they are added to the official waiting list. This means that the publicly available elective surgery waiting list data actually understate the real time people wait for surgery. Some people wait longer for assessment by a specialist than they do for surgery.”<sup>22</sup>

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

## **Reducing Costs for Taxpayers**

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

“Private health insurance plays a major role in supplementing public funding in some areas, and replacing public funding in others.”<sup>23</sup>

Private health insurance paid nearly \$20 billion in healthcare benefits in the 2016-17 financial year – this is \$20 billion that would otherwise have to be paid by government and taxpayers. For every dollar that people spend on private health insurance, the industry returns 86 cents back in benefits – a higher benefit return than for other insurance products.<sup>24</sup>

The Commonwealth Government encourages private health insurance through a means-tested rebate, but the rebate delivers significant returns to taxpayers. Given private health insurance pays nearly \$20 billion in benefits to consumers, this means that for every \$1 spent on the rebate, around \$3 does not have to be spent in the public system.<sup>25</sup>

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

“Private health cover in Australia promotes health system responsiveness. Insurees benefit from having greater choice over hospitals and the timeliness of hospital care. Private health insurance helps finance private hospital care, and, to the extent that demand shifts from public to private care, it helps relieve capacity and financial pressures from public hospitals, especially for elective surgery.”<sup>26</sup>

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

“...used private insurance to provide principal coverage for significant segments of their population and it is now used to relieve pressures on the public system...[Private health insurance] contribute[s] directly to the costs of health care, and serves as a mechanism to capture private funds to finance growing demands on the health care system.”<sup>27</sup>

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

“Both public and private sectors play critical roles in Australia’s world-class health system. While governments have sole responsibility for managing the public health sector, they should also support a strong and sustainable private health care industry.”<sup>28</sup>

“Labor believes that private health insurance will continue to play a key role in enabling working Australians to access the outstanding hospitals and medical services that are available in the private health sector.”<sup>29</sup>

And the Coalition stating:

“The Coalition understands that private health insurance is a fundamental element of our health system that offers consumers greater choice over their care whilst taking pressure off Medicare and public hospitals so that their universality remains sustainable.”<sup>30</sup>

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

## **Delivering Value for Our Customers**

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

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

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

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

We are continuing to invest in our primary care suite program, CareComplete, as one in five Australians is now living with two or more chronic conditions.<sup>31</sup> We have recognised the need for a fresh approach to patient care that drives better outcomes and are collaborating with more than 3,600 GP clinics on this evidence-based approach.

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

## Affordability of Private Health Insurance

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

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

Affordability of private health insurance is a real issue for Australians and, in response, Medibank's premium increase for 2019 was the lowest in 18 years, even as total spending on healthcare increased by more than double the rate of general inflation over the past decade.<sup>32</sup>

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

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

### Importance of the Private Health Insurance Rebate

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

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

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

#### Key Points on the Rebate

It is paid to individuals and families, NOT private health insurers.

For every \$1 spent on the rebate, around \$3 is generated in private health expenditure.

The rebate makes private health insurance more affordable, thus encouraging people to join and take pressure off the public system.

Reducing or removing the rebate will invariably mean people exiting private health insurance and turning to the public system.

Reducing or removing the rebate is a direct hit on family budgets and, in the longer term, on taxpayers as demands on the public system will increase.

"Not adjusting the income thresholds for three years may result in individuals with incomes just below each threshold moving into a higher income threshold sooner if their income increases. This means...if you have private health insurance, your private health insurance rebate percentage entitlement may decrease."<sup>33</sup>

Additional adverse changes to the private health insurance rebate will be detrimental as this will cause many consumers to drop or reduce their level of private health insurance with a view to relying on the public health system only.

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

"...increase the out-of-pocket cost of PHI [and] fewer people would take out PHI...[particularly] those on low incomes."<sup>34</sup>

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

Claims that a phasing down of the rebate will result in a net saving to the Commonwealth ignore or discount the adverse impact on public hospitals. Modelling by the Parliamentary Budget Office, for example, is based on the assumption there will be "no flow-on effect to public hospital expenses" and is acknowledged by the authors as being of only "medium reliability" that is sensitive to a raft of factors (such as premium increases, income changes, and behavioural responses).<sup>35</sup>

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

The Commonwealth Department of Health notes that the PHI rebate:

“...helps make private health insurance more affordable, provides greater choice and accessibility to access private health care options, and reduces pressure on the public hospital system.”<sup>36</sup>

Without the rebate a typical family with teenage children with hospital and extras cover receiving the standard rebate of 25 per cent would pay around \$1,500 a year more for their health insurance, which equates to more than the entire weekly earnings of an average household and will inevitably lead to a significant decline in industry participation and thus more pressure on the public system.<sup>37</sup>

Around 90 per cent of Medibank’s customers are claiming a private health insurance rebate to reduce their premiums – and the current rebate results in an average 25 per cent discount for these customers.

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

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

“The affordability of insurance remains a significant concern for consumers, which is supported by research confirming real household expenditure on private health insurance premiums has increased steadily over the past decade...as real household expenditure on private health insurance has increased, affordability has become a significant consumer concern.”<sup>38</sup>

If the private health insurance rebate is abolished, there will be an effective 34 per cent price increase for private health insurance.

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

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

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

It is further important to note that many young Australians hold extras/ancillary cover and tend to use these services vis-à-vis hospital services. Removing or reducing the rebate on ancillary cover would likely result in more younger people leaving private health insurance, thus placing upward pressure on premiums and eroding the sustainability of community rating in the longer term.

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

## **Need to Address Cost Drivers in the Health System**

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

Costs in the health system continue to increase.

The Australian Prudential and Regulatory Authority has clearly stated that rising health costs – not industry profits – are the key reason private health insurance premiums are increasing:

“While debate about the rising cost of health insurance is both appropriate and legitimate, it’s important the conversation is informed and correctly focused. APRA does not consider industry profits or capital levels to be the primary drivers of rising premiums. The underlying cost of Australia’s health system is the ailment; rising insurance premiums are just a symptom. Specifically, the fundamental forces pushing premiums up are higher claims costs experienced by insurers, through such factors as a greater uptake of medical services among policyholders and the rising cost of treatments and procedures. It is very much in the community’s interest that the current reform process continues, and private health insurers need to be an influential voice in that debate.”<sup>39</sup>

Private health insurance premiums have consequently risen by an average of around 6.1 per cent per annum since 2002, well beyond the rate of wage growth.<sup>40</sup>

Equity market analysts have recently estimated that:

“...premium rates would need to increase by 6 per cent per annum to hold net margins steady. This level is politically unpalatable and the Australian consumer wallet has simply run out of capacity to absorb this.”<sup>41</sup>

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

The Commonwealth Treasury estimates that real health expenditure per person will double over the next 40 years, with the Commonwealth Government's expenditure on health to increase from 4.2 per cent to up to 7.1 per cent of GDP by 2054.<sup>42</sup> This excludes expenditure by state governments, insurers, and consumers.

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

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

These regulations create perverse incentives where some providers in the private system pursue an inefficient growth strategy, regardless of the inflationary impact on the Australian health consumer. The number of private hospital beds increased 26 per cent over the period 2005-06 to 2015-16, with private hospital income doubling and capital expenditure more than tripling over the same period.<sup>43</sup> Between 2011-12 and 2015-16, the rate of hospital bed growth in private hospitals tripled that of public hospitals.<sup>44</sup>

By way of example, there has been double digit annual growth in private inpatient rehabilitation over the previous five years. There is also significant variation in inpatient rehabilitation rates across States, with New South Wales and Victoria having twice the rates of inpatient rehabilitation compared to Queensland and nearly four times the rates in Western Australia – and 43 per cent of private patients are referred to inpatient rehabilitation following knee replacement in private hospitals compared to only five per cent in public hospitals.<sup>45</sup>

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

More significantly, costs are being driven by waste, unnecessary and/or low value care, which are estimated to account for around 20 per cent of hospital episodes<sup>46</sup> and an estimated \$7 billion a year across the public and private healthcare systems,<sup>47</sup> and with the chair of the MBS Review Taskforce noting that:

“...roughly 25 per cent of all items on the [MBS] schedule do not have some form of evidence to support them.”<sup>48</sup>

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

## **Implications of Unaffordable Private Health Insurance**

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

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

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

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

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

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

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

## Responses to Discussion Paper Questions

### **1. Does the current system of incentives and penalties to purchase private health insurance provide sufficient support for the sustainable application of the community rating principle?**

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

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

The sustainability of community rating depends on consumer participation, which in turn necessitates value and affordability of private health insurance.

Recent initiatives by the Commonwealth to encourage younger people to join private health insurance are important to encouraging participation and thus sustaining community rating in the long-term. The Department of Health notes that the recent reforms, including youth discounts, will have a positive impact on industry participation:

“Over the four years from 2017-18, the number of people covered by private hospital insurance is estimated to be approximately 1 per cent higher than it would otherwise have been.”<sup>49</sup>

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

The incentives and penalties to purchase private health insurance must be maintained and even increased in order to place downward pressure on premiums and to ensure the private health system overall provides an efficient and valuable complement to the public system.

#### *Medicare Levy Surcharge*

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

“In 1997, there was very little impact on participation resulting from the introduction of the MLS [Medicare Levy Surcharge]. The decline in private health insurance participation continued until December 1998 when the lowest participation rate of recent years of 30.3% was observed. This suggests that by itself, the MLS is not a driver of participation and is a relatively minor reason for joining PHI.”<sup>50</sup>

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

Recent data from the Australian Bureau of Statistics<sup>51</sup> indicate that over the period 2012-13 to 2017-18 all income groups, except the highest earning quintile, saw increases in the proportion of their populations taking up private health insurance – suggesting that the relative erosion of the Medicare Levy Surcharge relative to premium increases is impacting at the margin on coverage (i.e. for those on higher incomes, there is a growing financial incentive to not take out private health insurance as the tax levy is decreasing relative to premiums).

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

But in isolation, a one-off increase to the Medicare Levy Surcharge may not be sufficient to maintain patient hospital cover in the long-term as:

- Continued growth of underlying cost and utilisation drivers in the health system will necessitate continued private health insurance premium rises that erode the relative consumer cost of any rise in the Medicare Levy Surcharge.
- An increase in the Medicare Levy Surcharge does not address the inefficiencies and opaque pricing in the health system that are eroding private health insurance affordability.

- The lack of effective competitive drivers in the health system (such as pricing transparency) means there is an incentive for market participants other than private health insurers to increase their costs by at least the same proportional amount of any increase in the Medicare Levy Surcharge.
- Revenue realised through the Medicare Levy Surcharge is not linked to funding of the private health insurance rebate and, as a consequence, any increase may have no impact on the affordability of private health insurance.
- Increased taxation is neither an incentive nor mechanism for economic sustainability in any industry.

Medibank notes that the Henry Tax Review found that “the Medicare levy surcharge is not ideal” and that “the name of the surcharge is also misleading as it is not related to the Medicare levy and does not reflect its link with private health insurance...As a result...tax arrangements for private health insurance, including the Medicare levy surcharge and the private health insurance tax offset, need to be assessed in light of an overall review of this sector.”<sup>52</sup>

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

An alternative is to increase the lifetime health cover loading.

#### *Private Health Insurance Rebate*

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

This submission previously noted that adverse changes to the private health insurance rebate will be detrimental as consumers will simply shift from private health insurance to the public system.

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

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

“The Government has reduced the pressure on the public hospital system by supporting individuals to purchase private health insurance. Rebates make private health insurance more affordable and provide greater choice.”<sup>53</sup>

What our customers are telling us is that detrimental change to the government health insurance rebate would hurt them. Around 90 per cent of Medibank’s customers are claiming a private health insurance rebate to reduce their premiums – and the current rebate results in an average 25 per cent discount for these customers.

As the rebate is not being indexed in response to annual premium increases, in effect, each year the government is incrementally reducing the rebate. The implication is that customers eligible for the rebate are forced to pay more for private health insurance every year, even without any increase in annual premiums. This gradual erosion in the value of the rebate has downside risks for the sustainability of community rating over the long-term.

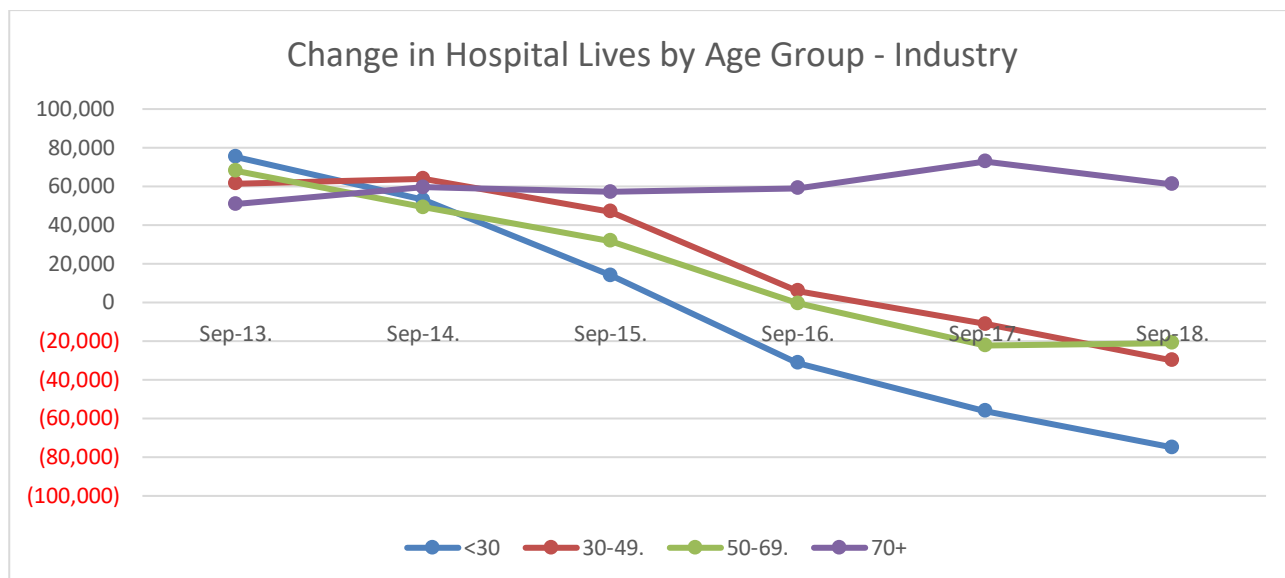
Without the rebate a typical family with teenage children with hospital and extras cover receiving the standard rebate of 25 per cent would pay around \$1,500 a year more for their health insurance, which will inevitably lead to a significant decline in industry participation.

If the private health insurance rebate is removed, there will be an effective 34 per cent price increase for private health insurance for those on the standard rebate. But some people will pay more. For example a typical elderly couple with hospital and ancillary cover receiving the maximum rebate of nearly 34 per cent will see a \$2,334 increase in their annual premium to \$6,910 (a 51 per cent increase).

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

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

Community rating is becoming increasingly difficult to sustain. The graph below shows that at an industry level the participation at younger ages is declining, meaning the cross subsidies to support community rating are not working.



The current trend will require increased premiums just to support community rating, with consequent affordability issues. Reduced rebates would add to the issue.

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

## 2. Would community rating be strengthened or eroded by raising the minimum standard for hospital insurance products?

Community rating will not be affected by changes to hospital insurance products *per se*. What matters for the long-term sustainability of community rating is participation rates in private health insurance. If consumers view private health insurance as delivering more value at comparatively lower cost, then this will drive greater industry participation and make community rating more sustainable.

The current minimum standards, especially Basic and Bronze tiers, play an important role in increasing participation by providing affordable price points.

An increase in minimum standards that delivers greater product value to consumers, but at little or no additional cost to premiums, should have a positive impact on the sustainability of community rating by encouraging take-up of private health insurance. But an increase in minimum standards that necessitates upward pressure on premiums is likely to have a negative impact on industry participation if premium increases outweigh the improved product value in the minds of consumers.

In addition, community rating is not well understood by most consumers. A communication program that explains what community rating is and its importance to our public and private health system, may also assist with participation, and support long-term sustainability. It is important to recognise that community rating supports older and sicker people to receive private healthcare at the same premium cost as someone young and healthy.

Raising minimum standards that do not deliver greater value vis-à-vis cost is also likely to result in younger people leaving private health insurance, thus placing upward pressure on premiums and eroding the sustainability of community rating in the longer term.

## 3. Will the current growth in policies with exclusions continue or will it level out? What implications will there be for community rating?

Product exclusions serve two important functions in the Australian private health insurance system.

First, exclusions enable consumers to purchase products which meet their health and life stage needs without paying for coverage which is superfluous to requirements. For example, an elderly couple or a single male do not require coverage

for pregnancy and therefore should be able to purchase a lower cost product that excludes this coverage. Similarly, there may be little merit to a 25 year old customer purchasing a product that provides coverage for hip and knee replacements and they should be able to purchase a lower cost product that meets their individual and life stage needs.

The risk, of course, is that consumers purchase products which are ill-suited to their health or life stage needs and are not covered for necessary treatment as a consequence. To mitigate this risk, Medibank performs comprehensive needs analysis with our customers at the time of purchase and ongoing cover reviews with existing customers to ensure they have the appropriate level of cover. We are on track to provide 500,000 cover reviews with existing customers in 2018-19 and have a dedicated clinical team to assist with and conduct those cover reviews.

Second, in a community rated system there are limited means to vary premiums so that private health insurance is affordable for a wide range of consumers.

In other countries, there are two broad mechanisms for premium variation that have not broadly been adopted in hospital insurance in Australia. One method is to operate 'narrow' or preferred provider networks where consumers are either restricted in their access to providers or, more likely, financially incentivised to access preferred providers. Another method is to offer high excess (often called high deductible) products where the consumer has to pay the first \$5,000 or \$10,000 of the claim. In both these models the claims cost to the insurer is usually lower, which is then reflected in a lower premium to the consumer. Since neither of these options have been adopted in Australian hospital insurance, the only remaining mechanism to offer products which can meet the financial capacity of a range of consumer budgets is to have different levels of exclusions. The greater the level of exclusion, the lower the premium cost to the consumer.

From a commercial perspective it is not in the interest of health insurers to have accelerating rates of customers holding products with exclusions, as this represents revenue erosion. However, in the absence of products with varying levels of exclusions (and therefore varying premiums) the likely outcome will be accelerating rates of customers dropping their private health insurance altogether as more people will be unable to afford the price of fully inclusive products.

Assuming economic conditions remain stable, as premium increases continue to slow Medibank expects that rates of downgrading will similarly begin to slow. Nonetheless, there will continue to be reasonable levels of downgrading and upgrading as growing consumer awareness of appropriate coverage will ensure that, as a consumer's circumstances change (i.e. their health and life stages) they will transition to coverage that meets their individual needs. Medibank does not expect this to have significant implications for community rating in the short to medium term.

The recently announced reforms will ensure the growth in exclusionary policies will level out, as the rules are prescriptive on what standard clinical categories can be restricted, and what must be fully included, to achieve a certain tier. From 1<sup>st</sup> April 2020, an insurer cannot sell products that include a mixture of included and excluded services outside of what is prescribed in the reforms for each tier. As a result, through this transition period, Medibank does not expect additional exclusionary policies to be launched.

As noted above, consumers will be more likely to join and remain in private health insurance if products offer value at comparatively affordable and competitive cost.

It is also important to recognise that if the rebate is reduced or removed, cost conscious consumers are more likely to move to products with greater exclusions.

#### **4. What effect will the current Government's categorisation of products into Gold/Silver/Bronze/Basic tiers have?**

The Commonwealth is implementing a classification system for private health insurance products, with tiers labelled gold, silver, bronze, and basic.

Enhancing the transparency and comparability of private health insurance products is welcome and it appears, on balance, that the classification system will avoid unnecessary additions to premiums and not restrict product innovation. This is because the categorisation increases transparency for the customer, where they can more easily compare prices, features and value between products. Therefore, insurers are more likely to innovate to differentiate their products to the benefit of consumers.

The new classification will also make switching easier for consumers and will make private health insurance easier to navigate for providers, as standard definitions and their underpinning MBS item numbers, will be harmonised across all products and health funds.

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

Our products are designed to:

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

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

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

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

## **5. & 6. How does the current system of risk equalisation affect competition and innovation? Could it be improved?**

Medibank supports community rating and a key supporting component is risk equalisation.

Community rating is intended to promote access to health care through affordability and equity.

The *Private Health Insurance Act* establishes a risk equalisation regime that operates within a set of complex rules made by both the Health Minister and the APRA. In essence, it involves claims sharing between funds operating in State-based markets. A variable percentage of experienced claims in set age bands are pooled into an aged based pool.

To this pool is added the high cost claimants' pool. The high cost claimants' pool for all its complexity is a minor component of the risk equalisation pool, representing less than two per cent and is not considered further in this discussion.

The system works based on a Gross Deficit (the sum of claims by all funds) and a calculated deficit (the amount per Single Equivalent Units (SEU) contributed by each health fund). The Gross Deficit (i.e. claim included in the risk equalisation pool) is then divided by the total average SEU in the State pool to calculate the average Deficit per SEU. Multiplying this average Deficit per SEU by a fund's market share of SEUs determines the Calculated Deficit (i.e. the Gross Deficit the fund would have if the claims experience per SEU had been at the average of the pool, in other words, equalised).

The difference between the Calculated Deficit and the actual Gross Deficit is transferred between funds. Funds having claims less than average (i.e. Calculated Deficit less than Gross Deficit) cross-subsidise funds with claims above average (i.e. Calculated Deficit greater than Gross Deficit). So there is no 'Fund' as such, just net transfers between funds – in effect a cost equalisation based on actual dollars paid.

### *Potential Changes*

It is important to clarify the objectives of risk equalisation before considering changes.

From a public policy perspective, the purpose of risk equalisation is to support access to health care by contributing to:

- Affordability (i.e. premiums that are affordable, irrespective of risk).
- Efficiency (i.e. incentives to manage benefit outlays while maintaining access).
- Equity (i.e. who subsidises who and by how much?).
- Optimal Health Outcomes (i.e. the fundamental goal is positive health outcomes for the nation).

Given these objectives, any proposed reforms to risk equalisation should be intended to:

- Incentivise funds to manage predictable costs.
- Enhance equity in health funding, particularly generational health funding and cross subsidisation.
- Strengthening complementarity of the public and private health systems to ensure people attain optimal treatment.

Consequently, limitations to the current risk equalisation scheme may need to be addressed before any changes are possible, including:

- There is no standard benefits package on which claims experience is assessed. This dilutes the claims pool and reduces the calculation of average claims disadvantaging funds offering more benefits.
- Competition in the market is mainly focused on risk selection by product exclusions, leading to risk stratification. This compromises affordability.
- Risk equalisation only includes limited age bands allowing funds to risk select on other predictable variables, such as region and socio-demographic predictors, and fails to incorporate chronic disease as a variable amenable to management. Data used in many overseas jurisdictions for prospective risk equalisation is not available in the Australian market.

Medibank's view is that an informed position of evaluating the current system is vital and changes cannot be made to risk equalisation in isolation. Risk equalisation is part of the private health insurance system and, as such, major changes in isolation from wider system changes may result in detrimental or unintended outcomes for policy objectives

Potential changes and learning from any successes in international markets should be explored and evaluated.

Any changes would require appropriate transition time to enable the system to successfully manage any changes and avoid unintended consequences.

## **7. Should insurers be required to pay benefits for services provided by all providers, or should selective contracting and benefit differentiation continue?**

Medibank strongly supports being able to selectively contract with, and differentiate benefits paid to, different providers, including medical specialists, other health professionals that provide general treatment, as well as hospitals. The capacity to do so delivers significant benefits for consumers and patients.

In hospital insurance, private health funds are effectively compelled to cover services provided by all accredited providers. This impacts the affordability of health insurance and out-of-pocket costs for consumers (see response to question 8).

While health funds are not compelled to pay benefits to all ancillary providers, in practice health funds include all providers in their recognised provider networks in order to provide the widest possible choice and access for members.

Contracts are struck between health funds and medical and ancillary providers, including preferred provider network contracts, which result in different rates and terms paid to different providers for the same basic service. However, these contracts usually include incentives for providers to deliver better health outcomes, improved patient experience and low/nil out of pocket costs for consumers, and are critical in developing new care models and service innovation.

Any move to standardise pricing and terms for the same service provided by different providers is fundamentally flawed as it does not consider varying levels of clinical outcome and service quality between providers, as well as input cost variability based, for example, on geographic location.

It would substantially limit innovation, including development of new care and service models, and it would eliminate any incentive to transition to new funding models which can deliver better health outcomes, a better consumer experience of healthcare, and sustainable cost growth, such as value-based purchasing models. It would also further homogenise private health insurance products and pricing and diminish competition in the system.

Furthermore, lack of regulation allows providers to levy different charges on a patient by patient basis, so it would be entirely asymmetrical to compel insurers to pay standard rates for services when providers can levy any charge to the consumer above and beyond the benefit rate received from a health fund.

### *Benefits Paid to Medical Specialists*

As noted in the discussion paper, insurers are required to pay a minimum benefit toward in-hospital medical services listed on the MBS, provided that service is within the patient's scope of cover.

Medibank pays an additional benefit towards the medical service if the medical specialist bills under the GapCover scheme. To access the higher benefits paid under GapCover, the specialist's 'gap' or 'out of pocket' charged to the patient cannot exceed \$500 (for the hospital admission). GapCover helps to reduce out of pocket costs for patients. In 2018 almost 80% of medical specialists billed through our GapCover scheme for 80 per cent or more of their medical claims. The ability to

differentiate benefits paid to medical specialists if they agree to participate in our GapCover scheme helps to reduce the out of pockets paid by our customers.

#### *Benefits Paid to Other Health Professionals under General Treatment*

Medibank operates preferred provider networks (Members Choice) across a number of modalities of general treatment, including dental, optometry and physiotherapy.

Medibank negotiates maximum agreed prices for various service items with Members Choice providers. Benefits paid to these providers may depend on the customer's product, but the total price is capped at the agreed rate.

Members' Choice networks are a key initiative to deliver value to customers through low or no out of pockets, as well as out of pocket certainty. For other providers that are not part of our Members Choice network, benefits paid toward their services vary depending on the product a customer chooses. For example, some products pay a certain percentage of the provider's charge as the benefit (e.g. 70 per cent), whereas other products include a set dollar benefit per service.

#### *Benefits Paid to Hospitals*

Medibank has contracts with many private hospitals across Australia. Prices paid to these hospitals (and therefore the benefits paid on behalf of our members) are the outcome of commercial negotiations and therefore will vary between hospitals. The ability to selectively contract with hospitals is an important lever in controlling the growth in healthcare cost and ensuring high quality care.

However, as discussed in response to question eight, the second-tier default benefit provides a generous safety net for private hospitals in these negotiations, strengthening their bargaining power and limiting the ability of insurers to control healthcare costs.

## **8. Are any changes to the second-tier default benefit warranted?**

The second-tier default is not functioning as intended.

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

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

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

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

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

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

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

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

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

Alternatively, the regulation could be amended such that in the event of an out of contract scenario between a health fund and large hospital group the out-of-pocket charge to the consumer would be capped at a maximum of the difference between the peer group average rate and the 85 per cent of the peer group average rate paid by the insurer under the second-tier regulation.

Second tier benefit amounts are payable toward hospitals' charges for "nursing care and accommodation," yet they are derived from an insurer's contracted rates with comparable hospitals that typically cover not only the provision of nursing care and accommodation but also theatre usage and things like ward drugs and other consumables. Revised regulation in this area that has the aim of limiting the out-of-pocket costs of consumers should recognise this and require the second-tier hospital to accept these benefit amounts (plus any permitted out-of-pocket if the hospital's charge is allowed to exceed the second tier benefit at all) in full satisfaction of all such charges, precluding additional charges for things like theatre fees.

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

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

## **9. What is the impact of preferred provider networks?**

See response to question 7.

## **10. Should private health insurers be better able to assist their policy holders to make choices about their care? If so, how would clinical decision-making be protected?**

Informing consumers of their healthcare options and costs is vital to informed choice.

It is also important to note that the *Private Health Insurance Act* already protects clinical decision-making, stating at section 172-5:

"If a private health insurer enters into an agreement with a medical practitioner for the provision of treatment to persons insured by the insurer, the agreement must not limit the medical practitioner's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments."

Refer to responses to questions 17, 18 and 20.

## **11. What measures can be taken to improve competition in the private health sector?**

Competition is fundamental to downward pressure on costs, innovation, consumer choice, and higher quality outcomes.

A Productivity Commission inquiry should give consideration to the market and legislative constraints and inefficiencies affecting competition, including:

- The level of contestability and concentration in the private healthcare system, particularly the ownership and market power dynamics affecting competition in private healthcare delivery, and the implications for competition and consumer outcomes.
- The impact of second tier default on industry structure, market power, and consumer costs.
- The operation of the Prostheses List which substantially drives up health insurance costs to consumers (see response to question 24).
- The prohibition upon private health insurance covering outpatient medical care, which lessens the capacity of insurers to invest more in upstream preventative care with a view to diminishing avoidable utilisation in the hospital system (see response to question 17).

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

Medibank believes there is a need to consider longer-term and more systemic health reforms that address demand pressures and ensure funding for health measures are grounded on sound, empirically-based clinical evidence.

#### *DRG Limitations*

Many hospitals are paid on the basis of the Diagnostic Related Group (DRGs).

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

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

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

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

“The AR-DRGs are used by public and private hospitals, and state and territory health authorities to provide better management, measurement and payment of high quality and efficient health care services.”<sup>54</sup>

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

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

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

Public hospitals currently use AR-DRG version 9.

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

Health outcomes and costs will be improved if:

- Private health providers, including private health insurers, are required to adopt the latest version of the DRG within 12 months or where there are existing contractual arrangements within 12 months of those contracting arrangements concluding.

Private health providers, including private health insurers, are required to transition to any updated versions of the DRG within 18 months of updated versions being approved and published, but excluding existing contracting arrangements.

## **12. What has been the effect of the transfer of functions from PHIO to the Commonwealth Ombudsman and PHIAC to APRA? Have these transfers improved efficiency or reduced costs?**

Medibank supports the role of the Private Health Insurance Ombudsman and welcomes its independent and transparent approach to consumer issues. An enhancement would be the Ombudsman releasing quarterly reports on pre-determined dates identified in advance to the public and market.

Medibank equally supports the role of the APRA and welcomes its independent and transparent approach to regulatory and prudential issues in the private health insurance industry.

Overall, we are supportive of move to the APRA regulatory oversight with a broader perspective. The APRA has a stronger voice with the public and Government than PHIAC had, which can be important in periods of uncertainty for the industry.

Importantly, APRA's concern with capital and prudential requirements means health insurers have to be more transparent and accountable, which in turn promotes a stronger compliance culture within health insurers.

## **13. Has the sector benefited from prudential oversight by a regulator with a wider perspective?**

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

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

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

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

## **14. How has the Commonwealth Ombudsman responded to an increasing number of inquiries and complaints?**

See response to question 12.

## **15. Could the model for PHI premium increases be improved?**

Medibank supports the current model for private health insurance premium reviews.

However, moving to a more independent process – such as the APRA or other statutory authority approving premium increases rather than the Commonwealth health Minister – would depoliticise premium reviews and ensure annual reviews centre on underlying financial metrics and the sustainability of private health insurance.

## **16. Is there a case for a “one stop shop” to combine the various regulatory and oversight functions?**

Medibank believes the current regulatory and oversight functions for private health insurance are effective.

**17. Should private health insurance have a greater role in paying for outpatient services such as radiotherapy? What impact would this have on overall costs? What impact might it have on uninsured patients?**

Some health services can be delivered away from hospital settings with no adverse clinical outcomes and with significant benefits to patients (such as reduced stress, reduced travel times, improved recovery times).

Health services like rehabilitation, chemotherapy, dialysis, home infusion therapies, and palliative care can be appropriately conducted in the home.

Encouraging home based care as an option where appropriate can deliver benefits for patients and take pressure off public hospital resources.

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

Restrictions reduce the capacity of private health insurers to develop and fund models of care intended to keep people out of hospital in the first place.

In its current form, private health insurance is effectively 'supplemental' insurance rather than full insurance for the whole of healthcare. In this system private insurers are effectively payors of hospital bills after the fact and have little insight into their members' health until such time as they present to hospital for treatment. While it is squarely in the interest of private insurers to support their members' health upstream in primary care, in practice private insurers do not have relationships with general practice as they are not responsible for funding these services on behalf of members.

In the most extensive expert review of the healthcare system in recent times, the National Health and Hospitals Reform Commission 2009 recommended an expanded role for private health insurance to fully insure their members' health.

Furthermore, there are numerous international examples where consumers can elect (entirely at their own discretion) to receive their health insurance from Government or from a private insurer. If the consumer elects to receive their coverage from the private insurer government transfers its funding contribution for that individual to the chosen private insurer. Medicare Advantage in the USA is one such example where a consumer can elect to get their coverage either from government or from a private insurer. There is no reason why such a consumer directed insurance system could not be feasible in Australia. In the first instance it could be applied to consumers with chronic conditions.

In the models described above the cost of healthcare will be lowered as payors will have both the incentives and levers to increase upstream funding of primary care in order to reduce unnecessary utilisation of the most expensive part of the healthcare system, hospitals. In the current model, where Medicare is the funding mechanism for outpatient medical care in a fee for service model, the financial incentive for primary care providers is to maximise volume of activity. In a privately insured funding model of primary care the quantum applied to primary care would increase materially and the incentives based not only on activity but also on global outcomes for patients. This would have benefits for all members of the community as the model of outpatient care would progressively change across the board.

Furthermore, in both the models described above, consumers that are not currently privately insured would have the option to get their basic insurance (i.e. Medicare) via a private insurer or directly from government. In this regard the system is entirely equitable and does not discriminate in favour of the privately insured.

Such models are often erroneously described as privatisation of Medicare. Whether Medicare benefits are paid directly to the consumer or channelled through a private insurer does not alter the fact that it is a universal insurance scheme funded by government. Nearly all of outpatient service provision, such as general practitioners and medical specialists, are private sector providers, and as such provision of outpatient care is conducted by the private sector already.

**18. Should private health insurance be allowed to play a bigger role in funding the management of chronic conditions at home, in community settings and out-of-hospital? What would the impacts be on other parts of the health care system were this to be the case, including costs to government of the provision of out-of-hospital Medicare services? How could the universality and sustainability of Medicare be protected?**

See answer to question 17.

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

As the National Strategic Framework for Chronic Conditions states:

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

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

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

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

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

## **19. Is general treatment or extras cover the most efficient way to fill gaps in Medicare?**

Medibank supports Medicare and Australia's universal healthcare system.

Private health insurance supports health services not fully covered by Medicare, such as dental. More than \$2.5 billion in dental care is paid for by private health insurance, more than the Commonwealth pays for dental care. Around 90 per cent of dental health services provided to low and middle income earners are subsidised by private health insurance.

Expanding Medicare to cover general treatment or extras would pose significant costs for taxpayers. For example, Australia's total expenditure on dental services in 2016-17 was \$10.15 billion (inclusive of government and non-government expenditure).<sup>57</sup> Incorporating dental into Medicare may also fail to improve health outcomes, with the Australian Dental Association stating:

“A ‘universal dental scheme’ is not a practical solution to improving oral health outcomes for Australians...Internationally, comprehensive dental care and satisfactory dental health outcomes have been difficult to achieve with universal dental schemes. In particular, the National Health Service in the UK and Germany has resulted in oral health outcomes worse than those of Australia. All countries, including those with universal dental schemes have a disparity in oral health with the disadvantaged having poorer oral health.”<sup>58</sup>

The Commonwealth Parliamentary Library also observes:

“In countries which the OECD identified as having 100 per cent dental coverage—that is, Austria, Mexico, Poland Spain and Turkey—the average number of DMFT [decayed, missing or filled teeth] in 12 year olds varied, from 1.4 in Austria, to 3.2 in Poland. Of those countries operating universal schemes (as identified in the report by the European Council of Dentists) Denmark, Finland, Greece, Italy and the United Kingdom all showed variation in the average number of DMFT. Denmark and the UK shared the lowest average (along with Germany) at 0.7, while in Greece the number of DMFT was 2.0. Australia ranks slightly better than the EU average, at 1.1 DMFT. In comparison, Sweden and Germany, countries without universal dental schemes, have low rates of DMFT at 0.9 and 0.7 respectively.”<sup>59</sup>

## **20. Is the information consumers need to make good choices about their interaction with the private health system (both at the point of entry and subsequently, including when they need care) adequate and easily available? What improvements could be made?**

In general, there is relatively poor consumer understanding of the private healthcare system and private health insurance. For example, consumers are often confused by what private insurance covers and what is covered under Medicare (e.g. outpatient medical specialist appointments), the existence and operation of community rating (e.g. many consumers

believe that it is a risk rated system), and generally how to navigate through the healthcare system and receive timely, useful and personalised advice on treatment options, risks and benefits. For this reason, Medibank has established a Health Concierge service to assist members in navigating the system, and to provide information and advice when required.

In addition, consumers often have little transparency as to the expected cost and outcomes of treatment.

Delivering greater transparency of the price, performance and quality outcomes of healthcare services will deliver better health outcomes for consumers.

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

There are currently no requirements for providers to make publicly available information that is of high relevance to consumers. For example, consumers are unable to know how often a given surgeon has performed a procedure per – this is basic information that would greatly help inform consumers and lead to better health outcomes.

As the Productivity Commission states:

“Good information is a prerequisite for an efficient and effective health care system. But transparency has fallen short of its potential in health because data do not exist or are not made available. Data on individual hospitals' costs are collected but not published, and there is almost no reporting on the performance of individual health professionals against cost or quality metrics...

...Transparency can be improved by all health ministers taking steps immediately to publish more information on the performance of individual health care facilities and clinicians, and to allow researchers greater access to government-held datasets.”<sup>60</sup>

The Australian Competition and Consumer Commission has also stated that:

“In the case of hospitals and health facilities... the sharing of information regarding medical treatment, patient management and other issues which relate to the health and wellbeing of patients can lead to improvements in the mode, quality or efficiency of medical treatment and care.”<sup>61</sup>

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

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

Introducing reporting of quality metrics for all healthcare providers is, for example, an axiomatic reform that makes the health system more transparent, more accountable, and more likely to deliver higher quality outcomes for patients. For example a possible solution would be to aggregate Patient Reported Experience Measures (PREMS) and Patient Reported Outcome Measures (PROMS) across the health system for hospitals, providing a rich source of information for consumers.

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

Consumers would also benefit from greater transparency of the fees and financial incentives provided to third party aggregators who 'assess' or promote private health insurance policies online. For example, aggregators should be required to disclose commissions paid to private health insurers (which is a system adopted for other industries, such as general insurance and energy). There are also legitimate concerns about the purpose and outcome of trailing commission, particularly given the findings of the Royal into Misconduct in the Banking, Superannuation and Financial Services Industry.<sup>62</sup>

## **21. How can knowledge and use of the Private Health Insurance Ombudsman's comparison website be improved? How can consumers be made aware of the portability protections available to them?**

Medibank supports the role of the Private Health Insurance Ombudsman.

The comparison website can be strengthened with a more user friendly and intuitive interface.

Consumers are acutely aware of portability options.

Both the comparison service and portability will be enhanced by the introduction of bronze, silver, gold and basic classification.

Refer to responses to questions 12 and 20.

## **22. What are the legislative and other barriers to improving transparency of out-of-pocket costs and how could these be addressed?**

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

As the Productivity Commission recently stated:

“Improved access to healthcare data could enable more effective and timely healthcare services for Australians, including the development of new products and services, earlier identification of population health issues, and more rigorous and better targeted health research.”<sup>63</sup>

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

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

- Doctors should be required to disclose their actual charges for the episode of care on the invoice to Medicare and to insurers. There are anecdotal instances of patients being charged ‘booking fees’ or ‘side bills’ not seen on invoices, that in some cases can amount to thousands of dollars.
- Insurers are limited in disclosing any data that is obtained or derived from Medicare data, although they seek authorisation from doctors to disclose medical gap scheme participation (which some doctors opt out of). Medicare and insurers should be obligated to disclose this data so that they can provide an indication of specialist fees to consumers. GPs (or referring doctor) should be required to inform their patients of this information and advise them of their right to choose a specialist (even if they issue a named referral).
- Prior to the hospital admission the admitting specialist should be required to gather and quote the fees and out-of-pocket costs of the other members of the care team, such as the anaesthetist and assistant surgeon. In the short-term this quote could be provided through paper-based or electronic communication channels and, in the long-term through digital channels (e.g. a portal) to enable retrospective audits of quoted out-of-pocket costs compared with actuals.
- Periodic, detailed, and publicly available audits should be conducted of MBS data to identify instances of overcharging and higher-than-peer volume and charging for MBS specific items by service providers.
- The introduction of quality metrics for health service providers, with reporting against these metrics made publicly available and readily comparable.
- Private hospitals are not required to take part in cost studies conducted by the Independent Hospital Pricing Authority. When they decide to take part, private hospitals often negotiate exceptions that reduce transparency, such as aggregating various procedures or having a single price for procedures regardless of care setting. A legislative requirement for private hospitals to take part in costing studies would improve cost transparency for the health system.

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

### **23. Should informed financial consent arrangements be formalised? How could current arrangements be improved? Could bills for in-hospital treatment be simplified?**

Medibank strongly supports greater transparency for patients and consumers in healthcare. Transparency is fundamental to informed choice, to promoting competition and innovation, to placing downward pressure on costs, and to allowing patients to choose healthcare options best suited to their individual needs.

Informed financial consent is an important aspect of healthcare transparency.

At a minimum, medical practitioners should be required to not only disclose fees and out-of-pocket expenses, but to obtain informed patient consent to these costs in non-emergency situations *prior* to any health services being agreed to and undertaken. We recognise that there are complexities for some providers (e.g. anaesthetists, assistants in surgery) and consideration needs to be given to solving such complexities. Ideally, prior to the hospital admission the admitting specialist should be required to gather and quote the fees and out-of-pocket of the other members of the care team, such as the anaesthetist and assistant surgeon.

If a patient decides to use their private health insurance in a public hospital, they should also be informed that they may face out-of-pocket costs.

### **24. Is there a need for the government to set prostheses benefits, or could the supply of prostheses be dealt with in another way?**

Medibank supports the proposal by Private Healthcare to move to a National Procurement and Pricing System for medical technology, which can be modelled on the successful Pharmaceutical Benefits Scheme, and state-based procurement authorities like Health Purchasing Victoria.

Further reforms to prostheses pricing will result in greater savings to consumers.

As the Commonwealth Department of Health states:

“If prostheses prices get lower, in the end, patients start paying lower private health insurance premiums.”<sup>64</sup>

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

The Prostheses Pricing List sets the minimum benefit amount that private health insurers must pay in respect of private patients in private hospitals and also for private patients in public hospitals if those public hospitals do not charge a lower amount (and public hospitals essentially never charge lower amounts).

The problem is that the prices that private health insurers must pay are substantially inflated relative to the amounts that are paid in the UK, New Zealand and the Australian public health system for the identical devices.

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

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

A recent Senate inquiry into the prostheses list found that:

“...action is needed to reduce the prostheses costs and that savings should be delivered as soon as possible and have an evidence base.”<sup>65</sup>

The issue is not merely one of pricing – the spectrum of items included on the Prostheses List enable growth in volumes of items billed even when pricing is reduced. Since the introduction of price reductions by the Commonwealth in 2017 there has been no overall reduction in expenditure on prostheses by private health insurers, as volumes have accelerated (despite declining lives covered) to compensate for the decline in price.

Moreover, there is no link between the efficacy of prostheses and Prostheses List pricing. The National Joint Replacement Registry provides unequivocal evidence that some higher cost prostheses deliver inferior outcomes to lower cost devices.

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

Medibank's position is that the current prosthesis list costs remain too high. Approximately \$300 million out of total of \$800 million savings have been achieved so far (i.e. \$500 million savings are yet to be realised compared to benchmark costs from the public system and global provider costs).

There are also legitimate concerns around gaming of the prostheses list, with unexplained increases in prostheses volumes occurring following recent price reductions.

**25. If the Prostheses List is to continue, what further consideration could be given to the transparency of pricing for listed medical devices and other items?**

See response to question 24.

**26. What changes, if any, should the Commonwealth consider in relation to private patients in public hospitals?**

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

Public hospitals often encourage patients with private health insurance to use their private health insurance when seeking treatment in the public system.

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

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

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

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

This is an important step to improving consumer health choices.

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

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

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

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

The Australian Institute of Health and Welfare found that:

“Between 2011–12 and 2015–16, the number of separations in public hospitals for private health insurance patients increased by an average of 10.5% each year and the number of separations for self-funded patients decreased by an average of 10.7% each year.”<sup>66</sup>

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

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

“...evidence of private patient targets in selected jurisdictions and a focus on promoting the benefits of private patient election to patients in public hospitals suggests that State and Territory health funding policy parameters are contributing to the recent trend of increased privately funded public hospital separations.”<sup>67</sup>

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

“...a pivotal role in encouraging the use of private health insurance by providing accurate and timely information about using private health insurance in a public hospital.”<sup>68</sup>

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

“Patients who use their health insurance directly help Royal Prince Alfred hospital.”<sup>69</sup>

Royal Perth Hospital indicates to patients that:

“By using your private health insurance, the money received assists our hospital to buy additional, new and replacement equipment, maintain facilities, undertake more elective surgery to help reduce patient waiting time and continue to provide a better service.”<sup>70</sup>

Royal Adelaide Hospitals indicates to patients that:

“The income we receive from your health fund helps to improve hospital facilities update equipment and provide staff education and training.”<sup>71</sup>

And Queensland Health indicates to patients that:

“The Lady Cilento Children’s Hospital is grateful to families who help support our hospital and health services by using their private health insurance. When families choose to use their private health insurance, the hospital receives additional funding from health insurance providers and Medicare.”<sup>72</sup>

States are evidently encouraging private health insurance use in public hospitals with the intent of generating revenue, an intention acknowledged by the New South Wales Government, with that State Government introducing a trial program specifically intended to raise \$11 million in additional revenue for the State across just three local health districts.<sup>73</sup>

The South Australian 2017-18 State Budget includes specific targets for private health insurance use in the State’s public hospitals, with the targets evidently contributing to revenue projections.<sup>74</sup>

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

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

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

This is an important step to improving consumer health choices.

At the very least:

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

Further, public hospitals are not currently required to provide hospital casemix protocol data to private health insurers, which leads to a bizarre situation in which private health insurers have no visibility of the procedures their own customers undergo when they choose to use private health insurance in public hospitals. The outcome is that private health insurers

simply see requests for payments from public hospitals, which creates an incentive for excess care by public hospitals. It is not infrequent for private health insurers to be billed for procedures already undertaken by the public hospital that are not even covered by a given patient's private health insurance product - public hospitals do not commonly undertake an eligibility check of the extent of patients' private health insurance coverage.

## Conclusion

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

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

Medibank supports the broad questions posed in the discussion paper, but proposes that the Productivity Commission be also directed to have regard to:

- A Labor Government's objective to keep private health insurance premium increases at two per cent per annum.
- The financial sustainability of private healthcare and private health insurance.
- The demand and financial pressures on the private and public health systems.

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

It is imperative that a Productivity Commission review results in meaningful and wide-ranging reforms that address the cost drivers in the healthcare system.

A Productivity Commission review that concentrates on private health insurance in isolation from the broader private healthcare system will be fundamentally flawed and incapable of examining the issues and reforms necessary for sustainably lower premium increases in the long-term.

The Productivity Commission has recommended a wide-ranging review of Australia's health system on many occasions over the past 20 years. A comprehensive review of the private healthcare system should now be conducted.

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

A Productivity Commission review should particularly consider:

- Ways to address out-of-pocket costs for consumers.
- The value private health insurance delivers for consumers, taxpayers and Australia's health system.
- Ways to promote greater cost, price and quality transparency in the health system.
- How to take unnecessary costs, such as prostheses prices, low value care and MBS payment integrity out of the health system,
- Alternative models of care, particularly for chronic disease.

Medibank's submission has outlined a raft of issues that should be examined by the Productivity Commission to boost the value and affordability of private health insurance in both the short and long term.

Crucially, any Productivity Commission inquiry must result in meaningful reforms, which is the only way premiums can be sustainably low for consumers without detrimental outcomes to both the public and private health systems and households.

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

## Endnotes

- <sup>1</sup> Many studies demonstrate that Australia's mixed health system matches or performs better than most comparable countries on selected health measures. See, for example, Australian Institute of Health and Welfare (2018) *Australia's Health 2018: In Brief*, p.7; OECD (2019) *OECD Health Statistics*, accessible at: <http://www.oecd.org/els/health-systems/health-data.htm>.
- <sup>2</sup> Australian Prudential Regulatory Authority (2018) *Private Health Insurance Quarterly Statistics*, September, p.3.
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- <sup>4</sup> Department of Health (2016) *Annual Report 2015-16*, p.125.
- <sup>5</sup> Private Healthcare Australia (2017) *Pre-Budget Submission*, p.16.
- <sup>6</sup> Australian Institute for Health and Welfare (2017) *Admitted Patient Care 2015-16*, p.ix.
- <sup>7</sup> Private Healthcare Australia (2017) *The Value of Private Health Insurance*, p.1.
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- <sup>19</sup> Australian Medical Association (2017) *2017 Public Hospital Report Card*, p.7.
- <sup>20</sup> Australian Institute for Health and Welfare (2017) *Admitted Patient Care 2015-16*, p.ix.
- <sup>21</sup> Australian Institute for Health and Welfare (2017) *Elective Surgery Waiting Times 2016-17*, p.viii & 28ff.
- <sup>22</sup> Australian Medical Association (2018) *Public Hospital Report Card*, p.10.
- <sup>23</sup> Productivity Commission (2015) *Efficiency in Health*, p.63.
- <sup>24</sup> Private Healthcare Australia (2017) *The Value of Private Health Insurance*, p.1.
- <sup>25</sup> Department of Health (2017) *Portfolio Budget Statement*, p.90. The Commonwealth will spend \$6.1 billion on the private health insurance rebate in 2017-18, increasing to \$6.6 billion in 2020-21.
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- <sup>27</sup> World Health Organisation (2004) *Private Health Insurance: Implications for Developing Countries*, pp.6 and 10.
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