

How to make private health insurance healthier

GREEN PAPER
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About the Actuaries Institute

The Actuaries Institute is the sole professional body for Actuaries in Australia. The Institute provides commentary on public policy issues where there is uncertainty of future financial outcomes. Actuaries have a reputation for a high level of technical financial expertise and integrity. They apply their risk management expertise to allocate capital efficiently, identify and mitigate emerging risks and help maintain system integrity across multiple segments of the financial and other sectors. This expertise enables the profession to comment on a wide range of issues including health insurance, general insurance, life insurance, retirement income policy, enterprise risk management, prudential regulation, and finance and investment.

This Green Paper was commissioned and overseen by the Actuaries Institute and reflects our public policy principles which can be viewed at: <https://actuaries.asn.au/public-policy-and-media/public-policy/policy-principles>. The Paper was prepared by Bevan Damm and Matthew Crane from Ernst & Young, guided by a Steering Group of senior Actuaries Institute members. It was developed following an engagement program with a wide range of stakeholders.

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Executive Summary

1.1 Background and purpose

The Actuaries Institute believes that healthcare is an important public policy issue and one where the Institute can contribute and provide independent advice in the area of insurance.

The healthcare system in Australia has unique complexities, not least because of the many different stakeholders involved in the system. These include both public and private funders and providers with competing interests, deep specific technical expertise and access to asymmetric information.

However, despite its complexity, the healthcare system in Australia is one of the best in the world and, for a long time, private health insurance (PHI) has been a part of that system. So, without reducing or expanding the role of PHI in the healthcare system more broadly, how can the community get more from PHI?

We suggest a range of potential opportunities worthy of further consideration that may improve the outlook. With each of these, there will be winners and losers, risks and practical difficulties. However, the intention is to bring the debate and discussion to the next level with a common understanding of what needs to be achieved. The Institute acknowledges the unique complexities of the healthcare system necessarily complicate consideration and implementation of potential reforms.

A key aspect of our approach was consultation – we collated views from a range of different stakeholders including government, insurers, PHI industry groups, private healthcare providers and medical professionals. This report summarises those views and incorporates our own research.

1.2 Current issues with PHI

Recently, PHI has been attracting negative attention from media, public, medical professionals and government and the opposition. Most of the negative attention relates to:

Affordability issues

- ▶ Premiums have been increasing faster than wage inflation for several years, which means that PHI has been becoming less affordable.
- ▶ Although private health insurers are profitable, it is the cost of the claims that they pay to members that are causing affordability issues.

- ▶ Claims costs are increasing at above-inflation rates because they reflect the total cost of healthcare services purchased. This includes both a cost and volume element. The cost element grows faster than CPI in the longer-term as it is largely driven by labour costs and technology. The volume component is driven by ageing and increasing demand for services for a given age band (driven by a combination of potential factors).
- ▶ Because PHI is voluntary and community rated, relatively healthy people are less likely to purchase PHI in the first place, and more likely to drop existing PHI coverage, due to affordability concerns. This leads to higher premiums for everybody that remains insured, leading to a self-perpetuating affordability issue.
- ▶ Insurers are not fully rewarded/incentivised for reducing unnecessary claims costs because of the way the risk equalisation mechanism has been designed. This limits the amount of potential savings that can be passed on to members through cheaper premiums.

Perceived poor value for money

- ▶ Even for a patient with top level PHI hospital coverage, out-of-pocket costs can be significant and arise partly because specialists are able to set higher fees than insurers can cover, and partly because of the volume of treatments performed out-of-hospital.
- ▶ Private health insurers can't contribute much more than they do because they are excluded from primary health care and most out-of-hospital health services. In addition, insurers have limited ability to control the services and associated costs that they do cover.
- ▶ Patients struggle to shop around for better value treatment because of a lack of information on fees and outcomes, and because of information asymmetries between them and the specialist.
- ▶ Many people are confused about coverage. It is difficult to fully understand coverage on products due to exclusions, restrictions and the limits of PHI products imposed by legislation.

Perception issues

- ▶ It is not easy for people to appreciate the benefits of PHI – it isn't clear how it complements the 'free' public system, and the products are confusing both in

terms of the benefits they cover and the price net of all government loadings and rebates.

- ▶ In addition, some people don't think of PHI as insurance and focus on comparing the amount the insurer has returned in benefits and the premiums paid over a number of years. In other forms of insurance, the peace of mind of being covered is valued and it's generally a good thing not to have need to make a claim.
- ▶ PHI tends to get more than its fair share of blame for high costs given that most of this is driven by healthcare and provider cost increases more broadly.

All of these issues are resulting in reduced participation, particularly amongst younger people.

The government has made some reforms to PHI recently intended to address these problems, but more needs to be done.

1.3 Opportunities for improvement

There are lots of potential areas for further reform that could make a meaningful and lasting improvement to how private health insurance benefits the public.

However, there are many competing interests in the private healthcare sector, and so careful consultation, research and analysis followed by decisive policy decisions will be needed.

The Actuaries Institute's view is that the key things that need to change are:

1. **Give potential patients a genuine informed choice about their treatment.** At present, navigating the healthcare system is complicated and there is a lack of data available to make informed choices. Specialists, whose primary concern is the health of their patient, also have a business to run and are the ones driving the choice of the healthcare pathways. This can be addressed by improving access to the right information (including through websites), providing patients with an independent advisor on their options (a 'care coordinator', which could possibly be fulfilled by GPs) and enhancing informed financial consent rules. This would help patients get the best treatment and would remove some of the surprise and disappointment around out-of-pocket costs.
2. **Fairly reward insurers who reduce unnecessary claims.** The competitive and regulated nature of PHI means that a reduction in claim payments is passed on to members through cheaper premiums. Insurers can drive these reductions in a number of ways without reducing coverage, for example by reducing claims fraud, discouraging unnecessary treatment and encouraging preventative treatment. However, at present, insurers have to share any savings they

identify with the rest of the industry. Although they still benefit from driving savings, the incentive for doing so is dampened. Changing the industry's risk sharing mechanism to being truly risk based would improve this situation by providing a short term efficiency reward while sharing the benefits across the industry in the medium term.

3. **Target inefficiencies in the supply side of private healthcare services.** There are many inefficiencies in the supply side of private healthcare services, including overly-expensive services being performed without supporting clinical evidence,¹ over-priced prostheses items, and inefficiencies arising from the multitude of separately set prices relating to a single healthcare pathway. These could be addressed through a combination of further government reform and more sophisticated contracting between insurers, specialists and providers.
4. **Improve the health of people with insurance.** Obviously, there are many social and economic benefits from improving the health of the nation. But it would also mean a healthier insured population, which would mean cheaper premiums. In addition, incentivising healthier people to join in the first place would also mean cheaper premiums. Insurers and governments are aware of this, and already have a number of initiatives in place. But more can be done: from providing additional benefits/ discounts for healthier people; to increasing the rebates, levies and surcharges that incentivise people to take out insurance; to providing health management services to insured people.

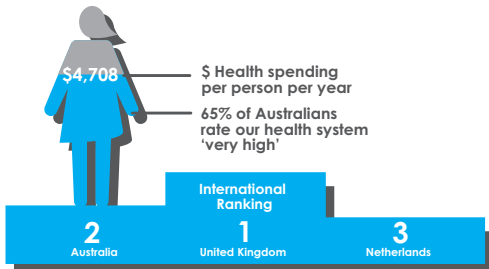
Some further opportunities are identified in Section 7.

Most of these changes would require government intervention, either through legislation, policy, education or media. The role private health insurers can play in reshaping their future is somewhat constrained by regulations that restrict their influence in large areas of the healthcare system. There are, however, opportunities for private health insurers, collaboratively and individually, to encourage a healthier and larger membership base through clearer articulation of the value proposition of PHI and promotion of health initiatives to manage the upwards pressure on PHI claims costs.

¹ See, for example, <https://www.medibank.com.au/livebetter/health-brief/health-insights/osteoarthritis-is-surgery-the-answer/> and <https://www.afr.com/lifestyle/health/mens-health/expensive-robotic-surgery-for-prostate-cancer-is-not-worth-it-20160726-gqdtws>

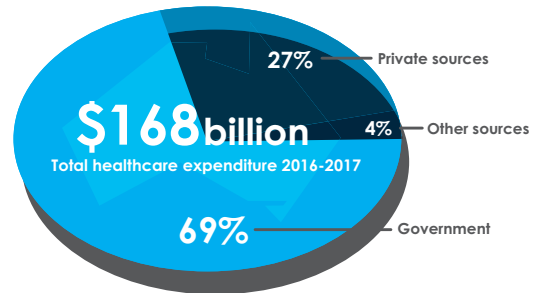
Australia's Healthcare System at a glance

Australia's Healthcare

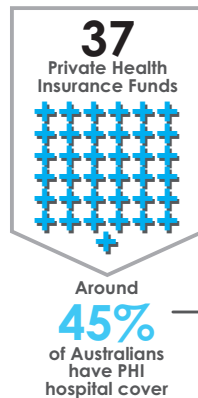
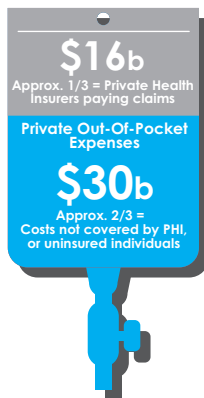


No.2 – Australia's health system by international ranking

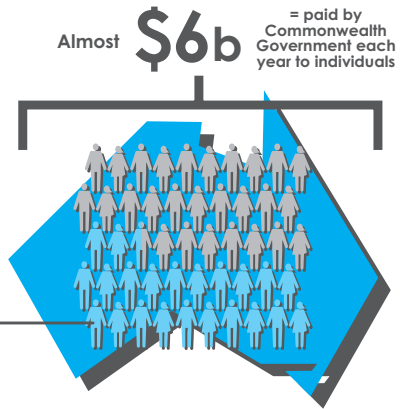
Healthcare Funding



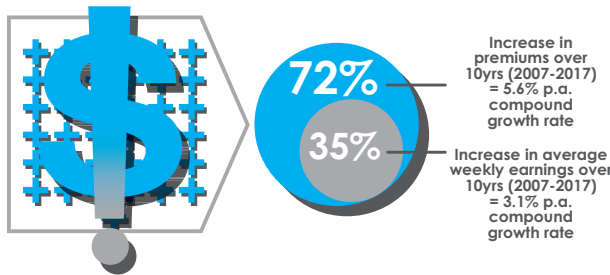
Private sources of funding



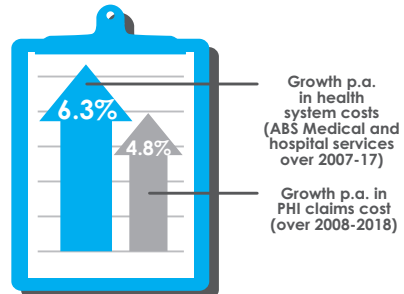
Government rebate



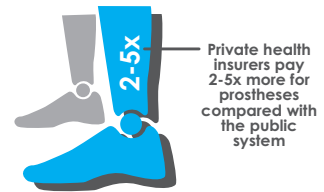
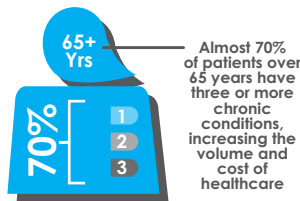
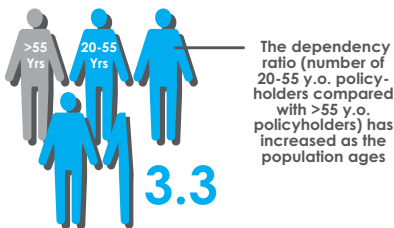
Affordability is a growing concern



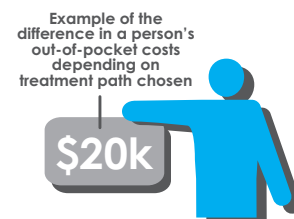
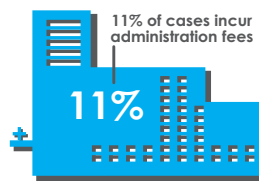
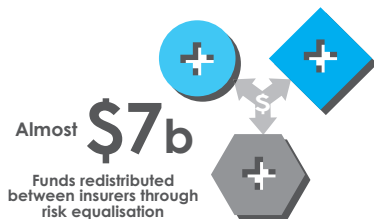
Growth in healthcare and PHI claims



Increased unit costs and inefficiencies



Other issues include



Healthcare and private health insurance in Australia

2

Key Points

- ▶ Australia's healthcare system is performing well, and is a unique blend of public and private healthcare service providers, and also public and private funders.
- ▶ Private health insurance is an integral part of the system. It enables the accessibility of private healthcare services so that they appropriately complement public healthcare services.
- ▶ So that private health insurance itself is accessible, especially to those with healthcare needs, it is community rated – i.e. everyone pays the same regardless of their health. However, for community rating to be effective in this regard, it requires that sufficient volumes of healthy (non-claimers) are insured.



2.1 Overview

Australia is considered to have one of the top performing healthcare systems in the world. The Commonwealth Fund's International Health Policy survey ranks Australia's as the second best health system (after the United Kingdom), compared to 11 countries of comparable income, and best in terms of efficiency and health outcomes. Compared with other member countries of the Organisation for Economic Co-operation and Development (OECD) Australia has the fifth highest life expectancy for males and the eighth highest for females. Australia's health spending averages \$4,708 per person (adjusted for local costs) which, although more expensive, is comparable to the OECD average of \$4,003.²

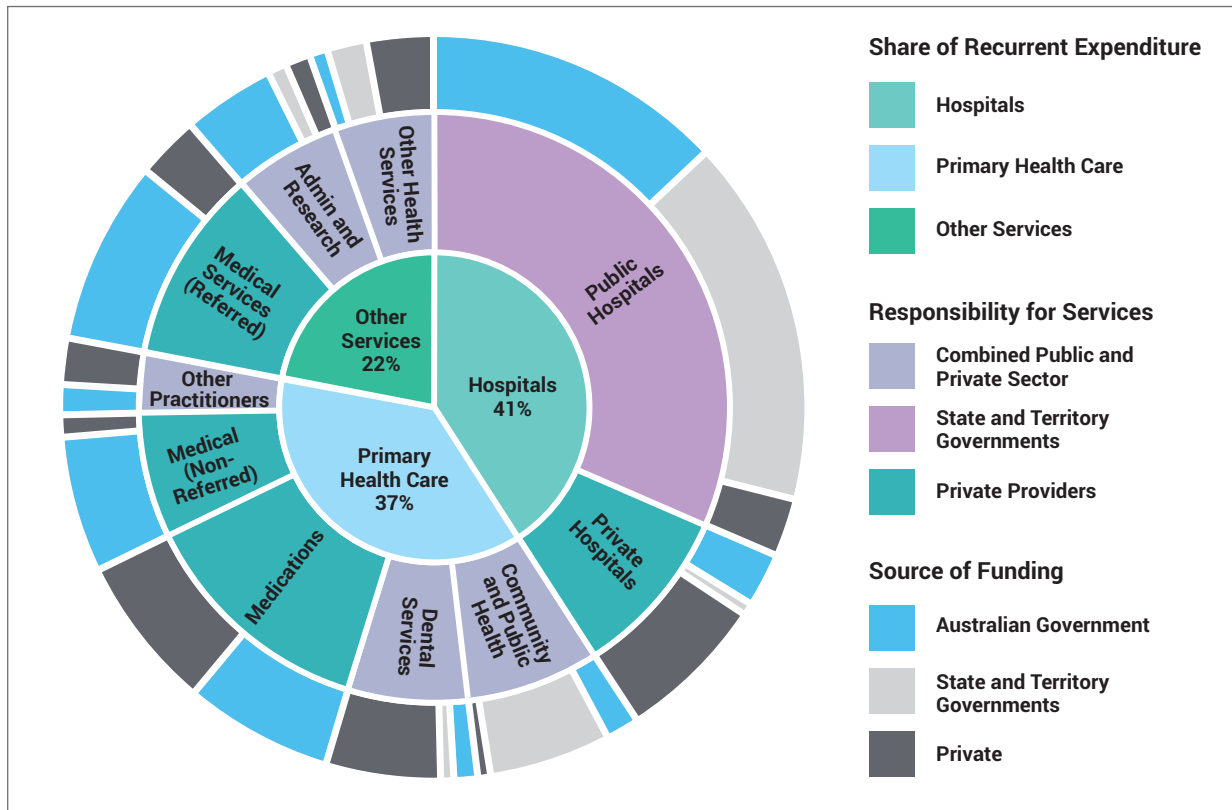
Australia's health system is a public and private hybrid, with different parts of the system funded to different degrees by government, private health insurance (PHI) and individual (out-of-pocket) contributions. The mixed public/private health system is also very highly regarded by the Australian community, with 65% of the population believing the quality of the health system in their state or territory is very high.³

PHI in Australia is unique as it is both voluntary and community-rated. Community rating is a pricing approach to insurance whereby every person (within certain specific communities, such as a state or territory) is entitled to buy or renew the same products for the same price as any other person. In most other countries (including Ireland and Germany) with community-rated PHI, participation is mandatory – this ensures that healthier-than-average people are insured, reducing the average insurance cost for everybody in the community. This combination of community rated PHI but with participation being optional participation stands out as unusual in the global context.

² <https://www.oecd.org/australia/Health-at-a-Glance-2017-Key-Findings-AUSTRALIA.pdf>

³ <https://www.privatehealthcareaustralia.org.au/wp-content/uploads/Private-Healthcare-Australia-Budget-Submission-2017-18.pdf>

Figure 1. Health services – funding and responsibility, 2015-16



Source: Australian Institute of Health and Welfare 2018.

2.2 Roles and responsibility for delivery and funding of health services in Australia

The healthcare system in Australia is complex and multifaceted, involving many funders and healthcare providers, both from the public and private sectors. Figure 1 summarises the relative size of expenditure in each of the three main sectors of the health system (i.e. hospitals, primary healthcare and other services), the split of responsibilities for the services within each sector (i.e. publicly provided, privately provided, or a combination) and the sources of funding for each of these services.

As a broad generalisation, the Australian Government, through Medicare and the Commonwealth/State health funding agreements, is primarily responsible for funding services to ensure universal access. The funding of Medicare is through the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS). The government also funds the PHI rebate and a range of other specific initiatives.

The private sector also provides a full range of healthcare services and facilities including private medical practitioners,

private hospitals, pathology services and pharmacies. Most of the funding of the non-primary private sector comes from private health insurers and individuals (through out-of-pocket costs). However, even in the private sector medications and medical services (referred and non-referred) are predominantly funded through PBS and Medicare.

Overall, the Australian health system is around 25% privately funded: 9% through private health insurers and 16% by individuals directly.⁴

2.3 Role of PHI in the current healthcare system

As described in Section 2.2, Australia has a unique, high performing healthcare system. Its strengths include “universal health insurance funded out of general taxation revenue, a mix of public, not-for-profit and private providers of services, and a high level of uptake of private health insurance.”⁵

PHI is an established part of the healthcare system in Australia. It provides millions of Australians with choice and access to private healthcare services, which are genuinely different to public healthcare services in nature, with a higher skew towards planned, elective non-emergency services. Private healthcare services can be attractive to patients as they typically have shorter waiting times than public healthcare services (for example 47-88 days compared to 17-28 days in the private system in our case study)⁶, offer the

⁴ See AIHW, Health expenditure Australia 2016-17, Table 3.2

⁵ A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission – June 2009

⁶ <https://www.hbf.com.au/-/media/files/reports/hbf-wait-times-report-2018.pdf?la=en&hash=0AE382008A66BC55E16BF5A4C9C3F0EF56F5C567>

Case Study: how PHI can be valuable

Emma lives in WA and was in the first year of her teaching career when she had an accident whilst mountain biking with friends.

She visited her GP who sent her for a scan. The scan showed she had torn her Anterior Cruciate Ligament (ACL) and needed an operation to repair the damage.

Working as a teacher, Emma was on her feet all day and had numerous sporting commitments. The discomfort and pain in her knee meant that she was unable to work.

As Emma had silver-level PHI when her injury occurred, she was able to book in for private surgery quickly and at the most convenient time for herself and her students.

Emma was also able to choose her own surgeon based on recommendations and location enabling her to be close to her family to help support recovery. Emma had to contribute towards her anaesthetist and paid her excess.

Without PHI, Emma would still have had a choice between being treated publicly or privately. However, if she had chosen to be treated publicly she would likely have had a longer wait for treatment (47-88 days compared to 17-28 days in the private system), which would have meant a loss of earnings in the meantime. If she had chosen to be treated privately but without PHI, she would have had to pay tens of thousands of dollars of costs out of her own pocket.

PHI gave Emma access to a quick and relatively low-cost healthcare pathway.

patient a choice of hospital and doctor, and enable access to more expensive facilities.

In 1953, the government⁷ decided that PHI itself needed to be affordable and accessible to everybody so that, in turn, private healthcare services were accessible. They decided that discrimination based on pre-existing conditions or previous health claims was inherently unfair. 'Community rating' was introduced to achieve this, whereby a single PHI product must have a single price regardless of the age, gender and health status of the individual insured.⁸

For community rating to be effective, it requires sufficient

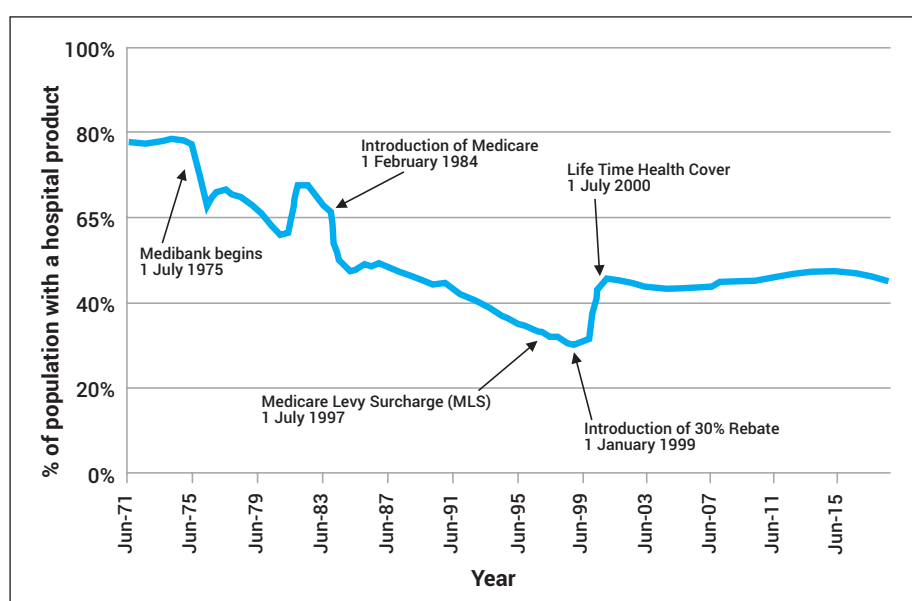
volumes of healthy (non-claimers) to be insured, otherwise the average claims cost would lead to less affordable premiums. However, community rating, by definition, means that PHI is not such a good deal for healthy (non-claimers), and so these people need to be incentivised, or even obliged, to purchase PHI.

2.4 About private health insurance

2.4.1 History of PHI

Healthcare system and policy settings have a significant impact on the relative attractiveness of PHI. Around 45% of Australians hold PHI hospital cover, although this percentage has changed significantly over time, as shown in Figure 2.

Figure 2 – PHI hospital participation rate



Source: APRA Statistics Private Health Insurance Membership Trends June 2018 (released 16 August 2018)

⁷ See PHI Act, supra note 59, s 55-1. Early community rating schemes in the National Health Act 1953, supra note 24, prevented private health insurers from declining coverage but limitations based on risk profile could still be imposed. See also Connelly et al, supra note 26 at 4; Willcox, supra note 45 at 157.

⁸ Under community rating in Australia, the price is allowed to vary by the State or Territory of the insured and by the number of people covered by the policy. In addition, Lifetime Health Cover loadings can apply, which can distort the price by age

Nearly 80% of Australians were covered in 1974, but increases in public funding for universal healthcare in both 1975 (Medibank) and 1984 (Medicare) led to corresponding reductions in PHI participation. By 1997 participation had fallen to around 30%, and remained at that level despite the introduction of the Medicare Levy Surcharge in 1997 and the PHI Rebate in 1999:

- ▶ **Medicare Levy Surcharge:** In 1997 the government implemented an income tested Medicare levy of 1%, and up to 1.5%, on tax payers who do not hold hospital cover. This was in addition to the current 2% taxable income paid for Medicare. The implementation of this tax penalty appeared to have had a marginal effect on the percentage of population covered by PHI. The income of the Medicare Levy and Medicare Surcharge Levy combined does not cover the full costs of the healthcare system in Australia.
- ▶ **PHI Rebate:** In 1999 the government began offering incentives for the purchase of PHI in the form of a premium reduction, or rebate scheme. The incentive was designed to encourage people earning below a threshold amount to purchase PHI, with consumers receiving a rebate from the Australian Government to help cover the cost of their premiums. The rebate is based on the income and age of the purchaser.

By that stage actuaries had developed a longstanding and deep understanding of PHI through working with government to design regulations and helping insurers develop products to meet members' needs. As a result, actuaries were already partnering with government to help design an additional incentive called the Lifetime Health Cover (LHC) loading. To support intergenerational fairness between consumers and to ensure it was effective, a premium loading was developed that would apply across the lifetime of consumers who do not have hospital cover from the age of 30. The supporting evidence to introduce the legislation for LHC was heavily reliant on actuaries engaged by the government directly, as well as submissions from the Actuaries Institute and a number of our members.⁹

The LHC policy effect was immediate. Together with the MLS and the Premium Rebate, it provided the third leg of a three-legged stool which at last could underpin community rating with a strong base. There was an influx of almost three million people into PHI during a few months in mid-

2000, with most of the growth driven by younger adults.¹⁰ Since then, participation in PHI has been relatively stable at around 45%.

2.4.1 Types of PHI cover

There are two types of PHI cover: hospital and general treatment. Consumers are able to purchase hospital and/or general treatment products. Some private health insurers also offer packaged products that cover both hospital and general treatment services in a single purchase.

Hospital coverage

There are two types of cost covered by hospital products: hospital costs and medical costs.

Hospital costs relate to the costs incurred by the (public or private) hospital facility itself, and include accommodation, nursing, theatre fees, intensive care, drugs, dressings and other consumables, diagnostic tests and pharmaceuticals. The proportion of the hospital costs covered by PHI is typically dependent on contractual arrangements between the hospital and the insurer.

Medical costs cover some or all the treatment by the doctor or specialist when performed as part of a hospital admission, or the costs of prosthetic items. The proportion of medical costs that are covered by PHI is typically dependent on the differences between the fee charged (as set by the doctor or specialist), any gap arrangements and the MBS schedule.

Since 1 April 2019, hospital products have been classified into 4 categories (gold/silver/bronze/basic) based on the MBS items covered. This reclassification of products is aimed at reducing the complexity of products by standardising inclusions and limiting the number of exclusions at each level of cover. In addition, the number of 'restricted' coverage items have been reduced with the intention of improving transparency for out-of-pocket costs.

Further variations to hospital products include excess (fixed cost per hospital episode and/or per year) and co-payment options which transfer some claim risk to the policyholder in exchange for a reduced premium.

General treatment coverage

General treatment products help fund some of the cost of services such as dental, optical, physiotherapy, chiropractor and other 'allied health' services. Insurance claim costs are generally fixed pre-agreed per-service amounts – either in dollar terms or as a percentage of the service fee. In most cases the amount covered by the insurer leaves a residual 'gap' that the patient must pay. The residual 'gap' is a necessary tool to control utilisation and control premiums given the more discretionary nature of these services.

⁹ https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/1999-02/lifetime/report/index

¹⁰ Health after Lifetime Health Cover, Andrew P Gale and Alan Brown, 2003

Most products also include annual limits on the total amount the insurer will pay to a member over the course of a calendar year. General treatment products have not been formally reclassified as part of the recent reforms, although all products can be defined as Comprehensive, Medium or Basic.¹¹

Ambulance transportation and Broader Health Care coverage

In addition to Hospital and General Treatment, PHI products can also include coverage for ambulance transportation in an emergency and for a range of hospital substitution or disease management programs that form part of the Broader Health Care cover scheme. Hospital substitution programs are targeted at meeting patient preferences and facilitating treatment in a cost-effective setting (i.e. within the home of the patient) where it is clinically appropriate. Examples include palliative care in the home or chemotherapy in the home. The other type of program – disease management – is targeted at the prevention of hospital separations and includes benefits for services aimed at targeting patients who utilise a high volume of health services or patients with chronic conditions.

2.4.3 Regulations and legislation

Risk equalisation

To support community rating, and reduce insurers avoiding underwriting higher risk consumers, all insurers pay a per-policy levy into a shared pool. This is then redistributed back across the industry based on each insurer's own eligible hospital payments profile associated with each insurer's claims from the higher risk consumers. This goes a long way towards ensuring that insurers with a higher risk consumer profile are not competitively disadvantaged in the community rated system.¹²

Risk equalisation is generally designed to be zero sum. The current mechanism for PHI applies retrospectively based on an actual claims paid basis. There are two key parts of the current mechanism, being an Aged Based Pool (ABP) and a High Cost Claims Pool (HCCP). The ABP is the most material aspect of the current risk sharing and the aspect that materially affects incentives. The HCCP limits significant claims losses for each insurer from particularly large claiming consumers.

The key issues with the existing system are:

- ▶ that a large market share insurer who makes an investment to create savings for high risk consumers will immediately give away a large aspect of any cost savings to all the other insurers in the pool; and
- ▶ that the 'free' return will go to all other insurers, whether they innovate and invest or not.

Similarly, small market share insurers are not incentivised to invest innovatively, and see a larger percentage of their

savings returned to all other insurers than for the larger insurers. Additionally, smaller market share insurers receive more significant rewards from the larger insurer investments.

The current system does not create significant incentive for insurers to invest strongly in reducing costs for the high risk consumers (i.e. in health/wellness or substitution services).

Price regulation

Further to the regulation on community rating, the Minister for Health regulates all premium increases. Insurers are only allowed to increase rates annually on the first of April each year, having gone through a rigorous submission and approval process with the Department of Health and the Australian Prudential Regulation Authority (APRA).

Insurers also need to notify policyholders of rate changes within a reasonable period of notice prior to the increase taking effect.

Benefits

The benefits provided on products for both hospital and general treatment products are regulated by the Department of Health to ensure adequate coverage/provision of additional health services by an insurer on top of public provision.

Although Medicare covers health services performed in hospital and out-of-hospital, medical costs covered by PHI hospital products are strictly limited to only cover in hospital services or hospital substitution services. This means that PHI is unable to cover out-of-hospital medical services which are partially covered by Medicare, including general practitioner (GP) and specialist services, selected diagnostic imaging and pathology services, dental care for children in some circumstances, allied health services in limited circumstances, and some medical services for private patients in public and private hospitals.

This legislation dates back to the commencement of Medibank in 1975 (which was later replaced by Medicare). Although General Treatment products and Broader Health Cover arrangements do allow insurers to fund some out-of-hospital services, insurers are only allowed to fund services which Medicare doesn't. This can lead to high out-of-pocket fees for patients accessing some important services under modern models of care. For example, diagnostic and post-surgery rehabilitation procedures are

¹¹ <https://www.privatehealth.gov.au/healthinsurance/howitworks/>

¹² Community Affairs References Committee, Value and affordability of private health insurance and out-of-pocket medical costs (The Senate, 2017)



being performed outside of hospital, and chronic conditions are moving more and more towards non-hospital settings.

The limited presence of insurance coverage outside of hospital can create a perverse incentive for doctors to admit patients to hospital (the most expensive setting of care), when it might not be clinically required.

2.4.4 What private health insurance pays for

For patients who elect to be treated as a private patient in a public or private hospital, Medicare will cover 75% of the government-determined MBS fee for the associated medical costs. This results in a large subsidy from Medicare to the private healthcare system (and indirectly, to private hospitals) as Medicare pays a share of the cost of inpatient medical treatments for private patients.

The remaining hospital and medical costs will be charged to the patient - some or all of these costs may be covered by PHI, depending on the active policy.¹³

Therefore, the privately funded costs paid by a combination of the PHI and the patient include:

- ▶ the remaining 25% of the MBS fees;
- ▶ the difference between the specialists' fees and the MBS fees. PHI medical contributions are typically capped in relation to the MBS fee, and so patients tend to pick up most of the 'gap' where this difference is significant;
- ▶ all related hospital costs, which include accommodation, theatre fees, intensive care, drugs, dressings and other consumables, prostheses (surgically implanted), diagnostic tests, and pharmaceuticals.

Most of the hospital policy claims costs from the insurer's point of view are for the related hospital costs with a much smaller proportion being for the medical specialists' fees.

The following table illustrates the distribution of 2016-17 healthcare expenditure between private health insurers, government and individuals.

¹³ <https://www.privatehealth.gov.au/healthinsurance/whatiscovered>

¹⁴ Individual in hospital costs are assumed to relate to private hospitals only, from Table 3.9 of the AIHW data. The \$1,447 m of individually funded public hospital services are assumed to have taken place off-site and have been included within out-of-hospital costs in this table.

¹⁵ PHI is not allowed to cover most primary care services, for example, GP visits. However, this definition of primary care includes dental services and other health practitioners (such as physiotherapists), which PHI is allowed to cover.

¹⁶ 'Other' includes funding by injury compensation insurers and other private funding. All non-government sector capital expenditure is also included.

Table 1: 2016-17 Health Expenditure in Australia (\$millions)

Service setting	Source of funds					Total	%
	PHI	Individuals	Government	Other			
In-hospital ¹⁴	9,041	1,795	53,782	3,022	69,087	41	
Out-of-hospital	4,033	7,796	20,824	221	31,426	19	
Primary care ¹⁵	2,785	20,213	36,888	2,064	61,951	37	
Other ¹⁶	0	3	5,167	357	5,527	3	
Total	15,859	29,807	116,661	5,664	167,991		
%	9	18	69	4			

Source: <https://www.aihw.gov.au/reports/hwe/073-1/health-expenditure-australia-2016-17/data>

Out-of-pocket costs are often higher than insurer contributions towards out-of-hospital and primary care services. Even in the hospital, total out-of-pocket costs are around 20% of the amount insurers contribute. This is partly because of uninsured people using private hospitals and funding the entire treatment themselves.

Because all private hospital costs can be included in contractual arrangements between hospitals and insurers, the prices are reduced due to bulk-purchasing. The insurers are negotiators on behalf of their members. Arguably this is one of the greatest value-add services that PHI provides for consumers.

2.4.5 A citizen's perspective of private healthcare

Deciding whether to participate in PHI

All Australians have the choice to be treated as a public patient in a public hospital, to self-insure and pay for private treatment directly, or to select a PHI product that would contribute towards future private treatment in public or private hospitals if needed.

In Australia, there are 37 private health insurers offering around 3,500 distinct health insurance products. However, the number of policies actually available to any one individual is much smaller – depending on where they live and their individual circumstances. The website www.privatehealth.gov.au is set up under legislation and every insurer is required to provide up-to-date information about each policy and its prices.¹⁷

As described in Section 2.4.2, consumers can choose between hospital cover, general treatment cover, or a combined product covering both, with varying levels of cover against each option.

Choosing a specialist, provider and hospital

If a patient elects to receive treatment as a private patient, they have the right to choose which hospital and specialist they're referred to by their General Practitioner (GP). Usually the GP will assist in determining the most appropriate specialist. Many private patients find their specialist through a recommendation from their GP, although some rely on recommendations or do their own research. There is a common misconception that referrals need to be addressed to a specific medical specialist.¹⁹

Additionally, private health insurers can provide the patient with a list of 'preferred' providers and/or hospitals for which they have agreements that reduce the out-of-pocket costs. The privatehealth.gov.au website provides consumers with a list of agreement hospitals for each insurer, however this does not provide any information on the quality of care provided within these hospitals. If a hospital or provider is chosen outside of this list, the out-of-pocket expenses may be higher.²⁰

Paying out-of-pocket expenses

Out-of-pocket expenses are the amount a private patient pays either for medical or hospital charges, over and above what Medicare and the private health insurer pay. Some health funds have gap cover arrangements to insure against some or all of these additional payments. Additionally, for any services provided outside of hospital for which a Medicare benefit is payable, if the fee for the service is higher than the MBS fee there will be a gap that generally is not covered by PHI.

Out-of-pocket expenses also hit low income earners the hardest. Reports suggest that some low income earners do not access the healthcare services that they need, and that many more experience significant financial difficulties in paying for healthcare services.²¹ Out-of-pocket expenses therefore have the potential to damage the principles of universal access to healthcare, as well as the accessibility of PHI (as it is less attractive as a product to people unable to use it).

Out-of-pocket expenses hit low income earners the hardest and have the potential to damage the principles of universal access to healthcare.

¹⁷ <https://www.accc.gov.au/consumers/health-home-car/private-health-insurance>

¹⁸ [http://www.health.gov.au/internet/main/publishing.nsf/Content/3A14048A458101BOCA258231007767FB/\\$File/Report%20-%20Ministerial%20Advisory%20Committee%20on%20Out-of-Pocket%20Costs.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/3A14048A458101BOCA258231007767FB/$File/Report%20-%20Ministerial%20Advisory%20Committee%20on%20Out-of-Pocket%20Costs.pdf)

¹⁹ <https://www.betterhealth.vic.gov.au/health/servicesandsupport/choosing-hospitals-and-specialist-doctors>

²⁰ Roy Harvey, 'Out-of-pocket payments for health care—finding a way forward' (Parliamentary Library, Parliament of Australia)



The current state of private health insurance

Key Points

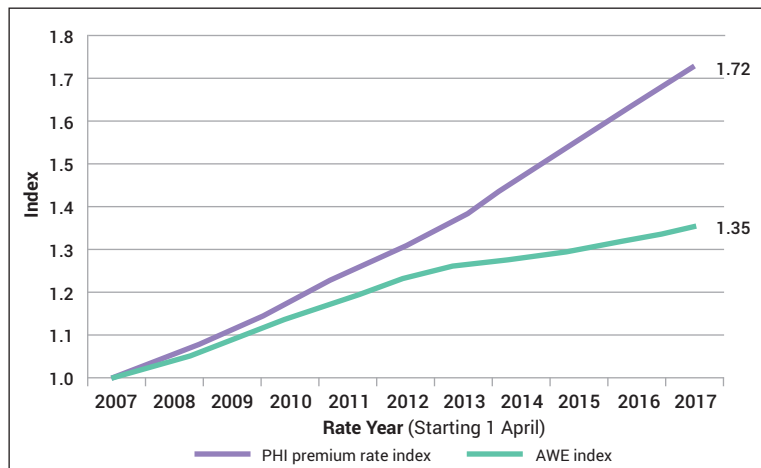
- ▶ PHI premiums are getting less affordable, which is starting to mean a drop in the proportion of people covered.
- ▶ The largest reduction in the proportion of people covered is amongst younger people.
- ▶ Under 'community rating' everybody pays the same regardless of their health, and so PHI is poorer value for younger people who are generally healthier than older people.
- ▶ As the proportion of healthier people with PHI reduces premiums must increase, which further compounds affordability issues.

3.1 Premium growth and affordability

PHI premiums have increased faster than wages over the last decade. The average premium per policy (in \$) has increased over the past nine years from \$2,385 to \$3,514,²¹ which is a 47.3% increase. However, this change is partially dampened by a shift towards more basic and/or higher excess products.

Hence, the true like for like comparison is that PHI premiums have increased at an even greater rate. Figure 3 shows that, at a product level on a like-for-like basis, premiums have increased by over 70% from 2007 to 2017.

Figure 3 – PHI premiums vs wages



Source: <https://www.actuaries.digital/2018/02/16/why-is-health-insurance-getting-more-expensive/>

Due to the differences in average wage increases and premium increases, participants in PHI are spending an increasing proportion of their income on PHI premiums – i.e. PHI is becoming less affordable. As PHI becomes less affordable, people start to question if it is value for money for them.

²¹ Based on the reports as released by APRA named Operations of Private Health Insurers Annual Report data

In addition to increasing premiums, the government’s premium rebate is linked to the Consumer Price Index (CPI), causing it to reduce as a percentage of premiums. Additionally, the freeze in the indexation of the rebate effectively reduces the rebate further for individuals with increasing incomes.

Escalating health claim costs and rising premiums within the context of a reduction in the effective premium rebate, slow wage growth and rising cost of living is causing consumers to question their need for private health insurance. The increasing popularity of the most basic policies on the market, designed mainly as a cheaper alternative to paying the Medicare Levy Surcharge (MLS), show that many people are questioning the value of paying more and having a higher level of insurance cover.

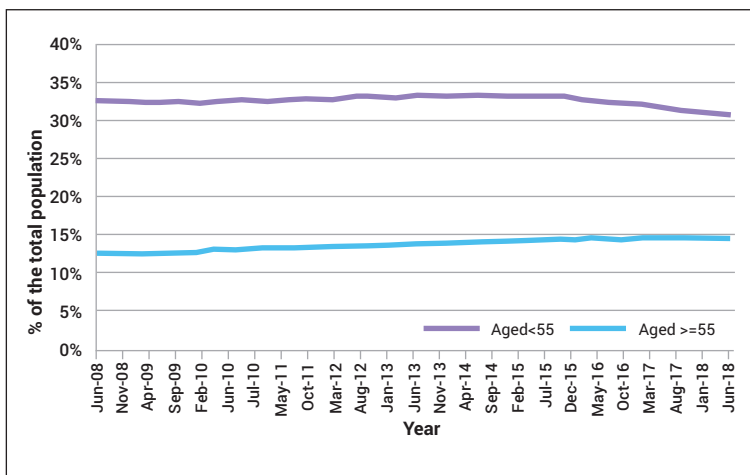
3.2 Decline in PHI participation

Figure 2 shows that, in recent years, there has been a steady and consistent decline in participation in PHI. The reducing premium affordability discussed in Section 3.1 is undoubtedly a major cause of this. Issues with declining participation have been very well-publicised. “Private health exodus: Premium rises lead to membership decline”²², “Private health cover at 11-year low”²³ and “How millennials’ choices are reshaping private health insurance for everyone”,²⁴ have been among the headlines. However, when viewed in the context of the last 43 years, the reduction in participation is not dramatic, reflecting that, from a customer’s point of view, reducing affordability has been a marginal year-on-year change.

Because community rating requires that everyone pays the same price for the same product, premium increases apply equally and are shared across all members, including members where their expected claims have not increased. Because of Medicare and the public hospital system, opting out of PHI does not mean losing access to healthcare if an unforeseen health event occurs.

As a result, the healthiest people with the lowest incomes (a group heavily skewed towards the younger generations) are dropping their cover, as shown in Figure 4.

Figure 4 – Proportion of the population who have a hospital PHI product



Source: APRA Statistics Private Health Insurance Membership Trends June 2018 (released 16 August 2018)

Reduced affordability has been a marginal year-on-year change, with the healthiest people with the lowest incomes the most likely to drop their PHI cover.



²² <https://www.news.com.au/finance/money/budgeting/private-health-exodus-premium-rises-lead-to-membership-decline/news-story/8041d9ffe7d9c6d9f877afeecfd2cd4f>

²³ <https://www.theaustralian.com.au/national-affairs/health/private-health-cover-at-11-year-low/news-story/52060658789164a9f4d60c869a97e26a>

²⁴ <https://www.abc.net.au/news/2018-07-10/private-health-insurance-analysis/9676562>

Many people do not know what their policy covers, if it is good value or is suitable for their needs.

Compounding the question of affordability and value, is the complicated mix of levies, surcharges and rebates – as well as complicated product designs that change regularly. This makes it very difficult for even astute consumers to judge the true cost and value of PHI. Many people do not know what their policy covers, how much it covers, if it is good value, or suitable for their needs. As premiums continue to increase, more and more consumers are expected to downgrade or opt out of PHI.

As older members are, on average, less healthy than younger members, they account for a significant proportion of the total cost of claims. Figure 5 shows the 'dependency ratio' between 20-55 year olds and over 55 year olds (e.g. a dependency ratio of 3.0 means that an average older person will claim three times the amount claimed by an average younger person on a like-for-like product²⁵).

Figure 5 – Dependency ratio between 20-55 and over 55 years old



Source: APRA Statistics Private Health Insurance Membership Trends June 2018 (released 16 August 2018)

These ratios mean that the reduction in participation of under 55s will necessarily, in and of itself, lead to increasing premiums for the remaining insured population.

But what's driving the affordability issues in the first place, that community rating is compounding? Are there any other non-price factors leading to the declining participation rate? There are many answers to these questions, so we've split them into whether they're related to members buying or using PHI. None of the root causes will simply go away on their own, and so our expectation is that, unless something is done about it, the participation rate is likely to continue to fall. The Institute questions at what point the effect of an increasing dependency ratio could make PHI, in its present form, difficult to sustain.

3.3 Planned reforms

In October 2017, the government announced a number of regulatory reforms aimed at improving premium affordability and addressing the growing public dissatisfaction with PHI. Most of these reforms were implemented by April 2019 and include:

▶ **Prostheses reform:** An agreement with the Medical Technology Association of Australia to lower the price of prostheses and thereby decreasing the average cost per claim. The aim of the reform was to not only help reduce insurer costs but to help increase the affordability of PHI. However, prostheses costs account for only around 10% of private health insurance claims,²⁶ and so the scope to meaningfully reduce premiums through this reform alone is limited.

▶ **Mandatory hospital product classification:** All hospital products have to use compulsory uniform coverage definitions and are classified into four categories (gold/

²⁵ In other words, we have adjusted for the fact that older people tend to choose higher levels of cover than younger people, and so the unadjusted ratio between claims costs would be even larger.

²⁶ APRA Quarterly Private Health Insurance Statistics June 2018 (released 16 August 2018) <https://www.apra.gov.au/sites/default/files/documents/1808-qphis-20180630.pdf>

silver/bronze/basic) based on the underlying clinical category coverage. Each category has a 'plus' and default sub-category. The reclassification of products is aimed at reducing the complexity of products by standardising inclusions and limiting the number of exclusions at each level of cover. In addition, the number of 'restricted' coverage items have been reduced with the intention of improving transparency around out-of-pocket costs. Previously, comparing and choosing between PHI products was difficult due to differences between the ranges of types of healthcare services covered. Although there remain 8 different sub-categories of product, the changes should make PHI (hospital) product comparison more straightforward. However, it does not eliminate other important areas of confusion for consumers, including around understanding the level of potential out-of-pocket costs in the event of a claim.

▶ **Under 30s discount:** This reform provides a discount of up to 10% on hospital insurance premiums for 18 to 29 year olds. The discount remains until the policyholder turns 41 if they remain on the same policy, after which the discount is phased out. The main aim of the discount is to provide another lever for insurers to target young policyholders. By encouraging more younger Australians to participate in health insurance, the average utilisation rate should decrease. However, it is uncertain whether lower young prices will be offset by higher volumes of new to PHI policyholders.

▶ **Increasing the maximum allowable excess on a hospital product from \$500 to \$750 for singles:** The desired outcome of this reform is to increase the participation rate by enabling insurers to offer cheaper products without additional exclusions or restrictions. Clearly, the out-of-pocket costs when a member makes a claim will be increased by the increase in excess. Whether or not the reform is a net positive to the affordability of PHI will depend on offsetting factors. Positive impacts should be that more new participants will join and some 'downgrading' to much cheaper lower-level products with more exclusions will be averted. This will increase premium revenue from those groups, which can then be spread across all members through lower premium increases in the future. On the other hand, healthier and less risk averse current members would be likely to move down to the higher excess product, reducing premium revenue by a larger extent than the reduction in expected claims cost.

Other reforms that are currently under consideration include:

▶ **Out-of-pocket review:** In 2017, the Minister for Health announced the establishment of a Ministerial

Advisory Committee on out-of-pocket costs to advise the government on best practice models to ensure consumers are properly informed about potential out-of-pocket costs for hospital treatment. The committee will look to develop the most effective way to make information on out-of-pocket costs more transparent. Key members of the committee include consumers, medical craft groups, insurers and hospitals. More recently, the Minister has pledged to develop a searchable website providing access to specialist service fees. This would enable consumers to have the ability to make informed decisions regarding their treatment and their pathway through the private healthcare system. However, doctors appear to be generally opposed to this type of initiative.²⁷

▶ **Administration fees:** The Department of Health and Private Healthcare Australia are currently investigating administration fees which are being added to bills as additional costs to episodes of care. Early patient survey responses indicate that booking and administration fees are charged in about 11% of hospital admissions and other 'hidden' fees in about 5% of admissions.²⁸

▶ **Capped rate increases:** Had it been elected, the Australian Labor Party proposed implementing a cap of 2% for PHI rate increases in 2020 and 2021. The intention of this was that it would maintain affordability at current levels, with insurers' profits reducing unless they were able to reduce their cost base. However, rate rises are a symptom of many underlying root causes, mainly related to the cost of claims, which insurers have limited control over e.g. specialist fees (see Section 5). As such, it is likely that insurers' profits would reduce as a consequence of a capped rate increase. Given the cap was intended to be temporary, it is unlikely that affordability would have been materially improved unless the underlying issues were addressed. As discussed in Section 5.1, industry operating profits before tax are around 7% of premiums, and so there is limited capacity for industry profits to absorb such reductions.

²⁷ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediareel-yr2019-hunt035.htm>

²⁸ [www.health.gov.au/internet/main/publishing.nsf/Content/3A14048A458101B0CA258231007767FB/\\$File/Report%20-%20Ministerial%20Advisory%20Committee%20on%20Out-of-Pocket%20Costs.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/3A14048A458101B0CA258231007767FB/$File/Report%20-%20Ministerial%20Advisory%20Committee%20on%20Out-of-Pocket%20Costs.pdf)



Using PHI to claim

Privately insured patients can face high out-of-pocket costs for out-of-hospital services, or alternatively, are incentivised to be treated in-hospital.

Key Points

- ▶ Even for a patient with top level PHI hospital coverage, out-of-pocket costs can be significant and arise partly because specialists do not contract with insurers and hence are able to set high fees, and partly because of the volume of treatments performed out-of-hospital.
- ▶ Private health insurers can't contribute much more than they do because they are excluded by legislation and regulation from primary health care and most out-of-hospital health services. In addition, insurers have limited ability to control the services and associated costs that they do cover.
- ▶ Patients struggle to shop around for better value treatment because of a lack of information on fees and outcomes, and because of information asymmetries between them and the specialist.

4.1 Case study

4.1.1 A patient with prostate cancer

John is 57 years old and, last year, visited his GP for a regular annual check-up. His GP suggested he have a Prostate Specific Antigen (PSA) blood test to test for prostate cancer. On revisiting the GP, John learnt that the results were positive, and so he was referred to a urologist. The urologist sent John for an MRI scan which also suggested the cancer was limited to John's prostate.

John's urologist recommended a Transrectal Ultrasound Guided (TRUS) biopsy, which unfortunately confirmed that he had prostate cancer.

The urologist quickly scheduled John in for robotic assisted surgery, which fortunately was successful in removing the cancer. John visited his urologist regularly thereafter.

Despite being covered by a top-level PHI product, John was out-of-



pocket for over \$20,000, mainly for the urologist's fees for the TRUS biopsy and the robotic assisted surgery.

John had to trust his urologist, who was acting in John's best health interests, and naturally John's only concern was getting rid of the cancer. But what John didn't know was that, had he taken a second opinion, he could have undergone traditional open surgery with a different surgeon, which has similar outcomes and would have cost him around \$3,000 in out-of-pocket expenses. Alternatively, he could have undergone radiation therapy in the public system, which also has similar outcomes, and which would have incurred around \$200 in out-of-pocket costs.

4.1.2 Observations

Note the services described in Section 4.1.1 were directly related to John's treatment of prostate cancer. However, more generally, there would be a range of the further potential services that may be required for related conditions. These could include physiotherapy, psychiatry and cosmetic surgery. Clearly, if cancer reoccurred then further treatment would also be necessary.

The key observations on John's pathway are:

- ▶ **Out-of-pocket costs are unavoidable:** Whichever route John had taken, he would have faced some level of out-of-pocket costs despite having top-level PHI cover.
- ▶ **Out-of-pocket costs are high and can vary:** These out-of-pocket costs can easily be tens of thousands of dollars across a healthcare pathway. Although John didn't know it, if he had assessed different treatment options with different specialists, he would have found a wide range of out-of-pocket costs.
- ▶ **Choice is driven by the GP and the specialist:** John didn't really have ownership over the direction of his healthcare pathway. There were alternative options at each point, but he was essentially steered by his GP and urologist. The ultimate pathway that they take therefore might not necessarily provide the best possible combination of healthcare services meeting the patient's longer-term needs nor their financial situation.
- ▶ **The pathway is complex and uses both public and private services and funds:** This is driven by the structure of the healthcare system in Australia. Often patients find themselves in the private healthcare system regardless of what PHI coverage they have and unable to switch to a valid public healthcare alternative.

4.1.3 Impact on private health insurers

The case study illustrated that PHI only partially covers the, largely unavoidable, costs related to a particular condition. In the case of cancer treatments, more than a quarter of patients with breast cancer had out-of-pocket costs \$10,000.²⁹ This brings into question the benefits of having PHI in the first instance, and can lead to reputational damage to the insurer through complaints and possible media coverage.

However, private health insurers have very limited control over the pathway chosen, which is often based on specialist's recommendations. With little to no additional knowledge and/or information, the patient is inclined to go with the recommendation.

Private health insurers are also exposed to higher costs than necessary through specialists navigating patients down a route that results in higher costs to the insurers through treatment options that are not necessarily the most cost effective option e.g. providers where there are no gap arrangements.

4.2 Private health insurers' influence over service costs

Insurance is often used to fund a separate goods and service provision industry that has its own (often competing) interests. In the case of motor insurance, insurers need to arrange fees and services with repairers.

However, private health insurers are uniquely separated from the benefits they fund for their members. In hospital insurance, there are at least three sets of different healthcare goods and service providers: the hospital, the various medical professionals involved, and the manufacturers of medical goods (e.g. drugs and prosthetic devices). Each has a say on the services that the member should receive. Fees are set independently of each other with little regard to the aggregate cost. And most importantly, the insurer has very little input into the last two of these decisions, other than pre-agreeing its fixed contribution for each service.

The choice of provider(s), and the fees charged in excess of the insurer's pre-agreed contracts, are almost entirely out of the insurer's control. They have little control over utilisation of services and only limited control over the cost of services.

To minimise the risks to the financial stability of the organisation health insurers have designed their products to control benefits paid and to provide incentives against excess utilisation (such as excesses and benefit limits as

²⁹ [https://www.abc.net.au/news/2018-04-05/medical-treatment-out-of-pocket-costs-top-\\$10k-study-finds/9619344](https://www.abc.net.au/news/2018-04-05/medical-treatment-out-of-pocket-costs-top-$10k-study-finds/9619344)

well as excluded or restricted services). Where possible they have also negotiated with providers to lock in costs through contracts. However, whilst important to control an insurer's risk some aspects of the product designs reduce the value of the product to the policy holder and result in high out-of-pocket costs in some cases.

4.3 In hospital 'gaps'

There is a trend towards out-of-hospital healthcare services. These can often produce better patient outcomes at a lower cost than in-hospital alternatives. However, insurers have limited ability to pay for out-of-hospital services:

- ▶ PHI is not allowed to cover any services provided out-of-hospital that are partially subsidised by Medicare – and there are wide ranging services and treatments that fall into this category: from GP consultations, to specialist consultations, to medical imaging. In each case, the patient will often have no choice but to pay a substantial fee out of their own pocket.
- ▶ Even where PHI is allowed to cover an out-of-hospital (non-Medicare subsidised) treatment, the difficulty is that insurers are not informed during the referral process and so will be unable to provide information relating to their members' needs until after the event. This can make it difficult for insurers to identify and consider designing funding arrangements to subsidise services such as these.

Both of these reasons mean that privately insured patients can face high out-of-pocket costs for out-of-hospital services, or alternatively, are incentivised to be treated in-hospital. There is evidence that out-of-hospital services can provide the best health outcomes for the patient, often at a lower cost,³⁰ and so this represents a failure in the funding mechanism for out-of-hospital services.

Appropriately funding out-of-hospital services is a broad healthcare system problem that could be addressed in many different ways. Although it is not a problem limited to PHI, high out-of-pocket costs do lead to a poor public perception of PHI and undoubtedly contribute to the declining participation rates.

Medicare makes a contribution to all hospital services, public or private. However, for private services, this contribution is obviously not intended to cover the full cost of the service. In particular, Medicare only covers a small proportion of specialists' charges. For example, Medicare pays \$988.35 towards hip replacements and knee reconstructive surgery in private hospitals, but specialists charge between \$18,000 and \$42,000 for these treatments.³¹

Specialist fees are unregulated and are set by the specialists

performing the services based on what they think their services are worth and what they think the market will bear. They can, and do, charge higher prices to patients who can afford to pay more.³² Equally, the Institute acknowledges specialists can, and do, charge lower prices to patients who can least afford to pay.

In particular, specialists can and do vary their fees based on their own view of the patient's capacity to pay. This includes whether or not the patient has PHI, effectively determining the relative sizes of out-of-pocket costs for patients with and without PHI. This therefore has a direct bearing on the perceived value of the PHI product.

It also gives specialists the ability and right to use their judgment to distort community rating principles for insured people (effectively, different people are buying products with different excesses for the same price). Given the fundamental importance of the principle of community rating to the private healthcare system, the lack of strict control over its application potentially introduces risk and misalignment to the policy intent.

Unlike private hospitals, most specialists do not contract with insurers directly, and so reserve the right to charge freely. Specialists are now billing using the Australian Medical Association (AMA) medical services and fees as a guide. Hence, the size of out-of-pocket costs may be influenced by the list of recommended fees published annually by the AMA. Most insurers set an upper limit for how much they'll pay over the MBS fees, and so the level of out-of-pocket fees is effectively determined by the specialists.

There is an evident relationship indicating that as fund benefits above the MBS increase, the doctors' fee charged over the MBS fee also increases. APRA data in the June 2017 quarter shows that a 1% increase in the fund benefit above the MBS fee generates an equivalent 1% increase in the fee charged over the MBS fee.



³⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3698621/>

³¹ <https://www.smh.com.au/healthcare/same-surgery-different-surgeon-huge-variations-in-outofpocket-costs-for-orthopaedic-operations-20170814-gxvppb.htm>

³² <https://onlinelibrary.wiley.com/doi/pdf/10.1002/hec.3317>

Figure 6 – Relationship between Fund Benefit and Fee Charged above the MBS

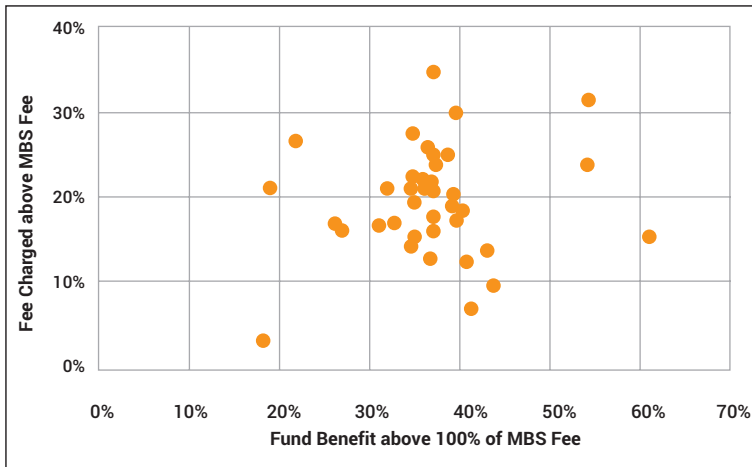


Source: APRA Statistics Private Health Insurance Benefits Trends June 2017 (released 22 August 2017)

Benefit

This could be because doctors have complete discretion over the fees they charge, and so are able to respond to changes in fund benefits and adjust their pricing. This is also supported by the limited evidence of a relationship between the gap as a proportion of the MBS fee and the fund benefit paid above the 100% MBS fee. The figure below illustrates that the majority of gaps are between 15% to 25% regardless of the benefit paid by the fund.

Figure 7 - Relationship between Gap and Fund Benefit



Source: APRA Statistics Private Health Insurance Benefits Trends June 2017 (released 22 August 2017)



4.4 General treatment ‘gaps’

Out-of-pocket expenses are an integral part of general treatment cover, since very few policies exist that fully cover the costs of general treatment services (except in certain situations, such as if preferred providers are used, or occasionally for prescribed spectacles / contact lenses). This is because of the selective nature of general treatment services, that often are chosen by the member for the purpose of monitoring and maintaining wellbeing rather than as an essential response to a health concern. The ‘skin in the game’ discourages members from accessing services unnecessarily, whilst the level

Medical advancements have led to more healthcare being treated out-of-hospitals.

More could be done to make member choices informed ones.

³³ <http://www.health.gov.au/internet/main/publishing.nsf/Content/phiconsultations2015-16>

³⁴ <http://www.health.gov.au/internet/main/publishing.nsf/Content/phiconsultations2015-16>

of PHI coverage enables affordable access to these services.

Generally speaking, general treatment products are valued by consumers who appreciate the contributions that their insurer makes towards services, even if it does not always offset the premium of the product. In addition, because general treatment services are relatively evenly accessed by people of any age, community rating does not impact the value proposition of general treatment products for younger people to the same extent as it does for hospital products.

4.5 Limited reach out-of-hospital

There have been at least two major changes over the last 20 or so years that have contributed to more healthcare services being performed out-of-hospital. First, advances in treatments mean that diseases that were once considered acute, such as breast and prostate cancer, now have a very long chronic phase managed in the community by GPs and allied health professionals. Second, as new technologies have emerged in the health sector, some healthcare procedures that were previously performed in private hospitals (and so funded by PHI) are now being performed outside of hospitals through community centres or in the home, or are being managed through alternative treatments that avoid the need to go to hospital altogether.

It is arguable whether the public and private funding mechanisms are adequately adapting to changing healthcare services. In particular, PHI is largely restricted to funding in-hospital procedures, meaning that the shift away from hospitals either increases the reliance on public (Medicare) and individual (out-of-pocket) funding, or it incentivises patients into private hospitals where a more optimal non-hospital treatment might exist.

Even where PHI is able to fund an in-hospital procedure, there are often a range of associated fees incurred outside of the hospital that the insurer is either unaware of or is unable to fund. This can include administration fees, which occur in around 11% of cases.³³ The patient is exposed fully to this cost.

Under Broader Health Cover arrangements, private health insurers are able to fund the provision of preventative care and chronic disease management programs that are provided out-of-hospital. They have the ability to identify members that may benefit from these services and approach them directly.

However, as discussed in Section 4.2, where specific medical treatment is required in response to a health condition, the choice of care pathway is largely dictated by GPs and specialists. Although private health insurers have a wealth of information around treatment pathways and outcomes for patients, they are unable to play a part in informing the referral process. This is partly because of the legislation that precludes insurers from funding primary care (GPs) and partly because of medical professionals' concerns about the doctor/patient relationship. Often the first time the insurer will become aware of a member requiring healthcare is at the point when a hospital claim is made.

4.6 Uninformed choices

One of the main benefits of PHI that is frequently referred to is that it provides members greater choice in the provision of treatment.³⁴ There is naturally a knowledge gap between clinicians with many years of training and experience, and consumers. However, we believe that there is more that could be done to make these member choices informed ones.

In most cases, the choice of service provider is driven by the GP's referral

and the specialist's recommendation. The former is reliant on the GP's own personal knowledge (rather than a detailed statistical database of health outcomes and costs). Clearly, the ultimate health outcome for the patient will be the main concern for any specialist recommending treatment. They also need to consider whether the patient can afford that treatment. However, because they have a business to run, there is reduced incentive to consider whether the treatment and associated fee is the most cost-effective possible option in order to meet the patient's desired health outcomes.

Medical colleges can and do play a role in promoting patient information regarding their rights on disclosure and transparency of fees as well as treatment options.³⁵ Although standards relating to giving informed financial consent have existed for over two decades, research shows that patients often do not receive sufficient and understandable information in time for them to make an informed choice.³⁶

Even when they do receive adequate information, the patient is generally not in a position to challenge, compare, or decline their treatment's associated costs. This is because the information usually comes too late in the process, and also:

- ▶ the patient has a health concern, and so their primary focus will be on healing that, rather than the costs associated;
- ▶ it is clearly in the patient's health interests to trust and accept the treatment advice being provided by the specialist – this makes it difficult to take a different stance on the costs associated; and
- ▶ as well as requiring energy, shopping around to get an alternative point of view will take time and attract additional consultation costs.

All of these factors actively discourage patients from seeking further opinions.

There is no public information on different specialists' fees and the health outcomes of the services they perform. There are increasing calls for some of this information to be made public, including from the government which has pledged to develop a searchable website providing access to specialist service fees.³⁷ This would better enable consumers to have the ability to make informed decisions regarding their treatment and their pathway through the private healthcare system. However, doctors appear to be generally opposed to this type of initiative.³⁸

In addition to all of this, the disparate nature of private healthcare service provision means that, even if it were possible to obtain perfect fee and outcome information from a single practitioner, there would still be other practitioners (e.g. anaesthetists) with whom the patient would have to consult before making a decision.

This can sometimes lead to patients receiving unnecessarily expensive treatments, with expensive out-of-pocket costs. An example is the robotic assisted surgery that John received in the case study. It is significantly more expensive than other options such as open or laparoscopic surgery and, in that particular case, there is no clinical evidence to suggest that it provides better results in the medium to long term.³⁹ Patients have limited understanding of alternative services performed by alternative specialists, unless they have the time, inclination and ability to fund further consultations themselves.



³⁵ See, for example, <https://www.surgeons.org/news/patient-information-on-surgical-fees/>

³⁶ https://chf.org.au/sites/default/files/informed_consent_issues_paper.pdf

³⁷ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2019-hunt035.htm>

³⁸ For example, President of the Australian Medical Association Dr Tony Bartone criticised the focus on specialist fees, saying such a website was looking at the problem "with one eye shut". <https://www.smh.com.au/healthcare/specialist-fees-published-online-in-exorbitant-out-of-pocket-crackdown-20190301-p51179.html>

³⁹ <https://www.afr.com/lifestyle/health/mens-health/expensive-robotic-surgery-for-prostate-cancer-is-not-worth-it-20160726-gqdtws>



Buying PHI

Key Points

- ▶ Although private health insurers are profitable, it is the cost of the claims that they pay to members that are causing affordability issues.
- ▶ Claims costs are increasing at above-inflation rates because they reflect the total cost of healthcare purchases. This includes both a cost and volume element. Labour costs and Health technology improvements are driving the cost element. Increasing number of services accessed for any given age (partly because improved health technology) and an ageing population are driving the volume element.
- ▶ Because private health insurance is voluntary and community rated, relatively healthy people are more likely to drop their cover due to affordability concerns. This leads to higher premiums for everybody that remains insured, leading to a self-perpetuating affordability issue.

Last year 84% of Private Health Insurance premiums were returned to members through claims.

5.1 Claims are the main reason for reducing affordability (not expenses or profits)

Private health insurers paid \$20.5 billion in claims in the last financial year, meaning that 84% of the \$24.5 billion premium revenue they received was returned to members through claims.

The other 16% of premiums represents 9% expenses (\$2.2 billion) and 7% operating profit before tax (\$1.9 billion). It is unsurprising that executive remuneration and industry profitability attract significant scrutiny, especially as the industry receives a public subsidy of around \$6 billion. However, the context is often lost: were it possible to drive down industry profit and management (non-claims) expenses by as much as 20%, and the industry passed on those savings in full to consumers, then PHI premiums would only reduce by 3%. As well as continued scrutiny on profit and expenses, there will need to be an increased focus on reducing unnecessary or inefficient claims costs to properly address affordability concerns.

5.2 PHI costs, like all healthcare costs, naturally increase faster than inflation

Of particular concern is that private health insurance is becoming less affordable each year. As shown in Figure 3, at a product level, premiums have increased by over 70% from 2007 to 2017. This has far outstripped average wage growth, which means that PHI has been becoming less affordable.

As discussed above, claims costs are the main driver of premium levels. PHI claims costs per insured person have grown at an average of 4.8% per year for the last 10 years.⁴⁰ However, similar annual growth per person has also been seen across the whole healthcare system for the whole population, with an annual growth in expenditure of 4.9% per person per year for the last 10 years.⁴¹

But why do healthcare costs increase so far above almost every standard measure of inflation? The reason is that unlike, say, CPI, healthcare cost increases are driven by three separate elements:

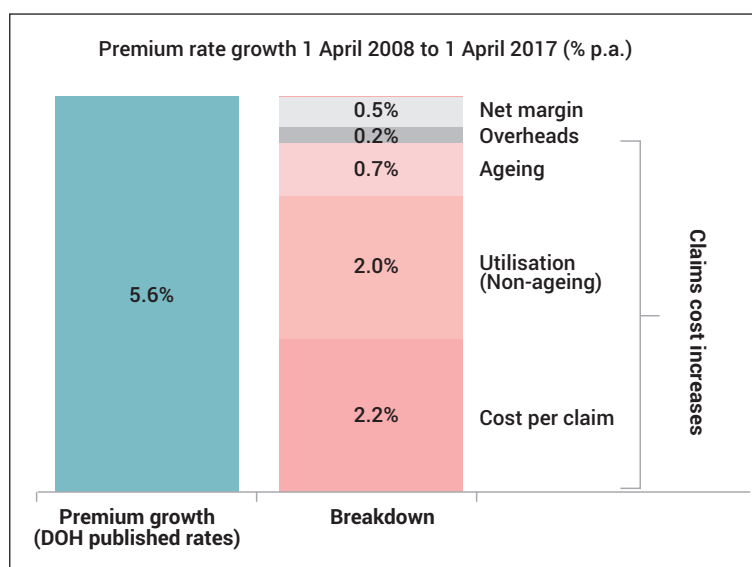
- ▶ increases in the price of the health services being covered (which is higher than CPI because it is predominantly driven by increasing labour costs as well as improving technology leading to more expensive treatments);
- ▶ increases in the number of health services accessed (also called ‘utilisation’) for a certain age; and
- ▶ ageing – which further drives increased utilisation.

Simply put, two of these three causes can be summarised as “Australians are accessing more healthcare services than they used to”. The implication for PHI premium growth is that it is reflective of the change in health purchases being made, rather than inflation.

In a PHI context, the relative contribution of each of these factors towards premium increases can be seen in Figure 8 below.



Figure 8 - The premium affordability issue



Source: <https://www.actuaries.digital/2018/02/16/why-is-health-insurance-getting-more-expensive/>

⁴⁰ From APRA statistics: the number of insured people has grown from 10.9 million at 30 June 2008 to 13.5 million at 30 June 2018, while claims paid has grown from \$10.4 billion in FY2008 to \$20.5 billion in FY18.

⁴¹ ABS population and AIHW health expenditure data from FY2007 to FY2017



Technological advances mean that more sophisticated, and hence more expensive, treatments are more readily available.

As discussed, increasing prices and community rating means that healthier people are more likely to drop their cover than less healthy people. This compounds the rate at which average claims costs increase for the population that remains insured.

Each of these aspects is discussed in more detail in the rest of this Section.

5.3 Cost per claim

The price of technological innovations in medicine, along with the associated equipment and the wages of medical staff, are rising. As a result, Australians have access to more sophisticated health services and medicines than ever before.

As described in Section 2.4.4, hospital claims include the cost of the medical procedure, any required prosthetic implements, and related hospital costs. The increases in costs for each of these elements is described in more detail below.

'Service' costs to the specialist(s) performing the medical procedure

The PHI-funded portion of medical costs is largely proportional to the pre-determined MBS fee for the procedure as discussed in both Sections 2.4.4 and 4.3. The public system (through Medicare) will pay 75% of the MBS fee, if it is performed privately - and insurers must cover at least the remaining 25%. As insurers can choose how much above 25% of the MBS they will cover, they are able to maintain an element of control over their claims costs for a given service (at the expense of specialists having control over the level of out-of-pocket costs faced by the patient).

Technological advances in healthcare mean that more sophisticated, and hence more expensive, treatments are more readily available. As well as leading to improved care and outcomes for a given condition, it also contributes towards increasing costs per service.

In addition, and as noted earlier, although specialists act in the best health interests of the patient, there is currently no control over the fees that are charged and they can be high. As discussed above, potential patients are not in a position to 'shop around' for the best value treatment and there is little to no information enabling clear comparisons of cost and outcomes. As well as potentially high out-of-pocket costs for patients, this means that insurers end up contributing towards a portion of services which are not the most cost-effective for a given outcome. This pushes up average claims costs and, in turn, leads to higher PHI premiums for everyone insured.

In summary, while insurers maintain a degree of control over these elements of their claims outgoings, they are intrinsically linked to the fees charged by the specialists. These fees naturally increase with Medicare and specialist wage inflation, but also with additional factors such as increasing sophistication of the services being performed. In addition, issues with transparency around the choice of services mean that there are cost inefficiencies.

The costs of any associated prosthetic implements

The Prostheses List is the list of surgically implanted prostheses, human tissue items and other medical devices that private health insurers must pay benefits for when they are provided to a patient with appropriate health insurance cover. They are provided as part of hospital treatment or hospital substitute treatment, and there is a Medicare benefit payable for the service.

Expenditure on prosthetic items accounts for around 9% of all PHI claims⁴², and the cost of these items is dictated in a government-controlled 'Prostheses List'. However, the prices in the list can result in insurers paying benefits two to five times the price paid in the public system⁴³ for the same item.

Initiatives are underway to reduce the prices in the list, which are estimated to save around \$300 million per year over four years, which is around 1% of premiums.⁴⁴ However, even after these savings, the prices paid by insurers will remain significantly higher than the price paid in the public system.

There could be significant savings to government, PHI policy holders, private health insurers and patients from reforms in this area.

Hospital costs relating to the facilities being used, including accommodation

Health funds typically cover all of the associated hospital costs related to a medical procedure – at least in hospitals through which they have directly negotiated an agreement. However, the contractual arrangements between hospitals and insurers vary between the many different parties.

A large part of hospital costs reflects the wages of the staff employed by the hospital, including nurses. Recently there has been pressure to increase salary levels for nurses, and so this component of cost has been growing faster than CPI.

Technological advances in medical treatment also increase the associated cost of the hospital facility.

In general terms, insurers either fund private hospital services using a 'case mix' funding model (where a single pre-agreed payment is made based on the complexity of the hospital service provided), or using a 'per diem' funding model (where the payment is linked to the total length of stay and individual services provided).

Under the case mix funding model, the insurer will pay the provider the pre-agreed fixed amount and so the provider will directly benefit from any efficiencies that they can deliver. The regular renegotiation of contracts means that insurers can also benefit from this arrangement in the longer-term.

Under the per diem funding model, the daily incremental payments tend to reduce the longer the patient is in hospital, reflecting their care requirements. Even so, the total amount paid to the hospital increases by the length of stay, which may discourage the provider from investing in improved care and efficiencies with a view to reducing the length of stay.

It is immediately apparent that bargaining power is a key determinant of this element of claims costs, which are then passed down to all PHI members through their premium

rates. The largest insurers have the scale to negotiate on a relatively even footing with the largest hospital providers and so have a good degree of control over these costs. At the same time, hospital providers also have a bigger incentive to get the best deals with largest insurers because they provide the bulk of the patients.

Smaller health funds have joined forces to negotiate better terms with private hospitals. The Australian Health Service Alliance (AHSA) is an alliance of small to medium health funds that negotiates with private hospitals as a collective allowing funds to achieve more favourable rates than would otherwise be achievable if these smaller funds negotiated individually. Given the beneficial effects on the health system, these arrangements are not prohibited under common law.

Summary

The price of hospital and medical services are largely dictated by specialist costs and hospital costs. Both of these cost bases reflect the wages in the healthcare sector, which have been increasing at relatively high levels, and also advances in healthcare technology. As a result, this component of the cost of healthcare services has been rising faster than CPI over a number of years. This is evidenced by the ABS' Medical and hospital services index, which has increased at an average rate of 6.3% per year from 2007 to 2017.⁴⁵

As well as high increases in cost, private health insurers have limited ability to influence that cost because of the reliance on specialist referrals and costs on the prostheses list which are dictated.

5.4 Utilisation and ageing

Insurers have even less control over the drivers of the other 60% of annual claims growth – utilisation and ageing. This is an issue faced by governments and private providers around the world due to ageing populations, worsening health profiles, improving medical technologies, increased access to care, wealth-driven demand and higher expectations.

Utilisation

Advances in technology have increased the utilisation rate for PHI-funded services in several ways, including:

- ▶ more services are available to treat any given condition;

⁴² APRA Quarterly Private Health Insurance Statistics June 2018 (released 16 August 2018) <https://www.apra.gov.au/sites/default/files/documents/1808-qphis-20180630.pdf>

⁴³ <https://www.privatehealthcareaustralia.org.au/governments-prostheses-list-reforms-make-phi-affordable/>

⁴⁴ <http://www.health.gov.au/internet/main/publishing.nsf/Content/private-health-insurance-reforms-fact-sheet-prostheses-list-benefit-reductions>

⁴⁵ See column BO in Table 13 of the ABS' 6401.0 series - Consumer Price Index

- ▶ more people with a given condition can be reached; and
- ▶ individuals and doctors are better able to monitor health and identify/diagnose conditions that would otherwise be missed.

As well as living longer in general, Australians are also living longer with chronic illnesses (due to advancements in care). Results from a large study of patients visiting GPs in Australia suggest that almost 70% of the patients over 65 years of age had three or more chronic conditions, known as ‘co-morbidity’.⁴⁶ Treatment of patients with co-morbidity can be very challenging for doctors and specialists. They are required to oversee multiple drug treatments and interventions, while also considering and monitoring their effects and interactions when treating patients. This can cause significant increases in the cost of care for patients of a given age.

Other potential factors driving increasing utilisation are changing behaviours and expectations relating to healthcare services as wealth and the standard of living improve over time.

Ageing

From an ageing perspective, one in every seven Australians in 2016 was 65 and over, accounting for 15% of the population. By 2057, this number is predicted to double according to the Australian Institute of Health and Welfare (AIHW). Age is an easily measurable risk factor that enables a prediction of claims behaviour, which is reflected through the current risk-equalisation arrangements. An ageing population is therefore an additional factor that is increasing private health insurers’ claims costs.

In addition, as shown in Section 3.2, the proportion of younger people holding PHI (with a lower expectation to claim) is reducing while a similar proportion of older members are remaining insured. This means that the age profile of the insured population is increasing more quickly than the population.

5.5 Community rating effect – everyone pays for increasing costs

Because PHI in Australia is voluntary and because community rating requires that everyone pays the same price for the same product, it is the healthiest people with the lowest incomes (a group heavily skewed towards the younger generations) that are dropping their cover. Fewer younger people means higher average claims costs, and so premiums increase further. This leads to self-perpetuating increasing premiums.

5.6 Incentives for private health insurers to reduce unnecessary claims

In Sections 4.2, 5.3 and 5.4, we explained why insurers have limited ability to control their claims costs. However, those

reasons alone should not deter insurers from trying to reduce the amount they pay towards ‘unnecessary’ claims. These could include claims that are:

- ▶ fraudulent – potentially either on the part of the claimant or the provider;
- ▶ unnecessary or avoidable – if, for example, they don’t improve the health of the patient and/or are required as a result of an issue with a previous healthcare service; or
- ▶ preventable – if the health risk of the patient could have been identified sufficiently in advance so that early intervention could prevent the need for later more expensive healthcare services.

By investing in reducing these types of claims, insurers would reduce claims costs without deteriorating the level of cover they provide to members. This would enable a reduction in premiums to be passed on to members.

However, the way that risk is shared across the PHI industry means that the return on investment for such an initiative is lower than it could be otherwise.

PHI is community rated meaning that everyone⁴⁷ pays the same for a particular product regardless of their age, sex or health status. There are also portability rules meaning that insurers are obliged to cover anyone that wants to buy one of their products. As a consequence, a mechanism is required to respread the costs of high-risk members between insurers. Risk equalisation is that mechanism.

The current risk equalisation method respreads high risk (measured by age) and high value claims paid in a previous quarter – i.e. it is applied retrospectively.

There are ways that an insurer can drive a reduction in high risk or high value claims (without eroding the cover that they offer to members). For example, they can invest in improving the health of their members or reducing incidents of claims fraud. However, the retrospective nature of risk equalisation means that part of every dollar saved is shared across the rest of the PHI industry. Although the insurer does still make a return, it is dampened by risk equalisation meaning that the business case for making such investments is weakened. This reduces the amount the insurer is able to pass on to its members through reduced premiums.

⁴⁶ <https://www.tandfonline.com/doi/full/10.1080/23288604.2017.1358796> General practice activity in Australia 2014–15. Sydney: University of Sydney, Family Medicine Research Centre; 2015. General Practice Series no. 38

⁴⁷ Under community rating in Australia, the price is allowed to vary by the State or Territory of the insured and by the number of people covered by the policy. In addition, Lifetime Health Cover loadings can apply, which can distort the price by age.



Perception issues

Key Points

- ▶ It is not easy for people to appreciate the benefits of PHI – it isn't clear how it complements the 'free' public system, and the products are confusing both in terms of the benefits they cover and the price net of all government loadings and rebates.
- ▶ The 'peace of mind' concept that PHI may provide is less prevalent than in other forms of insurance. Few PHI policyholders view not claiming as a positive experience, unlike policy holders of general or life insurance.
- ▶ PHI tends to get more than its fair share of blame for high costs – given that most of this is driven by health cost increases more broadly and provider costs.

6.1 Value not being sold clearly

Most people do not have a clear understanding of the roles and interactions between the public and private healthcare systems in Australia. This makes understanding the value of PHI difficult.

Public discussions and messaging around the value of PHI (for example, being able to avoid waiting lists, having more choice of care and enabling access to more expensive services) has been somewhat replaced by a focus on annual premium increases and high out-of-pocket costs.

The changing interactions between the public and private healthcare systems over time makes the system complicated to navigate through. There is no holistic management of the

delivery and funding of healthcare services, and the broader healthcare system has not been designed from a consumer centric perspective. Hence, the role that PHI plays in this changing healthcare system is difficult to understand and, because it is relatively constrained by legislation, it is difficult for it to adapt to changing needs. One consequence of this are the high out-of-pocket costs that are unable to be covered by either Medicare or PHI.

The disjoint nature of the public and private healthcare systems, and the different providers and funders within the private healthcare system means that there are many different stakeholders with competing interests and objectives. This leads to an environment of blame between stakeholders when there are failings with (or within) in the system. It also makes it difficult to design solutions purely from a public interest perspective.

Arguably, private health insurers attract more than their fair share of blame for issues with the healthcare system.

- ▶ Recently, most government messaging has been to do with controlling insurers – both in terms of constraining premium increases and ensuring product designs meet certain standards. There has been relative silence on the importance of PHI in the healthcare system, or other issues with the system more broadly that impact on PHI (as discussed in Sections 4 and 5).
- ▶ Medical professionals and hospitals naturally focus on the critical services that they offer and generally blame insurers for issues to do with costs and out-of-pocket expenses.

A united voice advocating the benefits of the private healthcare system as a whole could significantly change the perception of PHI.

To help support the value proposition of PHI the federal government introduced a package of reforms in October 2017, to make 'health insurance simpler and more affordable', and hence try to increase participation. As a result of the reducing affordability of PHI, members are increasingly lapsing as well as downgrading to cheaper cover options. The key issue with downgrading is that reduced coverage means higher out-of-pocket costs for private treatments or increased demand on the public system. The increasing number of lapses and downgrades of members has been driven not just by rising premiums but also by the reduction in the perceived value of PHI. The extent to which the reforms will increase participation is still unknown.

The downsides of a continuing erosion of perception include:

- ▶ reducing policyholder growth (both sales rates decline and lapses increase);
- ▶ skewing of the mix of business towards low benefit products as new consumers buy cheaper cover or downgrade. This ultimately reduces both premiums and profitability as higher claiming members are less likely to downgrade;
- ▶ greater consumer dissatisfaction with PHI resulting in reputational risk, as downgraders and consumers who purchase low benefit covers discover that they are unable to claim as much as they expected;
- ▶ increasing price comparison behaviours, which in turn lead to greater consumer use of aggregators, which ultimately results in higher acquisition costs and switching rates (with the switching generally towards lower premium products); and
- ▶ increasing government intervention to alleviate affordability and consumer dissatisfaction.

6.2 Complexity

Complex product designs and a lack of clarity about coverage are all contributing to the complexity of PHI. In addition, with 37 different health insurers each selling a range of different products with different levels of cover, it is very difficult for consumers to make meaningful comparisons. A mid-level product from one insurer may not be comparable to a mid-level product from another. The recent introduction of rigorous clinical definitions and product grades (Gold, Silver, Bronze, Basic) may go a long way towards resolving this – it is currently too early to say. One area of doubt is that because current regulations state minimum coverage only, benefits can still be restricted and/or partially covered.

Calculating the additional net cost of purchasing a PHI product compared to not purchasing PHI at all is not straightforward due to the combination of government incentives to buy PHI – the PHI rebate, the lifetime health cover loading and the MLS surcharge. For example, the PHI rebate is income tested and is provided to help cover the cost

Consumers may end up finding that the insurance product is not fit for purpose.

of premiums on hospital, general treatment and ambulance policies. The rebate, as a percentage of total premium, has been reducing and depends on annual income and age.

The key issue with consumers not being able to compare products or even understand what cover they have on the chosen product is that they may end up choosing a product that does not fit their need. Therefore, they may end up finding that the product is not fit for purpose in the event that they need treatment for a service which is either not covered or only partially covered. This can lead to high out-of-pocket costs for the consumer and damages the perception of the PHI product from a value perspective.

6.3 Other perception issues

6.3.1 Private health insurers attracting the blame for broader issues

The Australian healthcare system is made up of many funders and healthcare providers, both from the public and private sectors. Ageing populations, increasing chronic disease for a given age, improving medical technologies, increased access to care, wealth-driven demand and increasing healthcare expectations are putting increasing pressure on all aspects of the Australian healthcare system.

As described in Section 5, claims costs in PHI are growing at a similar rate to healthcare costs more broadly, reflective of the same underlying cost pressures. On average, a far higher proportion of gross income is effectively spent on health through taxation than through PHI premiums. However, tax payments are automatic, unavoidable and pre-fund a wide range of non-specific public services. As a result, issues with the cost of health to tax payers typically tends to be much more focussed on PHI premiums, which are very visible, change every year and are consciously selected and paid.

Further issues include that the MBS schedule most of the time does not reflect the actual costs. This allows the government to control their costs but inhibits the private sector and patients as it results in higher claims costs (leading to higher insurance premiums) and/or higher out-of-pocket costs. Government's influence on this situation is often muted, and medical professionals are highly regarded due to the important life-changing services they provide. There can be a tendency for private health insurers to receive the blame for these issues through negative media articles on premium rates and the huge out-of-pocket costs paid by members.

6.3.2 Perception issues

A common perception is that PHI premiums are unreasonably increasing at rates far in excess of inflation, and coverage is being eroded, so that insurers can make significant profits. However, as we have seen, this is not an entirely fair reflection of the situation.

When rate increases are announced, they are often compared to CPI increases rather than increases in claim costs. This gives consumers the wrong impression that rate increases are excessive. Many consumers are probably unaware that rate increases are monitored and regulated by the government and that insurers must justify proposed rates. There is currently a knowledge gap in the education given to policyholders by insurers around what drives premium increases.

The government and the media focus on rate increases tends to centre on the 'headline' rate (i.e. average) increase as a percentage. It does not take account of the actual absolute price and value of the products. This can create unfair and inconsistent perceptions about an insurer's pricing relative to other insurers. Naturally, a low-margin insurer offering better value (potentially even loss making) products will sometimes require higher price increases as a percentage than a high-margin insurer with poorer value (very profitable) products and, even after these changes, the low-margin products will remain better value.

There is a perception, in the older generation particularly, that members should be rewarded or entitled to compensation for premiums paid over many years. Similarly, the younger might view PHI as a long-term product in which they can invest in today and get something in return when they are older and less healthy. Community rating and Lifetime Health Cover has a part to play in this perception, as many years are spent paying premiums that are much higher than a rate that would otherwise reflect an individual's own risk profile.

However, the 'reward' should be good value risk coverage for older members. PHI is a short-term product providing risk cover only for the period of cover – and the premium rates reflect this. In most other types of (general) insurance, members tend to understand and value the risk cover as a product in and of itself. In particular, not making a claim (and therefore not receiving benefits from the insurer) is usually a positive thing. The value of peace of mind is often lost when considering the cost of purchasing PHI.

Even when claims are made, the lack of communication around the benefits received from the insurer can make it hard for members to value the benefits of being covered. This can be especially true when there is also a large out-of-pocket cost for the patient.

6.3.3 Comparison to the public health system

Understanding the value of purchasing PHI naturally involves performing a direct comparison with the benefits available through the public healthcare system. To the extent that the public healthcare system improves its services faster than the private healthcare system, there are negative impacts on PHI and its value. There is therefore a continuing incentive for the private healthcare system to improve in order that the balance between public and private healthcare is sustained.

Rate increases compared to CPI increases give consumers the wrong impression that the rates are excessive.



The value of peace of mind is often lost when considering the cost of purchasing PHI.



Opportunities for improvement 7

Key Points

- ▶ There are many potential areas for further reform that could make a meaningful and lasting improvement to how private health insurance benefits the public.
- ▶ The Institute acknowledges there are unique complexities of the healthcare system, including many competing interests, deep expertise and asymmetric information, all of which necessarily complicate consideration and implementation of potential reforms.
- ▶ Consequently, careful consultation, research and analysis followed by clear policy decisions will be needed to achieve reforms.
- ▶ The key opportunities are to improve accessibility to information around private healthcare costs and outcomes, to better align private health insurance coverage with the needs of people accessing private healthcare services, and to focus on further reducing costs per claim.
- ▶ There are a number of other opportunities aimed at improving the coverage, affordability and perception of private health insurance.

The threats to the long-term sustainability of PHI are represented in three key areas.

There are many issues with PHI that are threatening its long-term sustainability and, in Sections 4, 5 and 6, we have classified some of these issues into three key areas: **claiming (coverage), buying (affordability) and perception.**

Equally, there are many potential opportunities for improving the situation, most of which have been considered by different groups in recent years. But few have been implemented, largely because there are unique complexities in the healthcare system, including many different stakeholders. These stakeholders include both public and private funders and providers with competing interests, deep specific expertise and access to asymmetric information. This has also created difficulties in choosing which areas to prioritise.

In this section we aim to give an overview of the range of opportunities available. In each case, the outcomes are uncertain and there will be varying implications on the wide range of stakeholders. As such, our recommendation is that the priorities we have identified below be adopted to drive further consultation, research and analysis for each opportunity.

Table 2 below summaries the potential opportunities that we have identified as worthy of further consideration. They are intended to be in priority order. Each is described in more detail below.

Table 2: Overview of opportunities relating to the key issue

Opportunity	Coverage	Affordability	Perception
<p>Enable better choices between treatment options and fees What: This opportunity includes:</p> <ul style="list-style-type: none"> Increasing publicly-available information of out-of-pocket costs and health outcomes. If done in combination (i.e. information on both out-of-pock costs and health outcomes), this could empower individuals to make the right choice for their personal circumstances. Creating a role for care coordinators, who are independent and able to provide advice at every step of the healthcare pathway based on evidence of outcomes and fees. Enhanced informed financial consent rules so that they meet patients' need. <p>Who: Mainly government, with support from GPs, specialists and private health insurers. How: Government would need to release information directly, including by leveraging the role of technology, to consider policy levers that would incentivise specialists to disclose more of their own data, to support private health insurers in releasing insights from their own databases, and to consider how to create a defined role for care coordinators. Risks/challenges: Requires collaboration from a range of stakeholders with competing interests. There is a risk that specialists could respond by increasing fees but within a smaller range. It is unclear what the net effect on costs will be of a more coordinated care system and this requires further exploratory analysis.</p>	✓	✓	✓
<p>Incentivise insurers to reduce unnecessary claims costs What: This opportunity includes reforming risk equalisation so that savings can be passed on to members directly through reduced premiums rather than being shared with the rest of the PHI industry. Who: Government. How: Government should work with insurers and actuaries to design a new risk equalisation mechanism that is prospective, but is also relatively simple to administer and does not create perverse incentives for insurers. Risks/challenges: Any change to risk equalisation will lead to different insurers being either winners or losers. Care will be required to appropriately manage transition.</p>		✓	
<p>Target inefficiencies in the supply side of private healthcare services What: This opportunity includes:</p> <ul style="list-style-type: none"> Combining private healthcare fees so that all fees relating to a single patient pathway are set together with reference to an overall total cost or budget. Increasing the focus on eliminating additional and hidden fees. Continued prostheses reform. Linking funding to outcomes in order to incentivise providers to deliver the best service possible for a given condition. <p>It would have the potential to reduce the risks of increasing fees under the above opportunity. Who: Government in collaboration with providers, hospitals and private health insurers. How: Government would need to carefully review existing regulations and enforcement practices in these areas. Research and analysis into the optimal treatments from a cost and outcomes perspective. Consider the establishment of an independent national prostheses purchasing agency that operates on behalf of public and private providers. Risks/challenges: Likely to be unpopular with specialists and prostheses manufacturers who could see independence reduced, and requires collaboration from a range of different service providers and hospitals.</p>	✓	✓	✓

Table 3: Overview of opportunities relating to the key issue (continued)

Opportunity	Coverage	Affordability	Perception
<p>Focus on the health of people with PHI What: This opportunity includes:</p> <ul style="list-style-type: none"> Improving the health of people with insurance, ideally as part of a broader nationwide campaign to improve health. Focussing on providing more value for money benefits for people in apparently good health, such as increasing mental health benefits or other 'add-ons'. Change the incentives for healthier people to take out PHI, for example by providing selected discounts i.e. no claims bonus or changing the MLS arrangements. <p>Who: Private health insurers and government. How: Private health insurers would need to expand their offerings outside pure risk coverage, including providing members with access to wellness programs, chronic disease management programs and health management platforms, as well as providing more of a coordination role. Government to analyse options for incentivising healthier people to take out PHI. Risks/challenges: To be most effective, this would need to be part of a broader initiative to improve peoples' health including collaboration across the whole health sector. Providing additional services and benefits could mean a higher average premium unless a sufficient additional volume takes up PHI. Incentives that aren't applied to the whole population will create winners and losers.</p>	✓	✓	✓
<p>Improve perception of PHI What: This opportunity includes:</p> <ul style="list-style-type: none"> Uniting the private healthcare sector to jointly advocate its benefits and the benefits of being privately insured. Messaging from government around PHI. Insurers more actively promoting value. <p>Who: Government (especially politicians), and all private providers, hospitals and insurers. How: Public mutual acknowledgement and appreciation of the critical roles being played by each part of the private healthcare system. Government to ensure that it consistently advocates and educates on the important benefits PHI provides. For insurers there are many potential marketing opportunities for non-claimers. For claimers opportunities include providing an itemised breakdown of the total costs of all services used. Risks/challenges: Overcoming the self-interests of competing stakeholders.</p>			✓

7.1 Better information on treatment options and fees

7.1.1 Increase transparency of out-of-pocket costs

Despite having two publicly-subsidised health systems within Australia, a large proportion of costs are borne by patients at a time of need. As described in Section 4.3, specialists are now billing with reference to AMA fees, which can lead to significant out-of-pocket costs for the patient.

Specialists and insurers need each other for their businesses to remain viable in the longer term. An agreement should be reached through collaboration, and with government support, that enables meaningful data on fees and outcomes to be available to patients before they choose their specialist. We support the recently announced government initiative to develop a public website that publishes aggregate specialist fees. There may be other ways technology can further promote informed choice by patients.

Publishing data on out-of-pocket costs, and also providing better information directly to patients, would both:

- ▶ enable patients to make an informed choice on whether to go ahead or to consider alternative treatments with different specialists; and
- ▶ put more pressure on specialists to compete on fees.

To be effective, this will need to be comprehensive across treatment types, sufficiently detailed to show the range of potential costs, user-friendly and well-publicised.

There are several sources which could provide further information about out-of-pocket expenses in order to promote transparency:

- ▶ **Specialists:** Governments may reasonably require specialists to disclose their out-of-pocket expenses,

given that they are benefiting from public funds through the MBS. A mechanism to mandate this would be through an agreement to release this information online when signing up to the MBS.

- ▶ **Department of Health:** The Commonwealth has data available on out-of-pocket costs, which may be released for consumers to draw insights from.
- ▶ **Private Health Insurers:** Insurers have a wealth of data on fees charged to members by providers, which could be released at the hospital or provider level. Given the challenges around choice when the balance of power is skewed, insurers could play a pivotal role between specialists and consumers in communicating mandatory financial disclosures to promote informed consent.

Understanding out-of-pocket costs could empower individuals to make the right choice for their personal circumstances. This has the potential to create a national market for health care. For example, private patients living in NSW could opt to go to SA for a procedure if they have relevant information regarding costs and treatment options.

Increasing competition amongst health professionals through the publication of out-of-pocket data has the potential to reduce specialist fees as patients could be more selective when making their choice. Shifting the power from the specialist to the patient would also have a positive impact on insurer's costs, leading to more affordable premiums. The patient may be more inclined to get a second opinion, which could lead to reduced costs both for the insurer and the patient, as well as a better health outcome.

Risks and challenges

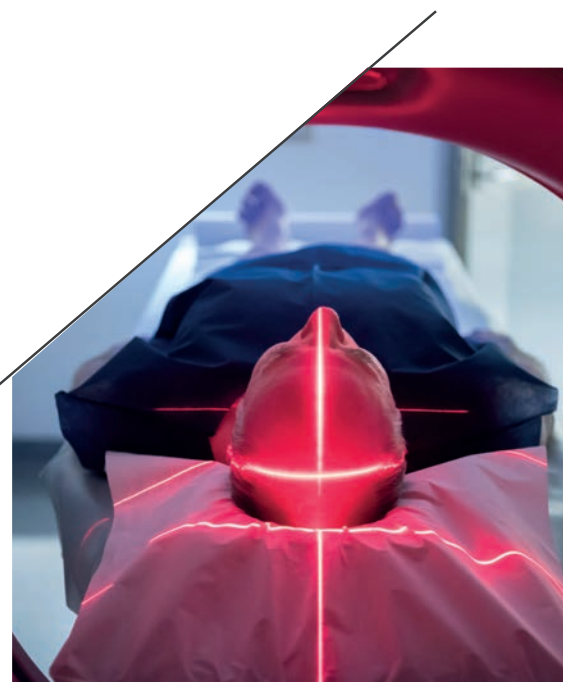
- ▶ Specialists do not have a single set fee, and are able to vary fees based on circumstances (including relative morbidity) of the individual. Hence, the published average out-of-pocket or total fees could be inaccurate or misleading.
- ▶ Specialists can bill additional amounts, such as administration fees, that are not covered by Medicare and so are not visible to the government or private health insurers. Obtaining and publishing accurate and relevant information on all associated fees would be challenging. In addition, it would be difficult to prevent specialists from lowering their fees for the published Medicare-subsidised services whilst, at the same time, increasing other fees to offset.
- ▶ There is a risk that publishing fees could have an adverse effect and may lead to some specialists increasing fees.

7.1.2 Increase transparency of outcomes

Whilst improving transparency of out-of-pocket costs in healthcare would be an important initiative, in isolation its effectiveness is limited – partly because more expensive treatment is naturally perceived to be an indicator of better quality. Perversely, some consumers might actively seek specialists with higher out-of-pocket costs.

As such, coupling transparency of out-of-pocket costs with information about outcomes would be a powerful measure to enable patients to make informed

Understanding out-of-pocket costs could empower individuals to make better personal choices.





What is missing is a single, independent care coordinator.

choices. Publishing benchmarks, hospital statistics, doctor statistics around common elective procedures, and creating transparency around outcomes, will lead to healthy competition between private hospitals and doctors to provide value of money and better patient outcomes.

Risks and challenges

This would be a very significant project and the benefits go well beyond the PHI sector. The analysis would need to adjust for the inherent risk and expected outcome before the treatment or procedure is undertaken. A specialist that specialises in more complex cases would, all else equal, have a worse outcome measure than a specialist that takes more straightforward cases. Making a fair and objective comparison would be difficult. It would require cooperation of Commonwealth and State and Territory governments, careful navigation of privacy laws, and a very significant investment of funds and time.

One way forward would be to start with high incidence, high cost-to-treat diseases such as heart disease and cancer. Although there is mandatory reporting of cancer diagnoses, there is not currently an outcomes register. Movember has been working with the Commonwealth Government on a prostate cancer outcomes register, but this is a multi-year, multi-million dollar and multi-jurisdictional initiative.

7.1.3 Care coordinators

As described in Section 4.6, care pathways are largely dictated by referrals and recommendations from GPs and specialists. This therefore relies entirely on the relationships that they have established, which may be small for a new GP. There is a common misconception that referrals from GPs have to be addressed to a specific specialist. In the case of specialists, the 'referral' is often for further treatment with the same specialist. Patients become unaware of alternative possible pathways, and there is limited continuity of care given the many different care providers involved.

Clearly what is missing is a single, independent care coordinator, who is able to provide advice at every step of the healthcare pathway based on evidence of outcomes and fees. Creating this role would require funding, upskilling and access to relevant data, and so a cost benefit analysis of potential funding models would be required first.

GPs should be well-placed to provide this service, although it would involve providing the GP with more comprehensive data on outcomes and costs, and also consideration of logistics later on in the care pathway - as 'primary' healthcare providers, a GP's involvement often ends after the initial consultation.

Other intermediaries could be used as a care coordinator to help navigate patients through the health system and provide a single point of contact. This would reduce unnecessary consultations and the associated costs, as well as improving continuity of care.

Private health insurers and the government have access to a wealth of data and information that could support a care coordinator in their role.

Risks and challenges

- ▶ This would be a very significant project and the benefits go well beyond the PHI sector.
- ▶ Done properly, a more coordinated care system should lead to greater value

for money from the system. The net effect on healthcare costs is uncertain. On the one hand, if personal risk for a coordinator who expresses an opinion about unnecessary treatments is high, the response may be to suggest additional tests, or have additional consultations. Even the service of enabling better access to previously difficult-to-access treatments could lead to additional costs. There is also the cost of the coordinator. On the other hand, a care coordinator should be able to guide patients through more effective treatment paths and minimise inefficient, lower efficacy and/or unnecessary procedures and tests.

- ▶ Using GPs as the care coordinator would involve engagement, training, access to data, appropriate funding to make the service viable.
- ▶ The funding of care coordinators would need to be independent so that care coordinators are not subject to funding incentives to recommend certain treatment protocols.

7.1.4 Enhance informed financial consent rules

Rules around informed financial consent give private patients a right to know who will be treating them, how much it will cost and what the out-of-pocket costs will be. However, they need to be cognisant of a potential patient's situation – by definition they are unlikely to be in a healthy condition, will naturally be predisposed to accept the treatment options being offered, and will likely be short of time. Clearly then financial consent rules regarding private healthcare treatment need to be very different to those that apply to other financial services. Government should review the rules and consider whether they are appropriate in these circumstances.

7.2 Prospective risk equalisation

Prospective risk equalisation would better incentivise insurers to invest in driving claims savings from high risk consumers. Such a system would respread risk between insurers based on risk factors that indicate health status rather than actual claims payments – i.e. it would be an amount paid or received when a policy is written, based on the risk category of the policy, not directly on the claims of the policy. This would mean any actual claims savings the insurer can drive would be retained by that insurer (and their members) in the short term and spread to the community in the medium term by reduced premium.

Prospective risk equalisation is not a new idea, but it has been challenged in the past as it is difficult to measure the potential benefits⁴⁸ and, until recently, it would have also incentivised insurers to offer lower quality products in an attempt to control costs.

However, recent PHI reforms have standardised product definitions within Gold, Silver, Bronze and Basic categories. If the prospective risk equalisation formula applies to all products within each of these categories separately, then the

definitional floor for each category limits the extent to which product erosion would occur.

7.3 Target inefficiencies in the supply side of private healthcare services

As well as being controversial, the possibility to directly regulate the fees that medical professionals charge is not possible due to restrictions that apply under the Australian Constitution.⁴⁹ The most effective solution to enhancing cost efficiency for private healthcare services is likely to be regarding transparency and coordination, as described in Section 1.1. That said, there are some more direct opportunities for private healthcare providers and government that could lead to cost savings.

7.3.1 Combining private healthcare fees

If all hospital, medical and other related fees relating to a single patient pathway were set together with reference to an overall total cost or budget, and these were agreed with the insurer, this would lead to increased accountability in fee setting between parties as well as encouraging a focus on delivering more cost-effective services so that the overall budget can be delivered. This should lead to a lower total cost for the healthcare pathway chosen.

The Institute acknowledges that this would be a significant intervention in the operation of these markets. However, based on the discussion in this paper, we conclude that the markets themselves are unlikely to be efficient, and that part of the problem arises from the fragmentation of a single consumer/patient service into separate markets, with the consumer having to negotiate each separately. As a result, the competition benefits that justify a market approach have been lost.

It would be difficult to implement something like this because it would mean designing a process that brings the many different, and often competing stakeholders together, and reaching an agreement on where in the pathway costs could and should be lowered in order to reach a certain total. Regulation or legislation could be required to enable the process to work effectively.

If the new arrangements meant, say, a hospital overseeing the budget and directly employing all service providers, then there are risks that fees would increase in order to attract the most popular providers, and there may be additional administrative fees.

⁴⁸ For example, the Department of Health established a working group to review Risk Equalisation that "...on the basis of current evidence, they did not advocate a move to: prospective risk equalisation;..." <http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac-risk-equalisation-meeting-3>

⁴⁹ Value and affordability of private health insurance and out-of-pocket medical costs, 13 July 2017, Shaun Gath (Narrabundah Partners).



Furthermore, the AMA has indicated that it is opposed to any kind of fee bundling arrangement.

That said, the stark differences between funding and fee-setting between the public and private systems does suggest that there must be room for improvement on the private side. Government could initiate research and consultations across the private healthcare system with a view to improving current fee-setting arrangements.

7.3.2 Increasing the focus on eliminating additional and hidden fees

Given that there is evidence of some providers bending and breaking rules around additional and hidden fees,⁵⁰ it could be worthwhile the government increasing its focus on eliminating this behaviour.

In addition, there is a role for the majority of the medical profession to proactively identify and call out this behaviour when it occurs. Media coverage of these issues would be likely to very quickly improve the situation from a patient's perspective.

Even where administration and management fees are entirely legitimate, they can still be excessive, opaque and unavoidable for the patient. Full transparency of costs and improved coordination of care, as described in Section 1.1 should help alleviate these issues.

7.3.3 Continued prostheses reform

Although recent reforms have been implemented that should see a reduction in prostheses costs in the private healthcare sector, the costs are likely to continue to be high by global standards, and will continue to exceed the costs of the same items in the public healthcare sector.⁵¹ Further work needs to be done, driven by government, private health insurers and providers to address this situation. An option would be to establish an independent organisation to gather cost information about high cost and high volume prostheses items, which then makes benefit limit recommendations to the government. There may also be scope for additional procedural requirements in the prostheses procurement process to ensure that all costs can be properly justified and scrutinised.

7.3.4 Link funding to outcomes

There are many opportunities in the private health system to improve outcomes without increasing costs and/or reduce costs while maintaining outcomes. The transparency around outcomes suggested in Section 1.1 should go some way to incentivising better outcomes (at the same price).

Current funding arrangements are generally fixed in relation to the treatments received.

Linking funding to outcomes would further incentivise providers to deliver the best service possible for a given condition, and reduce wasteful servicing by only funding certain treatments where there is sufficient clinical evidence of cost-effective health benefits. Recently, some insurers have been active in using clinical evidence to identify treatments that provide no clinical benefit for the extra cost in comparison with alternatives – an example was Robotic Assisted Surgery.

However, there needs to be a much more deliberate push towards outcomes-

⁵⁰ <https://www.abc.net.au/news/2018-05-28/your-out-of-pocket-costs/9775664>

⁵¹ <https://www.privatehealthcareaustralia.org.au/wp-content/uploads/PHA-Report-Costing-an-arm-and-a-leg-Oct-2015.pdf>

based funding. This would involve collaboration between providers and funders alike and ideally would be driven by government. In addition, there is still room for private health insurers to be more proactive about using evidence – both clinical evidence and their own claims data - to negotiate funding for certain procedures.

In addition, making safety and quality statistics for private hospitals and medical specialists more readily available in the public domain and, importantly, in the referral process could be expected to incentivise improvements in standards of care, as well as reducing costs arising from hospital acquired complications.

7.4 Focus on the health of people with PHI

There are many social and economic benefits from improving the health of the nation, as well as clear standard of living improvements for every individual that can be diverted to a better health pathway.

In addition, if the health of those privately insured improved, then the average claims cost per person, and hence the average premium per person, would reduce.

Similarly, incentivising more young people to take out PHI would mean that the average claims cost per participant would reduce and, in turn, PHI would become more affordable for everybody.

There are several possible ways this could be done, and some of these options are described below.

7.4.1 Improve the health of people with PHI

The idea behind prevention is to reduce the frequency and severity of healthcare claim incidences, which leads to a reduction in overall claims costs. This can then be passed on to all members through a reduction in premiums.

Although this initiative would mainly be driven by insurers, it would be most effective if it were just one part of a broader nationwide campaign to improve health. Some insurers already provide access to wellness and chronic disease management programs, but there's certainly scope for more to be done.

The issue associated to the current wellness programs available is that the most engaged members are typically the healthiest to begin with. As a result, direct reductions in private hospital costs are somewhat limited. A key challenge for the industry, and the government more broadly, is to get less healthy and older people more engaged in improving their health. This could be through education or improving access to exercise and wellness facilities. Alternatively, insurers may wish to consider collaborating on a pilot.⁵²

7.4.2 Focussing on providing value for money benefits for healthier people

The PHI industry could further focus its attention on developing products that provide better value for younger, healthier people. This could be focussing on providing more value for money benefits for people in apparently good health.

Although these would clearly create additional cost, experience on General Treatment products is that people value receiving some regular benefits from their insurance, even if it does not match the full costs of the premiums. This



⁵² This draws on the historical experience with fire brigades. Initially, general insurers established their own fire services to protect houses they had insured. In time they realised it would be more efficient to collaborate on providing fire services and eventually the government took over recognising the public good nature. Insurers and/or insurance policy holders have paid a significant contribution to the government provision of fire services.

suggests that there should be scope to offer a little more to younger people so that, after they join, the overall average claims cost reduces.

Many healthy people currently view PHI simply as a way of reducing tax or avoiding future premium loadings, but question its value over and above what is offered through the 'free' public system. Targeted marketing campaigns may also remind healthier people of the benefits of health insurance. For example, injuries can lead to being unable to work, and so avoiding long waiting lists can be critical in order to minimise loss of income.

Additional avenues would include providing access to a health management platform, with in-built features to encourage engagement (such as gamification for example), as well as providing more of a network coordination role.

7.4.3 Change the incentives to take out health insurance

Adapting community rating so that it at least partially reflects claims risk would make premiums cheaper for younger and healthier people and hence improve the incentives for healthier people to take out PHI. This could be through targeted discounting or bonuses, for example to non-smokers, people who haven't claimed to date, or participation in health-improving activities.

However, one person's discount is another person's loading – less healthy people would pay more for their insurance under these changes. This is unlikely to be popular, although if an adapted system encouraged enough additional non- or low-claimers into the system then it is possible that everyone would have a lower premium – i.e. the argument would need to be made that it would be worth changing community rating if everyone wins, even if some win by more than others. This requires non- and low-claimers to explicitly value the 'peace of mind' PHI may provide. 'Peace of mind' is likely to be most compelling for individuals who could not financially manage a sudden, unexpected large expense from a medical event, and who want and value relatively fast treatment for the event and possibly also choice of specialist and/or treatment.

A second aspect to the argument around whether or not to adapt community rating is the question of intergenerational equality in the context of the broader economy. There are inherent cross subsidies from younger people to older people and vice versa across everything from housing, to income tax, to pensions, to welfare, to education, and PHI is just one relatively small part of this.

The government could also look at other financial incentives to get more healthier people insured, for example by introducing a fringe benefit tax exemption or adjusting the current Medicare Levy Surcharge arrangements to further encourage

uptake. Freezing or even reducing the income thresholds and/or increasing the surcharge itself would encourage more lower-income people (skewed towards younger people) to take out PHI.

7.5 Improve perception of PHI

7.5.1 Uniting the private healthcare sector

As noted in Section 2.2, the private healthcare sector comprises disparate groups of providers of healthcare services and facilities, as well as funders. Each of these groups (including Specialists, Hospitals and Private Health Insurers) have different, and often competing, objectives.

Ultimately each of these three sub-industries needs PHI to be sustainable. In the long-term, if PHI participation continued to fall, demand for private hospitals would reduce and medical specialists would need to spend more and more of their time working for the (lower paid) public healthcare system or overseas. Already there are signs of excess capacity in private hospitals.

A united voice advocating the benefits of the private healthcare system as a whole, where each sub-industry acknowledged and appreciated the critical roles being played by the others, would significantly change the perception of PHI. It would be critical to enable co-designing better outcomes that are in the public interest (rather than the self-interest of each sub-industry).

One option would be to establish a working group focussed on the sustainable future of private healthcare. This group might have objectives to document and agree positions on a sustainable private healthcare operating model and the roles played by the different stakeholders. This could lead to an in-principle agreement between the disparate groups in private healthcare as to how each needs to operate to ensure the system is sustainable, how the parties will work together to maintain quality, accessibility and affordability, and how private healthcare can be repositioned so that the consumer/patient is at the centre.

7.5.2 Government messaging

The government recognises PHI as playing an important role in easing the burden on the public system, to the extent that it subsidises the PHI industry by \$6 billion every year through the PHI rebate. However, as described in Section 6.1, recently most government messaging has been to do with controlling insurers - both from a pricing and product perspective.

Although these areas are worthy of focus, if the government wants to sustain a balance between public and private healthcare provision in Australia, then it has a role to play in ensuring that the public is aware of the benefits of holding PHI.

7.5.3 Insurers more actively promoting value

The value of PHI will vary by life stage and it is critical that this is considered when looking at capturing certain demographics. Targeted marketing through consideration of need at each life stage should be considered to increase the uptake of PHI.

The value of having PHI is often only appreciated at or after a claims event. However, more could be done to educate consumers about the benefits of PHI in advance. A person's health is assumed to be effectively one of their most important assets, and so it makes sense to spend a reasonable amount of money each year for the peace of mind that, in that year, they will have access to the best quality healthcare if and when they need it.

Case studies showing the real differences in health and financial outcomes with and without PHI would be powerful.

Some insurers may be reluctant to be overly vocal about the benefits they provide for fear of attracting adverse selection from unhealthy members. Although there could be a role for government in advocating PHI's role in a manner that respects and supports a continued strong public system, it also means that insurers need to consider promotion and marketing cohesively as an industry.

Another way that insurers could better demonstrate the value they provide is after a claims event. Insurers could provide an itemised breakdown of the total costs of all services used, which shows the various amounts paid by the private health insurer and Medicare, as well as the out-of-pocket costs. This would highlight the large benefits by the insurer to the provider that are otherwise invisible and unappreciated by the patient.

The value of having PHI is often only appreciated at or after a claims event.



8

Conclusion

We have identified a number of issues with PHI in its current format, which are beginning to lead to declining participation and decreasing affordability. Without action, these trends are likely to continue at increasing rates, which would lead to a significant shock to the balance in how healthcare services are provided and funded in Australia.

However, it is not too late to address the issues faced by PHI, which would enable the balance between public and private provision and funding to be sustained into the future.

We have outlined a number of potential options in this paper. Obviously private health insurers will have a key role to play in ensuring these options achieve their intended objectives. However, on their own, insurers are unable to drive meaningful change because of the regulations that prevent them from getting involved in large areas of the healthcare system and because medical professionals are ultimately responsible for the healthcare services that patients receive. As a result, for any of these options to be effectively implemented, collaboration will be required between governments, hospitals and other healthcare facility providers, doctors and specialists, insurers and the public.

In many cases there will be winners and losers, but driving a high quality and efficient healthcare system needs to be the ultimate objective. Given the importance of these decisions, a strong evidence-base will need to be established. This will necessarily reflect forecasts of uncertain future health and financial outcomes. Actuaries are ready to work with patient representatives, clinicians, institutions, government, and other stakeholders in the multi-disciplinary task of creating the evidence base and designing effective solutions.







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