



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



## Budget Submission 2020-21

### Revised version

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# 1 Foreword

Since Private Healthcare Australia presented our pre-Budget submission in December 2019, the world has changed significantly. The prospect of a surplus in an environment of economic growth has been replaced with a health and economic crisis unfamiliar to Australians.

Amid the uncertainty, a few things are clear:

- Australians value health care and those that provide it,
- Fewer Australians will be able to afford private health insurance without support,
- For those without insurance, waiting lists for public hospitals will be at unprecedented levels
- The likelihood public funding alone will be able to meet consumer demand for health care in future is remote.

The government has worked through the early stages of the COVID-19 quickly and effectively and put ideology aside to provide massive levels of support to public hospitals, prop up private hospital businesses, and delay public interest reforms to prostheses.

Private health funds have also contributed, propping up the health system with over \$500 million in support. The majority of this support was delaying premium increases, along with providing support to individuals in financial distress, directly funding public health measures like COVID-19 testing and masks and introducing rebates for telehealth services.

Furthermore, the private health sector stepped up by providing continuity of access for essential non-emergency surgical and mental health services, while the public sector's capacity was reduced to prepared for an anticipated influx of COVID-19 patients. Much of the heavy lifting in terms of provision of inpatient care through the pandemic has been done by the private sector.

The pandemic has clearly demonstrated that our health system is strong and flexible, with a mixture of public and private provision ensuring our systems did not get overwhelmed as has happened elsewhere across the world. The outcomes of the pandemic in the mostly private, fragmented health system in the USA, and the purely public National Health Service in the UK have been nothing short of a disaster. Not only have there been mounting deaths from COVID-19, but from excess deaths from other causes as people with chronic and mental health conditions are unable to access appropriate levels of care.<sup>1</sup>

Our community will not tolerate Australia dismantling or neglecting its uniquely balanced health system.

The initial government support was necessarily concentrated on the public hospital system. The 2020-21 Commonwealth Budget provides a once –in-a-generation opportunity to pause, to reflect and to rebalance Australia's health system

The cost of private health insurance premiums is driven by the rise in medical inflation. As the Government has accepted a 6.5% annual increase in hospital costs through the National Healthcare Agreements, we need to either understand a similar figure for private health insurance premiums is likely, or work together to bring down the excess costs in the system.

We need to repeat the collaborative effort made with private hospitals, doctors, consumers and the government we saw in the first round of private health sector reforms.

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<sup>1</sup> See, for example, [www.theeconomist.com](http://www.theeconomist.com)

First, participation of younger people needs to be better incentivised to stabilise premiums for everyone. Working middle-income families with young children are bearing a disproportionate share of the cost of private health as they cross-subsidise a large, baby-boomer cohort, who at the average age of 72 are claiming record numbers of procedures.

The rebate should be restored to 30%. Providing subsidies to private health insurance is the most cost-effective way for the Australian Government to support the growth in hospital and health services over the coming decades.

Subsidies for private health insurance-funded services cost the Commonwealth Budget around 30 cents in the dollar. The alternative, providing more services in public hospitals, costs the Commonwealth Budget 45 cents in the dollar.

In addition, the government should look at a possible fringe benefits tax exemption for private health insurance premiums for people aged under 40.

Second, we need to address one of the key frustrations consumers have with private health insurance and permit health funds to pay for health care out-of-hospital on a broad scale.

The rules confining health funds to hospital care were conceived in the 1970s, when health technology and even diseases were different.

Today, we are predominantly funding the treatment of chronic diseases, many of which can be safely managed by health professionals in the community or in patients' homes.

Third, we need to protect Australians from escalating premium costs caused by fraudulent and wasteful claims. Our members are not rich, with an average taxable income of \$50,000 per year. They have the right to healthcare at a time of their choice, by a fully trained specialist responsible for their care, and not be gouged. There are a range of regulatory restrictions and compulsory payments that promote low-value care that need to be addressed.

In particular, steps must be taken immediately to remove the Soviet-era fixed price regulation of prostheses (medical implants) by the Commonwealth and improve the quality and safety regulation of medical implants in line with the Pharmaceutical Benefits Scheme (PBS).

We also need to address the regulatory incentives for in-hospital care, and the Second-tier default benefits that increase the cost of care and penalise both patients and high-quality hospitals.

The desire of the majority of the population to pay something towards the cost of their healthcare in return for timely access to care, and a specialist fully responsible for their care, should not be denied because of a private system made less affordable by outdated and toxic regulatory constraints.

There are challenges, they are fixable, and it's time for action.

**Dr Rachel David**  
**CEO, Private Healthcare Australia**

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## 2 Background

Key points:

- The cost of healthcare is rising faster than inflation.
- The costs of private health insurance are rising faster than overall health costs.
- Over half of the Australian population (13.5 million people) choose to be covered by private health insurance.
- Younger, healthier people are dropping cover, while older Australians are maintaining their cover.

Australian governments, health providers and health funds work together with the shared purpose of maintaining one of the world's most innovative and successful health systems. Our healthcare system delivers universal access, patient choice, and excellent health outcomes at reasonable cost, drawing on a balance of public funding and patient contributions.

This common purpose is pursued most determinedly when the health system is under stress. In the 1990s, for example, participation in private health insurance fell to almost 30 percent, leading to long public waiting lists and greater public health spend at the risk of other essential public services. Well-designed incentives restored participation levels to ~50 percent, reversing these negative impacts.

Some of the same trends that were apparent in the 1990s are re-emerging, threatening the balance of Australia's health system.

### 2.1 COSTS ARE RISING

#### 2.1.1 Healthcare costs are rising faster than inflation

Like other developed countries, Australia is seeing its healthcare costs rise well above the consumer price index and wages. Healthcare is increasing its share of both government spending and consumer spending.

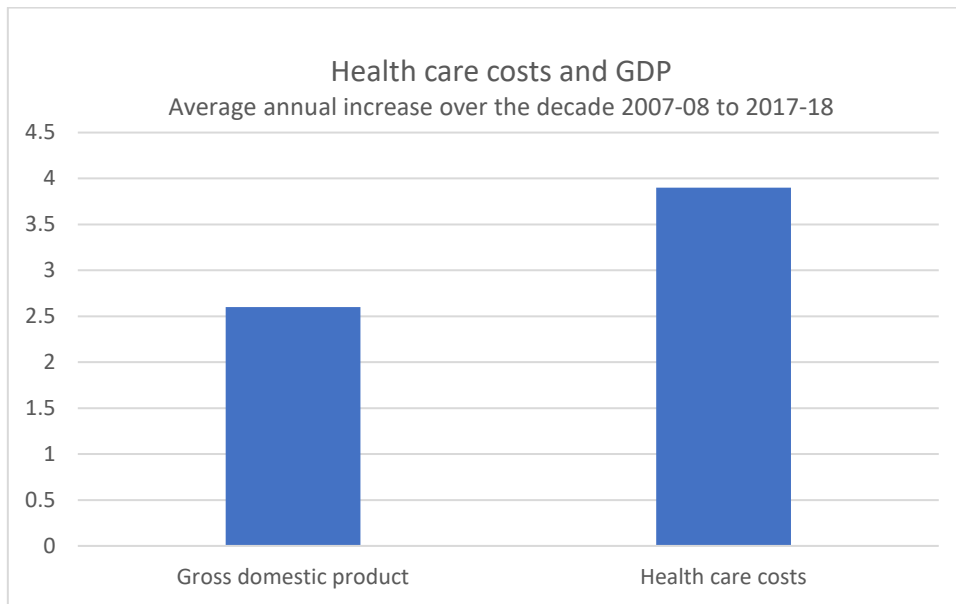
In the decade to 2017-18, Australia's total healthcare expenditure (that is, recurrent and capital expenditure combined) grew at just under 4 percent per annum, compared to an increase in CPI of 2.6 percent per annum. In 2017-18, an estimated \$185.4 billion was spent on health goods and services in Australia. Health spending has now reached 10 percent of gross domestic product.<sup>2</sup>

Real growth in Australian Government spending averaged 3.4% per year in the decade to 2017-18. Growth in government spending on health was lower in 2017-18 than the long-term average, due partly to a decrease in spending on private health insurance premium rebates (-1.9%).<sup>3</sup>

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<sup>2</sup> Australian Institute of Health and Welfare 2019. Health Expenditure Australia 2017-18. Health and welfare expenditure series no.65. Cat. no. HWE 77. Canberra: AIHW.

<sup>3</sup> Australian Institute of Health and Welfare 2019. Health Expenditure Australia 2017-18. Health and welfare expenditure series no.65. Cat. no. HWE 77. Canberra: AIHW.



The drivers of the rising cost of healthcare include demographic factors such as our ageing population and the increasing prevalence of chronic disease. Health system factors include a shift from outpatient to inpatient settings, where more doctors are available and more treatments are offered; more investigations of presenting symptoms due to the availability of more diagnostic tools; and a fee-for-service system.<sup>4</sup>

Much of this rising healthcare spend is an expression of consumer and national choice. It reflects our national wealth, good health as a personal and national priority, the desire to sustain both personal and national productivity, and an investment to reduce future healthcare costs. It also reflects that previous life-limiting illnesses are now treatable, and so life expectancy is improving.

It is clear from governments' interventions through the 2019-20 financial year and the generous National Healthcare Agreements with state and territory governments that the trend of healthcare costs rising faster than inflation will continue for the foreseeable future. The Commonwealth's National Healthcare Agreements with the states and territories anticipate hospital inflation rates up to 6.5% per annum.

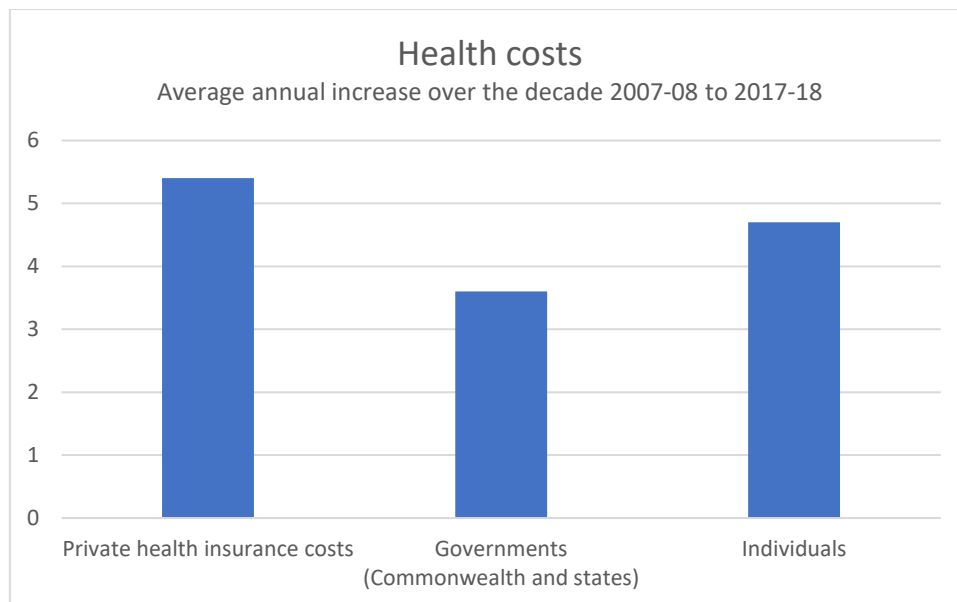
Nonetheless, both public and private systems should always be seeking to achieve the same or better outcomes for lower costs where possible, with the savings returned in reduced taxes or premiums, or re-invested in other areas of care.

<sup>4</sup> For example: The Productivity Commission (2017), *Shifting the Dial: 5 Year Productivity Review*; Australian Institute of Health and Welfare, *25 years of health expenditure in Australia: 1989-1990 to 2013-2014*

## 2.1.2 Costs for the health insurance industry are rising faster than overall health costs

Private system costs are subject to the same underlying drivers as the public healthcare system, but costs for private healthcare are growing faster than the overall costs of healthcare, with an average annual growth rate of 5.4% per year from 2007–08 to 2017–18.<sup>5</sup>

This has resulted in a significant increase in the proportion of Australian health spending covered by private health insurance, from 7.4% in 2011–12 to 9.0% in 2017–18.<sup>6</sup>



Each member is claiming more services (that is, higher ‘utilisation’ of services), and the cost of services is rising. In the five years to 2019, the number of hospital episodes grew at 2.4 percent per member per year. The number of other treatments grew at 2.2 percent per member per year.<sup>7</sup>

While the public health system and Australian Government own expenditure is taking advantage of greater efficiencies such as promoting different models of care and using market-based pricing for medical devices, the private health care industry is locked into an old-fashioned, often inappropriate regulatory structure than strangles efficiency.

The overall rise in benefit payments is occurring despite more members taking up lower levels of insurance cover and choosing higher excesses. This means the average policyholder is now covered for fewer treatments or hospital episodes and/or must pay higher excesses to access them. While these policies mean insurers are paying less of the cost of a health service, the consumer is paying more. These ‘out-of-pocket’ expenses are having as much of an impact on consumer decisions on private health insurance as the premiums.

<sup>5</sup> Australian Institute of Health and Welfare 2019. Health Expenditure Australia 2017-18. Health and welfare expenditure series no.65. Cat. no. HWE 77. Canberra: AIHW.

<sup>6</sup> Australian Institute of Health and Welfare 2019. Health Expenditure Australia 2017-18. Health and welfare expenditure series no.65. Cat. no. HWE 77. Canberra: AIHW.

<sup>7</sup> APRA Health Insurance Statistics, [www.apra.gov.au](http://www.apra.gov.au) (accessed December 2019)

### 2.1.3 Increased utilisation of hospital services

There are two key factors driving an increase in hospital services for people with private health insurance – demographic factors and increased rates of hospitalisation. Some of this hospitalisation is inappropriate, driven by perverse incentives.

The first reason more hospital episodes are being claimed by private health participants is on average those participants are becoming older and are more likely to have higher healthcare needs. This is driving increased utilisation in the healthcare system.

Second, utilisation is rising significantly for the *same* age cohort. For example, utilisation per member in the 85–89 age group rose by 16 percent in the five years to 2019, and there was a 3 percent increase in the 0–55 year age groups in the same period.<sup>8</sup>

Further, perverse incentives are causing a shift from outpatient to inpatient care. Rehabilitation is an example where the incentives promote inappropriate inpatient care where community-based rehabilitation is demonstrated to be more effective.

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<sup>8</sup> APRA Health Insurance Statistics, [www.apra.gov.au](http://www.apra.gov.au) (accessed between May-September 2018)

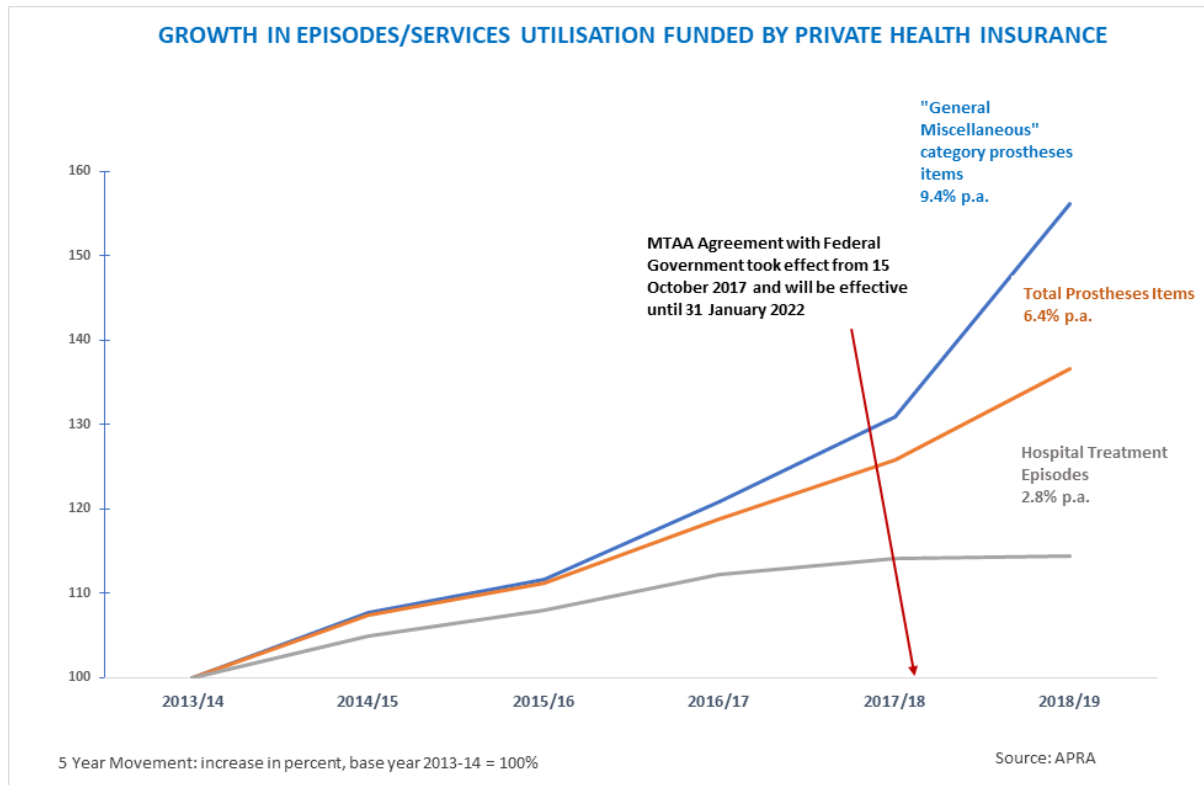


## 2.1.4 Increased costs of prostheses

The Australian Government's deal with the Medical Technology Association of Australia (the MTAA agreement) has failed to deliver the expected savings. Through a massive increase in the volume of items subsidised through the Prostheses List – many of which are consumable items such as sponges and glues – the savings from the price cuts have been undermined.

Instead of savings, there has been a \$23.9 million increase in prostheses benefit payments in the year to September 2019. This growth has been driven by a 169,382 increase in items in the "General Miscellaneous" prostheses category (9% benefits increase with a 18.4% increase in utilisation in the year to September 2019).<sup>9</sup>

The growth in volume is illustrated below.



The Government's deal with the MTAA in April 2020 to pause public interest reforms will ensure that this trend continues for at least another year, costing health insurers and Australian families paying private health insurance premiums.

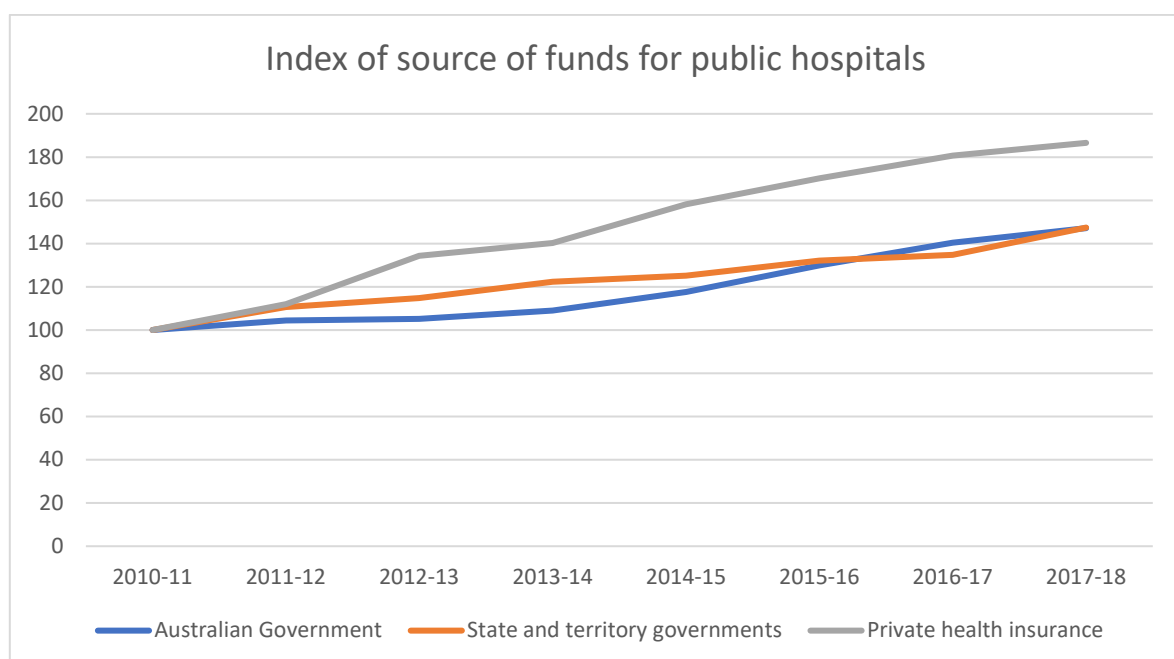
<sup>9</sup> APRA Health Insurance Statistics, [www.apra.gov.au](http://www.apra.gov.au) (accessed November 2019)

## 2.1.5 State governments are shifting costs to the privately insured

In 2017-18, public hospitals attracted \$1.25 billion in revenue from private health insurance. There has been an 87% increase from this source of funding since 2010-11. In contrast, state and territory's funding contribution and the Commonwealth contributions to public hospitals have each increased by 47% over this period.<sup>10</sup>

This increase in state and territory hospital expenditure puts upward pressure on private health insurance premiums for families. Federal government expenditure through the Medicare Benefits Schedule also increases.

Many public hospitals have an active program to drive private health insurance use to increase revenue, particularly targeting patients presenting to Emergency Departments. This may include designated staff, revenue targets, or inappropriately pressuring vulnerable patients and families with a strong suggestion that they should use their private health insurance. This happens despite the [National Health Reform Agreement](#) stating, "hospital employees will not direct patients or their legal guardians towards a particular choice." (cl G18).



In some instances, the benefits of private health insurance (such as choice of doctor) are not exercised – in emergency departments for example, choice of doctor is impractical. There are also reports of staff asking about private health insurance before seeking information about a patient's medical condition; and/or not making it clear that all Australians have the right to free care in a public hospital.

Asking a patient about their private health insurance coverage in an emergency department prior to being admitted may be contrary to clause G18 of the [National Health Reform Agreement](#), which states, "An eligible patient presenting at a public hospital emergency department will be treated as a public patient, before any clinical decision to admit."

Private Healthcare Australia notes that the new National Healthcare Agreements from July 2020 seek to reduce the incentives for states and territories to cost-shift in this manner, and we look forward to working with governments and the Independent Hospitals Pricing Authority to deliver on this promise.

<sup>10</sup> Australian Institute of Health and Welfare 2019. Health Expenditure Australia 2017-18. Health and welfare expenditure series no.65. Cat. no. HWE 77. Canberra: AIHW.

## 2.2 PARTICIPATION IS DECLINING

### 2.2.1 Participants are facing higher costs

Joining, lapsing or downgrading private health insurance is driven primarily by financial considerations. Consumers weigh the benefits of private health against the value of the public system, as well as other goods or services they could spend their money on.

The affordability of healthcare has been reduced by years of rising premiums, increasing (and unexpected) out-of-pocket costs and the decline in the government rebate. As well, slow wage growth and increasing housing, energy, fuel and education costs have added to the pressure.<sup>11</sup>

- The average premium rise for each level of hospital cover has increased more than wages over each of the last five years.
- Rebate adjustments have increased effective premiums by an additional 1 percent per year. In 2012, the government introduced means-testing and an adjustment factor to limit its total spend on PHI rebates. As a result, the average effective premium payable by consumers has risen even faster than the nominal premium rate.
- Out-of-pocket expenses are rising, and lack transparency. Though out-of-pocket costs are a long-standing issue for PHI members, the number who cite medical out-of-pocket costs as a reason to drop out of PHI has more than tripled over the past five years, now reaching a third of participants.

While a record number of services are now covered under ‘no’ or ‘known’ gap arrangements (97% in the September 2019 quarter), members must pay out-of-pocket costs for one in ten medical services. Patients may incur multiple out-of-pocket costs for the same procedure, since the surgeon, assistant surgeon and anaesthetist each bill the patient separately.

Consumer research shows that it is the lack of transparency rather than the costs themselves that tempts them to downgrade or lapse their cover. Of a sample of consumers who had recently paid out-of-pocket costs, 29 percent had negative feelings for their insurer when they were made aware of all costs in advance. However, that proportion jumped to 61 percent for the one-third of consumers who were unaware the costs were coming.<sup>12</sup>

The decline in affordability of private healthcare comes at a time that government has been investing a significant amount of capital in public hospital system infrastructure. While such investment is unlikely to be sustainable in the long run, it has created an additional incentive for consumers to either remain in the public system or lapse their private cover.

The recession caused by COVID-19 will make affordability issues more acute. Prior to the pandemic, an increasing number of Australians were already finding it difficult to join or keep their private health membership. Fifty seven percent of Australians without private health insurance cited lack of affordability as the main reason they do not have it. More than a third of insured Australians were finding they cannot comfortably afford it, with 8 percent (representing 400,000 people) having ‘real difficulty’ paying.<sup>13</sup> Since these data, more than 800,000 Australians have lost work, many more are under-employed and retirement incomes have decreased markedly for millions of Australians.

More than 100,000 Australian families have sought and been granted financial hardship support from health funds between March and June 2020.

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<sup>11</sup> ABS Household Expenditure Survey, 2015–2016

<sup>12</sup> IPSOS, Consumer Research, July-August 2018

<sup>13</sup> IPSOS, Consumer Research, July-August 2018

## 2.2.2 Participation is declining, particularly for younger Australians

These concerns are reflected in recent declines in both PHI membership and a downgrading of cover.

- **Overall participation is declining.** In the five years to 2019, the proportion of the Australian population with PHI hospital cover has declined from 47 percent to 44.1 percent.<sup>14</sup>
- **Downgrading is increasing.** Rather than drop their cover completely, many members are choosing a lower tier of cover, and pay more excess. For example, one fund reports that its lowest-tier hospital cover now covers more than a third of all members, up by 50 percent in just five years.
- **Fewer Australians in their 20s are taking up PHI.** Historically, young adults have dropped their membership when they are no longer eligible for their family policy, and then returned to PHI by the end of their 20s. However, over the past 5 years the proportion of 25–29-year-olds with PHI cover has fallen by 8 percent.

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<sup>14</sup> APRA Health Insurance Statistics, [www.apra.gov.au](http://www.apra.gov.au) (September 2019)

## 2.3 CURRENT GOVERNMENT SUPPORT FOR PRIVATE HEALTH INSURANCE

The Australian Government has three key mechanisms to support private health insurance:

- The **Medicare Levy Surcharge** is a 1–1.5 percent surcharge payable by consumers who earn taxable income above \$90,000 and who do not take out private health insurance with hospital cover. The impact of the surcharge is significant: PHI participation in the \$70,000 to \$90,000 income bracket is 71 percent, and rises to 90 percent in the \$90,000 to \$105,000 bracket.<sup>15</sup>
- The **premium rebate** reduces the amount payable by those with PHI by a percentage of their premium, with the rebate determined by the insured's age and, from 2012, their income. The rebate entitlement has been reduced from ~30 percent in 2012 to less than 25 percent now for most members.
- **Lifetime health cover** loading adds 2 percent to lifetime private health insurance premiums for every year after the age of 30 that a person chooses not to take out membership. This incentive was very successful when introduced,<sup>16</sup> but is now becoming less effective.

These three incentives are efficient, equitable and cost-effective policies to maintain private health insurance participation at sustainable levels, and so reduce costs for the public system.

Each dollar of rebate spent draws in between \$1.60 and \$2.40 additional funding from the insured consumer for their healthcare.<sup>17</sup> If that consumer were not insured, the public cost of their public healthcare would be higher than the incentive paid, with each dollar of Commonwealth spending on public hospitals being matched by \$1.22 in state government spending. (In addition, there are economic benefits of early treatment through the private system.) For this reason, a redirection of public expenditure from the incentive to the public system will reduce the efficiency of total government spend.

The value of the private health insurance rebate has been significantly reduced since its introduction as a 30% rebate on health fund premiums for all members introduced in 1998.

In recent years there have been multiple variations to the regulations governing the rebate aimed at controlling government outlays in this area. These include:

- means-testing introduced in the 2009-10 Budget;
- indexation to CPI, uncoupling the rebate from premium increases legislated in 2012;
- removal of the rebate from Lifetime Health Cover loadings, announced in 2009-10 Budget; and
- freezing of the income thresholds for rebate eligibility and the Medicare Level Surcharge at 2014-15 levels through 2017-18.

The net effect of these measures is to slow the growth of private health insurance rebate outlays. The cost of the rebate has been declining in both real terms and as a proportion of Australian Government health expenditure. Over the ten years to 2017-18, Australian Government health spending on its own programs has increased by an average of 4.0 percent per annum, spending on

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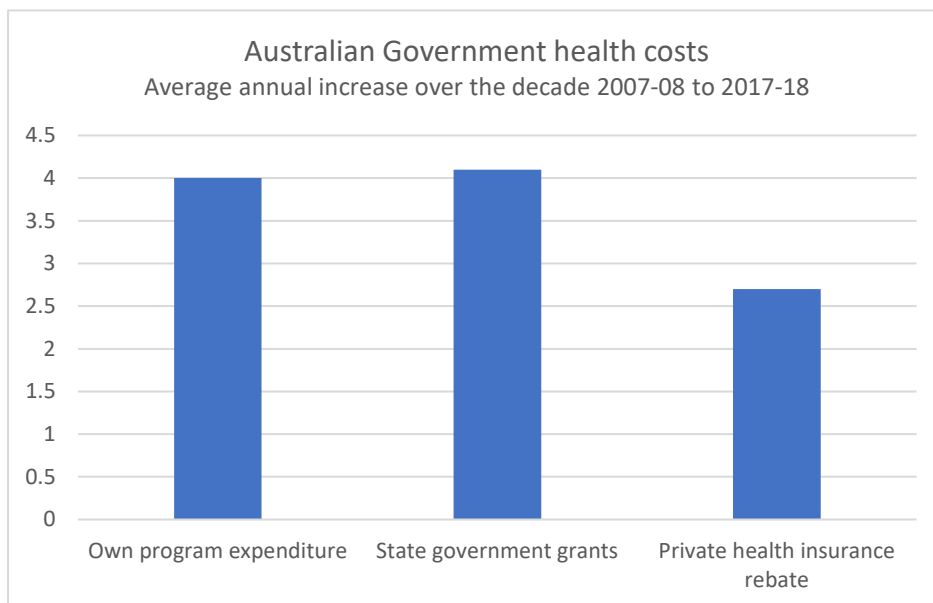
<sup>15</sup> Analysis based on ATO Income Distribution Statistics, FY2015–16

<sup>16</sup> Comparison of 30–34 age group raw participation numbers between September 1999 and September 2000, based on APRA Statistics, *Membership and Trends* (2018)

<sup>17</sup> Range reflects fact that some members receiving the rebate would without the rebate also consider entering into private health

state grants have increased by 4.1 percent per annum, while spending on the private health insurance rebate has only increased by an average 2.7% per annum.<sup>18</sup>

These trends will be accelerated by the Australian Government’s support for our public health system during the COVID-19 pandemic. State government grants will increase significantly as the Government provided cash injections to public hospitals in March 2020, then signed a generous National Healthcare Agreement with a 6.5% indexation component in May 2020. Australian Government own program expenditure in health will also likely increase, with the introduction of a number of new programs such as the private hospital revenue guarantee in 2020, new Medicare expenditure on telehealth items through Medicare, and a range of other support programs.



<sup>18</sup> Australian Institute of Health and Welfare 2019. Health Expenditure Australia 2017-18. Health and welfare expenditure series no.65. Cat. no. HWE 77. Canberra: AIHW.

## 2.4 A PLETHORA OF REVIEWS SHOW WHAT'S NEEDED

Over recent years, there have been several reviews and investigations into health care and private health insurance in particular. Some of the major reviews over the last five years include:

- Ministerial Advisory Committee on Out-of-pocket Costs (Department of Health 2018)<sup>19</sup>
- Shifting the Dial: 5 year productivity review (Productivity Commission 2017)<sup>20</sup>
- Private Health Ministerial Advisory Committee (Department of Health 2016-18)<sup>21</sup>
- Private Health Insurance Consultations (Department of Health 2015-16)
- Better Outcomes for People with Chronic and Complex Conditions (Primary Health Care Advisory Group 2015)<sup>22</sup>
- Efficiency in Health (Productivity Commission 2015)<sup>23</sup>
- Senate inquiry into value and affordability of private health insurance and out-of-pocket medical costs (2014)<sup>24</sup>

Reviews have generally called for private health insurance regulation to be lessened,<sup>25 26 27 28</sup> reducing perverse incentives,<sup>29 30</sup> better integration between public and private care, hospital and

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<sup>19</sup> Department of Health 2018. Ministerial Advisory Committee on Out-of-pocket Costs: Report. Available at <https://www1.health.gov.au/internet/main/publishing.nsf/Content/min-advisory-comm-out-of-pocket>.

<sup>20</sup> Productivity Commission 2017. Shifting the Dial: 5 Year Productivity Review, Report no. 84. Australian Government: Canberra.

<sup>21</sup> There was no report from this group, but meeting outcomes are available at <https://www1.health.gov.au/internet/main/publishing.nsf/Content/phmac>.

<sup>22</sup> Primary Health Care Advisory Group 2015. Better Outcomes for People with Chronic and Complex Health Conditions. Australian Government: Canberra.

<sup>23</sup> Productivity Commission 2015. Efficiency in Health. Research Paper. Australian Government: Canberra.

<sup>24</sup> Senate Community Affairs Reference Committee 2014. Out of Pocket Costs In Australian Healthcare. Commonwealth of Australia: Canberra.

<sup>25</sup> Productivity Commission 2017. Shifting the Dial: 5 Year Productivity Review, Report no. 84. Australian Government, Canberra.

<sup>26</sup> National Commission of Audit 2014. Towards Responsible Government: the Report of the National Commission of Audit, Phase One. NCOA: Canberra.

<sup>27</sup> Primary Health Care Advisory Group 2015. Better Outcomes for People with Chronic and Complex Health Conditions. Australian Government: Canberra.

<sup>28</sup> Productivity Commission 2015. Efficiency in Health. Research Paper. Australian Government: Canberra.

<sup>29</sup> Productivity Commission 2017. Shifting the Dial: 5 Year Productivity Review, Report no. 84. Australian Government, Canberra.

<sup>30</sup> Paolucci, F and M García-Goñi (2015). The Case for Change Towards Universal and Sustainable National Health Insurance & Financing for Australia: Enabling the Transition to a Chronic Condition Focussed Health Care System, Australian Health Policy Collaboration Technical paper No. 2015-07. Melbourne: Australian Health Policy Collaboration.

community care,<sup>31 32 33</sup> greater transparency<sup>34 35</sup> and greater investment in prevention and primary care.<sup>36 37 38</sup>

COVID-19 means there is less capacity for waste and poor regulation, and less capacity for Australian families paying private health insurance premiums to prop up the system. Further, our public health system is under severe strain, with elective surgery waiting lists likely to blow out to over 24 months for some procedures. Even a moderate drift away from private health insurance will put untenable pressure on public hospital systems.

The government has all the data and review material it needs for further reform of the private health sector, now is the time for action.

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<sup>31</sup> Productivity Commission 2017. Shifting the Dial: 5 Year Productivity Review, Report no. 84. Australian Government, Canberra.

<sup>32</sup> Paolucci, F and M García-Goñi (2015). The Case for Change Towards Universal and Sustainable National Health Insurance & Financing for Australia: Enabling the Transition to a Chronic Condition Focussed Health Care System, Australian Health Policy Collaboration Technical paper No. 2015-07. Melbourne: Australian Health Policy Collaboration.

<sup>33</sup> Primary Health Care Advisory Group 2015. Better Outcomes for People with Chronic and Complex Health Conditions. Australian Government: Canberra.

<sup>34</sup> Department of Health 2018. Ministerial Advisory Committee on Out-of-pocket Costs: Report. Available at <https://www1.health.gov.au/internet/main/publishing.nsf/Content/min-advisory-comm-out-of-pocket>.

<sup>35</sup> Senate Community Affairs Reference Committee 2014. Out of Pocket Costs In Australian Healthcare. Commonwealth of Australia: Canberra.

<sup>36</sup> Productivity Commission 2017. Shifting the Dial: 5 Year Productivity Review, Report no. 84. Australian Government, Canberra.

<sup>37</sup> Paolucci, F and M García-Goñi (2015). The Case for Change Towards Universal and Sustainable National Health Insurance & Financing for Australia: Enabling the Transition to a Chronic Condition Focussed Health Care System, Australian Health Policy Collaboration Technical paper No. 2015-07. Melbourne: Australian Health Policy Collaboration.

<sup>38</sup> Productivity Commission 2015. Efficiency in Health. Research Paper. Australian Government: Canberra.



## 3 Supporting private health insurance is cost effective

### Key points

- Australian Government subsidies for private health insurance are cost effective
- Options to increase support include:
  - Restoring the rebate to 30%
  - Increase the rebate for younger Australians
  - Introduce a fringe benefits tax exemption
  - Increase the Medicare Surcharge Levy

Supporting private health insurance reduces pressure on the Australian Government's Budget by reducing pressure on public hospitals.

Put simply, increasing demand in public hospitals costs the Australian Government 45 cents in the dollar, through fixed rates of increase in the [National Health Reform Agreement](#). Subsidising that demand through supporting private health insurance costs the Australian Government much less – around 25 cents in the dollar for the private health insurance rebate.

Subsidising private health insurance is the cheapest and most effective way for the Australian Government to manage the increasing demand for hospital care.

### 3.1 OPTIONS TO INCREASE SUPPORT

Private Healthcare Australia released a paper in October 2019 outlining a range of options for supporting private health insurance for Australians under 40, [Levers to Increase Young Adult Participation in Private Health Insurance](#).

One of the key drivers of reduced private health insurance participation among young people has been increases in premium cost, alongside reduction of the effective rebate as a proportion of premium and increased cost of living pressures. Due to the community rating system, younger participants must pay similar premiums to older participants despite being substantially less likely to require hospital services. Community rating drives a cross-subsidy of approximately \$900 from people aged under 50, to those over 50 and this amount is increasing.

#### 3.1.1 Restore the rebate

Independent economic research commissioned by PHA has consistently found the rebate is an efficient way to fund planned surgery. To address the declining effective rebate, we recommend that the government restores the rebate to 30% of the premium for low and middle-income earners in the first instance.

As a first step, restoring the 30% rebate for 18-39 year-old participants is estimated to incur a direct cost to the Commonwealth of approximately \$418m per annum in 2024-25, but after savings from reduced need for public hospital funding is considered the net impact would be -\$261m. Full details of the modelling are available in [Levers to Increase Young Adult Participation in Private Health Insurance](#).

### 3.1.2 Increase the rebate for people under 40

[Levers to Increase Young Adult Participation in Private Health Insurance](#) modelled an increase in the private health insurance rebate to 40% under the age of 40. The option of increasing the base rebate to 40% for younger participants should be considered as an opportunity to clearly signal the importance of young adult participation in the private health insurance system. While restoring the rebate would help return private health insurance participation among young people to its previous levels, increasing the rebate would increase the likelihood of generating a significant step-change in uptake of private health insurance in this age group.

Increasing the total base rebate amount for younger participants to 40% is estimated to incur a direct cost to the Commonwealth of approximately \$1.1bn in 2024, but the net impact is -\$0.9bn once cost shifting from the public hospital system is accounted for. Full details of the modelling are available in [Levers to Increase Young Adult Participation in Private Health Insurance](#).

### 3.1.3 Fringe benefits tax

[Levers to Increase Young Adult Participation in Private Health Insurance](#) recommended a Fringe Benefits Tax exemption for participating employees under the age of 40. Inclusion of private health insurance premiums as an exemption from fringe benefit taxes, allowing employers to provide private health insurance as a fringe benefit and thereby reduce the taxable income of the employee, effectively delivers a discount on private health insurance for the employee. It is assumed employees will be able to opt in or opt out from this option.

With the assumptions modelled in the report, a participation increase of 1.5% points could be expected by 2024 among young people from implementation of this policy, relative to the momentum case.

Based on an assumption that 30% of employers are participating in the program and that the exemption is only applicable to taxpayers between the ages of 18-39, implementation of a Fringe Benefits Tax exemption would have a net impact to the Commonwealth of -\$584m on an annual basis in 2024. Full details of the modelling are available in [Levers to Increase Young Adult Participation in Private Health Insurance](#).

### 3.1.4 Increase the Medicare Levy Surcharge

Despite the existing Medicare Levy Surcharge, almost 200,000 high income Australians are not covered by private health insurance.<sup>39</sup> The large number of people with high incomes who choose to rely wholly on Medicare places an unfair burden on all Australians, particularly the most vulnerable. With waiting lists for elective surgeries in the public system blowing out due to COVID-19, this burden is even greater.

It is important in this to recognise that the Medicare Levy Surcharge is not a tax even though, as a penalty, it is expressed as incremental taxation. The purpose of the surcharge is to encourage private health insurance membership, rather than to raise taxation, so the preferred Treasury income from this measure is zero.

That said, from the economic perspective of a consumer, the Medicare Levy Surcharge can be modelled as a reduction in the perceived price of private health insurance. Thus an increase in the surcharge may increase the likelihood of a person holding insurance, and may also increase the attractiveness of a higher tier product.

Private Healthcare Australia has commissioned modelling on the effects of an increase in the Medicare Levy Surcharge. Changes to the Medicare Levy Surcharge have been undertaken previously, when higher penalty contributions were introduced for those on higher incomes, ranging from the original 1% levy to new rates of 1.25% or 1.5% depending on income level.

These changes were not without some controversy but, at the same time, align strongly with many other government initiatives, payments and taxes which are means-tested. This alignment allows changes to the surcharge to be argued in a manner consistent with broader government approaches and is generally well accepted by the Australian public who perceive means testing as both reflective of the application of equity and justice.

Private Healthcare Australia recommends an increase in the Medicare Levy Surcharge of 100 basis points.

Our modelling suggests that this would result in increased private health insurance revenue of \$435 million; a rebate cost increase of \$41 million, and an increased Medicare Levy Surcharge penalty of \$206 million. The nett revenue to government would be approximately \$164 million per annum.

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<sup>39</sup> Australian Taxation Office supplied figures for 2016-17.

## 4 Reduce the costs of inefficient care

### Key points

- Healthcare costs generally rise faster than inflation
- Private health insurance is more vulnerable to health inflation due to regulatory and structural issues
- Reducing the costs of private healthcare reduces the Australian Government contribution to the rebate

Australia's healthcare costs will tend to rise due to our ageing population, rising chronic disease and complex multimorbidity, and higher expectations for care quality. However, structural characteristics of our system affect health inflation, including the cost of prostheses, cost-shifting, wasteful spending and inefficient pricing. The result is healthcare inflation that is consistently higher than CPI and wage growth, with a corresponding upward pressure on private health insurance premiums.

The economic downturn as a result of the COVID-19 pandemic means that we can no longer afford to continue to pay much more than necessary for health care.

The key areas of private healthcare expenditure are private hospital costs, medical fees, primary care fees (for general treatment which covers dental and other allied health in the community) and public hospitals. The areas of costs growing most rapidly include prostheses and state government charging for private patients in public hospitals, as outlined previously.

While reform in these areas are often independent of the Australian Government budget process, policy changes affecting the cost of private health insurance does have budget implications due to the rebate.

For example, simply reducing the prices paid under the Prostheses List for 6,000 drug-eluting stents used in Australia from one company alone to the same price paid in New Zealand would save the Australian Government over \$2 million each year.

## 4.1 CONTAIN THE PROSTHESES LIST

Prostheses (broadly defined as implantable medical devices used in surgery and procedural medicine) in Australia are often overpriced, overused, and in many cases, there is little or no evidence that there is a patient benefit.

Prostheses use is one of the fastest areas of private health fund expenditure growth over the last decade. Current expenditure by health funds on prostheses is around \$2 billion, meaning that the Australian Government is subsidising prostheses (indirectly through the rebate) by around \$500 million per annum.

The Australian Government sets the price on over 11,000 individual items, determined by reference pricing rather than any market mechanism. Health funds are required to pay a set price regardless of quality, efficacy, efficiency or even safety.

The Grattan Institute has described the Prostheses List as “redolent of Soviet-era central planning at its worst.”<sup>40</sup> In a recent presentation Stephen Duckett noted,

*The current prosthesis pricing approach incorporates all the wrong incentives, creates arbitrage opportunities, encourages rent seeking, and leads to poor outcomes for patients, health insurance members and taxpayers. It does nothing to improve efficiency. It is, in short, a protection racket.*<sup>41</sup>

Other significant areas of government health expenditure like the Pharmaceutical Benefits Scheme (PBS) include price disclosure, health technology assessments, group premiums, reference pricing, brand premiums and linking reimbursement to use only for clinically-approved indications. The Prostheses List process generally lacks this spending discipline.

The waste is significant and harmful. Estimates vary widely, but savings from greater spending discipline are likely to save \$250-400 million per annum without affecting patient care. The Commonwealth would reap approximately a quarter of those savings through the rebate, with the rest distributed among Australian families paying premiums.

Private Healthcare Australia (PHA) notes the Australian Government is undertaking reviews across many areas of the Prostheses List, including the general and miscellaneous category, to improve public benefit. These reviews were halted in April 2020 for a period of up to one year, following an agreement between the Government and the MTAA. This agreement needs to be terminated immediately and the reviews recommence. Failure to do so will add approximately \$200-\$300 million to inefficient expenditure over the twelve month period, adding to pressure on premiums.

A greater investment is needed into bringing standard discipline and restraint to the Prostheses List prior to the expiry of the MTAA Agreement in 2022. Further, an investment in better policy options for post-2022 are required now, to assess the public benefit of different reform options and reduce the current wastage.

PHA has previously recommended that the Commonwealth establish a national independent body to manage the procurement of prostheses (including the implementation of international reference pricing). While still favouring a body such as the Independent Hospitals Pricing Authority taking this role and developing an efficient price for prostheses used in public and private hospitals, the rorts within the system currently are seeing many in the sector favouring complete deregulation following the expiry of the MTAA Agreement with the Australian Government.

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<sup>40</sup> Grattan Institute 2019, <https://grattan.edu.au/wp-content/uploads/2019/08/Prostheses-speech-final-updated.pdf>

<sup>41</sup> Ibid.

## 4.2 STOP COST SHIFTING

The Commonwealth Government is overpaying for public hospital services, as many state and territory governments are inappropriately targeting people to use their private health insurance in public hospitals.

Regulations permitting State Government cost shifting, that is charging private patients twice when they use the Medicare system, need to be tightened up. This shifts over \$1.25 billion every year directly on to premiums (and the Commonwealth Government rebate), and also increases costs of the Medicare Benefits Schedule.

There will always be some private patients needing treatment in a public hospital, however the practice of chasing patients to use their health insurance is not always in the best interests of the consumer or the health system.

Private Healthcare Australia welcomes the new provisions in the new National Health Agreements designed to reduce the financial incentives for state and territory governments to further increase cost-shifting. We will work with governments and the Independent Hospital Pricing Authority to assist in data collection and setting up the systems required to enforce these provisions.

Private Healthcare Australia further recommends that the Government:

- Clarify that patients may not be approached in emergency departments to determine if they have private health insurance
- Disallow states and territories nominating patients as private if they enter the hospital through an emergency department
- Ensure visiting medical officers are physically present if their provider number is used for services provided in a public hospital
- Ensure no private patient is admitted to a public hospital through the ED unless they have been assessed by a fully-trained specialist in the relevant treatment area (in effect, not the ED physician or a junior doctor)
- Enforce a standard patient election form which outlines all the pros and cons of electing to be a private patient in a public hospital, and
- Consider a reference to the Australian Competition and Consumer Commission to examine the tactics used by state and territory governments to determine if it is misleading and deceptive conduct.

### 4.3 STOP THE WASTE

The Productivity Commission estimates that 10 percent of healthcare spending either has no effect, causes harm or is not worth its cost,<sup>42</sup> noting that ‘unjustified clinical variations, including the use of practices and medicines contraindicated by evidence remain excessive, an indicator of inadequate diffusion of best practice, insufficient accountability by practitioners, and a permissive funding system that pays for low value services.’<sup>43</sup> This is a price we can no longer afford to pay now Australia is in a pandemic-caused recession.

Low value care is defined as care that either has no effect, causes harm, or is not worth its cost. The global ‘Choosing Wisely’ initiative is an academic collaboration, which identifies unnecessary or harmful medical procedures and tests. PHA has commissioned from the University of Sydney a detailed analysis of low-value procedures still occurring and being funded by the Medicare Benefits Schedule (MBS) and private health insurance.<sup>44</sup> Examples of low value procedures that could be removed from the MBS are arthroscopic surgery for knee osteoarthritis and back x-rays, saving approximately \$90 million per year. The Atlases of Health Variation researched and published by the Australian Commission for Safety and Quality in Healthcare provide an indication of where low-value or even harmful care is occurring.<sup>45</sup>

PHA supports the MBS Review to prevent outdated and wasteful clinical care. Health funds are committed to ensuring members are able to access quality clinical care when and where they need it. However, increasing pressure is being placed on the system by having to fund what may no longer be appropriate or necessary and potentially diverting resources from areas of need.

The MBS Review has already had a number of successes, and as expected, some implementation issues. PHA will continue to work with the Australian Government to identify wasteful practices such as patients admitted to hospital unnecessarily for eye injections and other minor procedures, inappropriate and unnecessary screening and inappropriate hospitalisation for rehabilitation.

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<sup>42</sup> The Productivity Commission (2017), *Shifting the Dial: 5 Year Productivity Review*.

<sup>43</sup> The Productivity Commission (2017), *Shifting the Dial: 5 Year Productivity Review*.

<sup>44</sup> Prof Adam Elshaug, Kelsey Chalmers and Tim Badgery-Parker (2018) *Measuring low-value services in Medibank, Bupa, GMHBA and HCF data:2015/16 to 2016/17*. Sustainable Health System Solutions.

<sup>45</sup> *The Third Australian Atlas of Healthcare Variation*, ACSQHC, December 11, 2018.

## 5 Unlock the potential of the industry to improve care across the continuum

### Key points

- Australia's health system does not promote least disruptive care
- We need to balance burden of disease and burden of care
- Regulatory and financing barriers need to be addressed

Australia's health system is built on a regulatory and funding structure which encourages hospitalisation, encourages inappropriate servicing, over-servicing and over-diagnosis. The simple fact is that a fee-for-service system means that a service must be provided in order to secure a fee. In addition, our system is siloed, fragmented and is not well focused on what is important to the community.

The corollary is that our system discourages community-based care, discourages self-management, fails to incentivise prevention, discourages collaboration, stifles innovation and creates barriers of entry for new providers. Australia lags much of the developed world in utilising new technologies, sharing information and providing tools for communities to manage their own care.

We need to ensure our health system:

- provides people with the right type, quality and timing of care
- provides that care at the right price, and
- pays that price in the most efficient way.

Improving the regulatory environment in conjunction with the cultural environment will help promote innovation and manage costs into the future, reducing the burden on the Australian Government's budget.

PHA would like to promote a discussion across the community on least disruptive care, and how the Australian Government can unlock the potential of private health insurance to improve health care across the continuum.

### 5.1 REDUCE BURDEN OF TREATMENT

We are cognisant of the burden of disease, but rarely pay attention to the burden of treatment. Measuring the burden of treatment goes well beyond costs. The burden includes time, stress, productivity, and the opportunity cost of each of these burdens.

The objective of health care should be an improved quality of life, not the eradication of disease. This is particularly the case where our health system is dealing with a rapid rise of chronic disease rather than just seeking to address acute conditions such as injury or infectious diseases. Millions of Australians live with chronic health conditions – we need to address disease to help them manage their lives, not put their lives on hold to manage their diseases.



## 5.2 COMPLEX AND CHRONIC CARE IS NOW THE NORM

Around one in two Australians lives with a chronic health condition.<sup>46</sup> Many Australians live with heart conditions, diabetes, arthritis, back pain and mental health conditions. Fewer people are dying from these conditions, meaning that more and more Australians are living longer with chronic health issues. There has been a substantial increase in recent years in the number of people living with multiple chronic health conditions, both as a result of population ageing and more younger people having a chronic condition. Mental health conditions have been a substantial driver of comorbidity.<sup>47</sup>

Australia's health system is based on an acute care model, including our financing and regulatory structures. The supply of health care, based on these outdated platforms, no longer matches the community demand for health care.

The approach to helping people manage chronic conditions must be as holistic as possible, with both medical treatment and behavioural elements. By their nature, chronic and complex diseases will often require hospital treatments. They also require ancillary care that can be provided out-of-hospital, and preventive action on contributing behaviours such as poor diet, low exercise, lack of medication compliance, alcohol consumption and smoking.

There is significant scope for healthcare providers, public and private funders, and the broader community to work more closely on the prevention, early treatment, inpatient and out-of-hospital care of these conditions. Both international and Australian research supports the case for holistic care programs for people living with chronic or complex diseases, improving quality of life and reducing the demand for hospital admissions.

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<sup>46</sup> Fetherston H, Calder R, Harris B. 2019. *Australia's Health Tracker*. Mitchell Institute, Victoria University Melbourne.

<sup>47</sup> Harris B, et al. 2018. *Australia's Mental and Physical Health Tracker: background paper*. Australian Health Policy Collaboration, Mitchell Institute, Victoria University.

## 5.3 REGULATORY BARRIERS ARE PREVENTING BETTER PATIENT CARE

The sheer volume of regulation in the private health insurance industry is staggering. In addition to the *Private Health Insurance Act 2007* (the Act), the industry is subject to several other primary Acts and scores of legislative instruments. There are literally thousands of pages of law that affect the business of private health insurance.

The *Australian Government Guide to Regulation* (2014) notes,

The Government's rigorous approach to policy making seeks to ensure that regulation is never adopted as the default solution, but rather introduced as a means of last resort.<sup>48</sup>

Private health insurance regulation fails this ideal. More importantly, the existing regulation causes harm, preventing private health insurance funds from unlocking the potential of improved health promotion and prevention, modern and effective mental health care, promoting out of hospital care, and innovative care options. This harms consumers and health funds, and costs the Australian Government through increased private health insurance rebates.

### 5.3.1 Mental health

Mental health conditions are increasingly prevalent across the population, and cause immense damage to individuals, their families and carers, the economy and the community.

To improve mental health care through private health insurance, it is imperative that regulatory barriers that prohibit health funds from funding mental health care in the community be removed and enable cost-effective community initiatives and care packages to be provided at scale.

Several funds are running trials and preparing to improve models of care for people living with mental health conditions. Many of these programs show promise, but are limited by the *Private Health Insurance Act 2007* (the Act), the *Private Health Insurance (Complying Product) Rules 2015*, and the *Private Health Insurance (Health Insurance Business) Rules 2018*.

Both the Act and the Rules place strict definitions on the type of care that may be covered by private health insurance. The definitions of hospital care and hospital-substitute treatment are out of date and stifling innovation in mental health care. For example, the exclusion of general practice in chronic disease management programs (cl. 12, the Business Rules) is contrary to accepted medical practice in Australia.

Despite health funds currently being constrained by the legislative barriers, PHA is working with our members on an outline of a framework to provide services to Australians living with mental health conditions in the community. This work has the potential to be transformative and lead the way in modernising private health care in Australia. This is an absolute priority for PHA and our member funds. We will continue to work with the Minister for Health, the Hon. Greg Hunt MP, and across government to address the regulatory barriers.

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<sup>48</sup> Australian Government 2014. Australian Government Guide to Regulation. Available at <https://www.pmc.gov.au/resource-centre/regulation/australian-government-guide-regulation>.

### 5.3.2 Out of hospital care

The Australian Government must address the legislative barriers that only allow health funds to pay for hospital-substitute care, rather than out of hospital care across the continuum. The legislation in many cases prescribes what must happen, rather than proscribe what may not happen. That leads to some unintended results and significant fragmentation. For example, Paolucci and García-Goñi describe, “a further and startling fragmentation in the Australian health care arrangements is the exclusion of private health insurance from the capacity to purchase or pay for primary health care.”<sup>49</sup>

Again, the legislation is out of date. AMA President Dr Tony Bartone, has noted, “Chronic disease is not best managed in an acute hospital environment ... Hospitals are a very expensive setting to conduct ambulatory care.”<sup>50</sup> Many more insurers, health provider bodies and commentators are calling for reform to allow more flexibility in out of hospital care.

### 5.3.3 Rehabilitation and Second tier default benefits

The Australian Government needs to do more than just allow insurers to fund more flexible out of hospital options; it must address perverse incentives for inappropriate hospitalisation.

The two most urgent reforms to prevent inappropriate hospitalisation are to address the legislative rules on rehabilitation and second tier default benefits.

There is growing evidence that the best outcomes from **rehabilitation** for a range of procedures is done in home rather than in hospital. In Australia, financial incentives mean that in hospital rehabilitation is increasing, rather than declining. This means that patients are getting lower quality care at a higher price, putting pressure on private health insurance premiums.

PHA is working with the Minister for Health seeking a change in the definition of “rehabilitation patient” in the *Private Health Insurance (Benefit Requirements) Rules 2011* to make it clear that a patient in hospital for rehabilitation must receive a minimum standard of care in line with the Australasian Faculty of Rehabilitation Medicine Standards.

Up to 45% of private patients spend an average 15 days of hospital care for uncomplicated primary surgery such as a knee or hip replacement, while the standard inpatient rehabilitation rates for the public system and in other countries for knee and hip replacements are 5-17% with an average stay of 5-6 days. If the length of stay was the same in the public and private systems, around \$205 million would be saved from health insurance premiums, with approximately a quarter of this amount saved by the Australian Government through lower expenditure on the rebate.

**Second tier default benefits** were originally set up to protect smaller and regional hospitals, but the safety net has now created a perverse incentive to establish hospital beds, including day hospitals of marginal value. This spreads the health fund dollar too thinly as particularly new day facilities can rely on the second-tier benefit and not truly substitute for overnight care. Restoring the second-tier default benefit to its original intent (to protect rural and regional hospitals) would save \$200 million annually, while consumers can be protected from rising out-of-pockets charged by uncontracted hospitals. Again, the Australian Government would save approximately a quarter of this amount. As a protection for consumers, hospitals falling out of contract with health funds should not be permitted to charge the patient more than 100% of the average charge for the equivalent episode of hospital treatment.

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<sup>49</sup> Paolucci F, García-Goñi M. 2015. The Case for Change Towards Universal and Sustainable National Health Insurance & Financing for Australia: Enabling the Transition to a Chronic Condition Focussed Health Care System, Australian Health Policy Collaboration Technical paper No. 2015-07. Melbourne: Australian Health Policy Collaboration

<sup>50</sup> Dr Tony Bartone quoted in Robinson N. 2019, ‘Let private health funds cover all GP bills’ *The Australian*, 29 October 2019.

## 5.4 TRANSPARENCY NEEDS TO BE IMPROVED

Too often, consumers and health providers cannot make optimal care decisions, as they lack accurate information on procedural outcomes, out-of-pocket costs, waiting times and other essential data. A collaborative, online platform for that data would improve decision-making by clinicians, patients, health funds, hospitals and researchers, and allow consumers to choose lower cost providers.

Private Healthcare Australia is ready to work with the Federal Government and other stakeholders to promote and improve the Medical Costs website and add in additional transparency measures.

## 6 The costs of inaction are high

### Key points

- Private health insurance takes pressure off the public system.
- The public health system would not be able to cope with a large influx of uninsured Australians
- Private health insurance provides choice.

Dr Tony Bartone, AMA President, has pointed out that “we need to remember that the private health industry, the private health system, underpins access and equity in the public system.”<sup>51</sup>

If private health insurance participation declines only to 40 percent, it would mean 1.5 million additional people becoming fully dependent on the public hospital system (given a 2017 population), having a significant impact on both waiting times and government spending.

With rising unemployment, lower investment incomes and uncertain economic conditions, people need support and reassurance to maintain their private health insurance. Doing nothing will see more people drop their insurance.

For the 2020-21 financial year and beyond, the focus of the public health system will continue to be on management and care for people with COVID-19 and catching up on the backlogs of elective surgery resulting from the shut down in the first half of 2020. We cannot afford neglect to cause more people to drop private health insurance and add pressure to our public health systems.

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<sup>51</sup> Dr Tony Bartone, sky news, 31Oct19

## 6.1 PRIVATE HEALTH INSURANCE HELPS MAINTAIN THE PUBLIC SYSTEM

If participation rates decline at the currently forecasted rates, the ability of the private health insurance industry to insulate the public health system against over-utilisation and higher costs could be significantly reduced.

The private insurance sector supports the public system in several areas, for instance:

- **Funding hospital admissions:** 42% of hospital admissions in Australia are funded by private health insurance.<sup>52</sup>
- **Earlier surgical procedures:** private health insurance funds about 60 percent of all elective (planned, non-emergency) surgery in Australia, funding 1.283 million elective surgeries compared to 703,000 funded by the public health system.<sup>53</sup> This reduces waiting times and lowers demand for public hospital beds. In turn, this earlier intervention means there are less likely to be complications in the surgery, which could otherwise have led to greater healthcare costs.
- **Setting a performance benchmark:** private health insurance provides competitive efficiencies in the private sector as well as performance benchmarks for the public sector. This is most clearly demonstrated in the provision of essential non-emergency surgery.

More than two thirds (69 percent) of health decision-makers agree that private hospital insurance takes pressure off public hospitals, enabling the public system to offer improved access to those needing public hospitals.

Government spending would have to significantly should private health insurance participation declines to 40 percent, with an additional 1.5 million people shifting to the public system (excluding population growth, which would add even more):

- An additional 3,600 hospital beds would be required – equivalent to Australia’s four largest hospitals
- Hospital operating costs would rise by 7.2 percent per year
- Waiting lists would increase by over 90 percent.<sup>54</sup>

During April and May 2020, an estimated 200,000 elective surgeries were cancelled across the public health system, with another 10,000 in Victoria during a five week slowdown in July and August. It will take many months to catch up – elective surgery waiting lists have blown out significantly. Even with increased investment by state governments, capacity issues mean that some people will be waiting two years for treatment. The public health system needs to be protected from any additional surge in demand coming from people leaving private health insurance.

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<sup>52</sup> AIHW 2019. *Hospitals at a Glance*. Available at <https://www.aihw.gov.au/reports/hospitals/hospitals-at-a-glance-2017-18/contents/hospital-funding-and-expenditure>

<sup>53</sup> Australian Institute of Health and Welfare 2019, *Admitted patient care 2017–18: Australian hospital statistics*. Health services series, cat. no. HSE 225

<sup>54</sup> Detailed modelling and assumptions are available in the Private Healthcare Australia Budget Submission 2019, available at [www.pha.org.au](http://www.pha.org.au).

## 6.2 PRIVATE HEALTH INSURANCE PROVIDES CHOICE

Consumers who take out private health insurance have more control over their healthcare, being able to select their practitioners, avoiding waiting lists and having a wider range of available treatments. For these reasons, 73 percent of PHI participants either agree or strongly agree that private health insurance is essential.<sup>55</sup> Reasons stated include:

- **Choice and control:** selecting a practitioner from a wide range of options, choosing when and where to be treated, and so being more likely to have a better care experience. For many patients, there is a need to have one fully-trained specialist responsible for their care, rather than a trainee or shift-worker who cannot provide full continuity of care.
- **Emotional security and reliability of care:** shorter wait times for elective surgery and broader options. The average reported wait for elective treatment in a public hospital is considerably higher than private hospitals for nearly all procedures in every jurisdiction. This does not include the 'hidden' waiting lists, which are generated by wait times for outpatient services. A report by HBF focussing on public hospital services in Western Australia found that the median 'wait-to-wait' time, that is, the amount of time a patient waits between first presenting with a health issue and getting a first consultation with a specialist, was 8.78 months.<sup>56</sup>
- **Access to a wider range of services outside of public care:** private health insurance extras cover subsidises important services such as dental, optical and physiotherapy that are not funded through Medicare.

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<sup>55</sup> IPSOS, Healthcare & Insurance Australia, 2017

<sup>56</sup> HBF, A Comparison of Wait Times for Public and Private Hospitals, 2018.

## 7 Conclusion

Intergenerational Reports and a range of other studies demonstrate that there will be rapid growth in health and hospital services, well ahead of inflation. To ensure that the Commonwealth Budget is not crippled by health costs into the future, the Government must take the most cost-effective path to manage growth; supporting private health insurance and thus leveraging the community's desire for choice and control in their own care.

This is particularly important as Australia manages, and recovers from, the health and economic impacts of COVID-19. Put simply, we can no longer tolerate waste and inefficiency in health care.

Providing subsidies to private health insurance is the most cost-effective way for the Australian Government to support the growth in hospital and health services over the coming decades.

Subsidies for private health insurance-funded services cost the Commonwealth Budget around 30 cents in the dollar. The alternative, providing more services in public hospitals, costs the Commonwealth Budget 45 cents in the dollar.

However, increasing subsidies for private health insurance alone will not provide the best results for the community and for the Australian Government. There also needs to be a greater focus on reducing the costs of inefficient care, including reforming the regulation that forces funds to pay for poor performing goods and services.

The Australian Government needs to promote the least disruptive care for the community. This means reducing reliance on in-hospital care and invasive, disruptive procedures. Each decision, each regulatory choice, and each discussion must be 'how can we make it easier for the patient?' Least-disruptive care reduces the burden of treatment – making it easier for people to live their lives and participate in work, education and the community.

Private health insurers can and should do more to help Australian families manage their health throughout life, but Australia's regulatory regime for private health insurance is not fit for purpose. The regulatory approach is based on acute, hospital-based care while the demand in the community is for integrated services to address chronic health conditions. We need to unlock the potential of the industry to improve care across the continuum, throughout families' lives.

The alternative to supporting private health insurance is to allow the private sector to decline, as happened in the 1980s and 1990s. If private health insurance coverage falls to 40% in the next five years, another 1.5 million Australians will be wholly reliant on the public system. If in a decade after that coverage falls to 30%, then the Commonwealth will have to provide an additional \$19 billion a year for public hospitals – more than the current spend for every public hospital in Victoria and South Australia.

The scenarios above are the current trend – if the Australian Government does nothing. There is no doubt that hospital and health care demand will continue to rise, and that demand will fall to the public system (with the Commonwealth paying 45c in the dollar) or in the private system (30c in the dollar). A strong investment in private health insurance is the most effective means of meeting future demand. This investment should be coupled with real action to reduce cost inefficiencies, promote least-disruptive care, and unlocking the potential of private health insurance to help families throughout their lives. Over time, these recommendations will provide a strong, balanced and competitive health care system to help all Australians participate in the community.