

A sustainable private health sector: an economic study

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Evaluate

Evaluate was formed in 2016 to bring fresh thinking to policy and economic questions, particularly those in the social sphere.

Our particular goal is to identify long-term solutions to ensuring the sustainability of Australia's social compact, including universal access to healthcare and education, and the supply of aged care, housing and other social infrastructure.

Our approach is based on a traditional microeconomic toolkit, moderated by the knowledge that social services are accessed by people with a vast variety of experiences, needs and resources. Consequently, we have no bias towards either public or private supply of services, noting that the access and welfare needs of different Australians typically require a mix of both.

The Principals of Evaluate are experienced professionals, and we complement this with external expertise where possible.

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Executive summary

This paper finds that private health insurance (PHI) contributes \$61 billion to the Australian economy annually and, in addition, adds to economic wellbeing through supporting Australians' health so they can remain productive. This in turn contributes to economic growth.

This paper considers ways in which PHI could become both more productive and more sustainable and specifically looks at how more value can be achieved from the same or lower expenditure – an outcome that is desirable for consumers, the health sector, governments and the economy more broadly.

Sustainability of the private health sector

As highlighted above, a sustainable private health sector has significant personal and economic benefits. A sustainable sector supports the health and wellbeing of insured people and, through the reduction of public hospital waiting lists, also benefits those without insurance. Governments are also beneficiaries of private health given the private sector helps to alleviate and minimise the demand pressures on the public health system.

The value that the private health sector delivers to Australia is implicitly recognised by the long-term support that the Australian Government has provided to the sector. Private health insurance is a central element in helping Australia maintain its world-class, universal health system.

The increasing stresses on, and consequent concern about, the sustainability of PHI are therefore unfortunate and unintended. Higher participation in private health insurance is important and regulatory systems should therefore seek to maximise membership across the lifecycle. Incentives do exist to support this but there are also regulatory inefficiencies which, when coupled with the information asymmetries present in this sector, will result in neither membership nor overall public welfare being maximised.

To consider how best to sustain and support PHI, this paper seeks to distinguish between:

- The rules and structures which are necessary to, or valuable, in addressing the limits of the traditional market, particularly those caused by information asymmetry;
- Those which have been designed to address specific problems in an imperfect system, but which may contribute more inefficiency to the health market than they resolve; and
- Gaps in the rules which drive inefficiency, such as when one party to a contract is constrained and the other is not.

Given the purpose of insurance is to facilitate risk sharing and financial settlement between buyers and sellers, it is important to consider whether Australia's regulatory structure addresses the market limitations of healthcare via insurance or simply reallocates them from individuals to private health insurers. It is also important to note that there are many instances where the private health sector departs from the standard model of an efficient competitive market. This raises many issues which need to be considered and addressed.

This is not to suggest that an unregulated market for PHI should exist but does indicate that reforms are necessary to help address the asymmetries and anomalies in the PHI sector in order to generate greater efficiencies and increase productivity.



The options outlined in this paper are not presented as the sole solutions at delivering a sustainable PHI sector but offer fertile areas for further consideration and investigation. This work should inform future rounds of PHI reforms beyond those already being undertaken.

A sustainable private health sector: the principal goals of reform

Three principal goals should inform reform of the private health sector as follows:

1. Membership of private health insurance should be increased and broadened as the key to sustainability;
2. Solutions should be sought that will substantially reduce the mean cost of PHI instead of pursuing minimum price increases which will not lead to increased membership, and
3. These solutions should not undermine the core value proposition of PHI which is that it offers immediate treatment where needed.

Restoring the PHI value proposition – options for reform

Drawing upon the analysis above, there are five general paths to restoration of the value proposition which are:¹

1. Removing the asymmetry whereby PHI funds are price-takers including from hospital accommodation and device suppliers;
2. Addressing the out of pocket (OOP) costs issue;
3. Reducing expenditure on low-value care, which may usefully be defined as treatment which would not move to the front of a public waiting list under any circumstance. This is mostly because it has poor evidence or poor economic efficacy but, for some patients, it may particularly be inefficient or inappropriate;
4. Allowing market completion by allowing health insurers to fund care options involving hospital substitution within hospital cover; and
5. Investing in consumer education to reduce information asymmetry and address some of the myths about healthcare in Australia.

Each of these is aimed at reducing the overall costs while maintaining the core benefits of PHI. Each of these potential reforms is considered in detail in the paper while Table One provides a summary of the various options.

Table One: Summary of reform options

Reform options and work proposed	Economic rationale	Stakeholders impacted
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¹ These exclude the potential impact of prospective risk equalisation which is an important reform option but is being addressed elsewhere.



<p>Removing asymmetry between PHI and hospital and device suppliers</p> <ul style="list-style-type: none"> - Formal alignment of the PL or similar mechanisms to prices in the public health system - Extension of IHPA’s oversight to the total cost of care on a DRG basis 	<p>These reforms would add significant downward pressure to prices whilst also creating a more level field between PHI and suppliers</p>	<p>PHI Hospital suppliers Commonwealth as payer through the rebate</p>
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Table One: Summary of reform options

<ul style="list-style-type: none"> - Introduction of a series of measures that permit a more symmetrical negotiation between PHI and hospitals including: <ul style="list-style-type: none"> - Either removing the default rate or reducing it to incentivise negotiation and decrease the profitability of low-value care; - Amending the Private Health Insurance Act 2007 so the Commonwealth has to approve hospitals that access the Commonwealth-specific default rate; and, - Together with the proposal for DRG-based pricing, allow PHI and hospitals to negotiate on total cost of services, potentially with the exception of professional fees - Review of the supply rules utilised by governments to put down pressure on prices - How default rates might be set to incentivise health care being provided in the most efficient or costeffective setting 		
<p>Addressing OOP costs</p> <ul style="list-style-type: none"> - This could be addressed through the contracting model outlined in the section above and through incentives to encourage medical practitioners to participate in no-gap and known gap arrangements 	<p>Decreasing overall costs while maintaining the core benefits, and sustainability, of PHI</p>	<p>PHI customers Medical practitioners PHI Commonwealth as payer through the rebate</p>



<p>Reducing expenditure on low-value care</p> <ul style="list-style-type: none"> - Undertake a comprehensive review to describe and quantify what might be included in various definitions of low-value care - Review of the supply rules utilised by governments to minimise the provision of low value care - Exploration of means of promoting value-based care - Calculation of savings available to consumers through the minimisation of low-value care 	<p>Probably the most productive option to reduce PHI premiums over time although potentially most challenging as it resembles part of the rationing that occurs elsewhere in the health system</p>	<p>Patients Hospitals PHI Medical practitioners Commonwealth as payer through the rebate</p>
<p>Allowing market completion</p> <ul style="list-style-type: none"> - Cost-benefit analysis of the potential impact of market completion including: - Extending the capacity for PHI funds to invest in health promotion activities; and, - Allowing funds to pay for treatment without hospital admission, including both preventive and hospital substitution treatment - Reviewing reasons for the low management expense ratio (MER) in PHI versus other insurers 	<p>Decreasing overall costs while addressing the asymmetrical nature of the market</p>	<p>PHI funds Hospitals Commonwealth as payer through the rebate</p>
<p>Table One: Summary of reform options</p>		
<ul style="list-style-type: none"> - Evaluation of PHI’s contribution to the economic activity of small business and its impact as a catalyst for additional personal spending on health and wellbeing - Calculating the incremental impact of PHI on GDP 		
<p>Investing in consumer education</p>	<p>Decreasing the information asymmetries between consumers, medical practitioners and PHI</p>	<p>Patients Medical practitioners PHI Commonwealth as payer through the rebate</p>

Two alternative approaches are also outlined in the paper. These are not as formal proposals but do represent useful intellectual exercises. These include floating the rebate and re-targeting the rebate and principally serve to underscore the asymmetrical nature of the market in which PHI operates.

Conclusion and next steps

Looking to the future, if PHI becomes increasingly dominated by older and sicker Australians, the value of increased life expectancy and work productivity benefits provided by the sector will decrease. This in turn will reduce economic growth while healthier Australians remain on ever-increasing public waiting lists. This scenario is obviously detrimental compared to the current or ideal environment which only emphasises and underpins the need for the above options to be modelled, considered and, where appropriate, adopted.



Reforms underway in the PHI sector, such as those to the Prostheses List pricing, will deliver clear benefits. This paper explores a number of options for the next round of reforms which would make the private health insurance system more sustainable, benefiting patients, the health system and the economy more broadly. The options outlined in this paper seek to reframe the system for long term sustainability not simply for the sector but to maximise the health and wellbeing of Australians, support the sustainability of government expenditure on both public and private healthcare and to remove pressure from public hospital waiting list.

Further work is needed to flesh out some of the details and potential impacts of the proposed reforms. This would enable identification of those most valuable and their prioritisation for adoption.

Purpose

This paper was commissioned by Bupa with the aim of exploring options by which the sustainability of private health insurance in Australia might be improved.

As such, it looks at the value of the private health sector in Australia, the operating limits of various participants but particularly private health insurers and builds a map of complementary and competing incentives for those participants.

The Economics of Private Health Insurance: Core Principles

Background: Arrow and Uncertainty

This paper is focused on questions of which regulations to private health insurance are necessary and productive and which are only part of the natural accretion of regulation over time. To do this, it is useful to revisit some of the foundations of contemporary economic thinking with respect to healthcare.

The fundamental economic arguments for regulatory intervention in pricing and access to health insurance – both social and private – are found in the American Nobel laureate Kenneth Arrow's 1963 paper *Uncertainty and the Welfare Economics of Medical Care*.²

Arrow's central observation in this paper is that healthcare is a good which suffers from exceptional levels of information asymmetry. The consequence of this is that an unregulated market is unlikely to maximise overall public welfare as those with greater knowledge are incentivised and able to maximise their returns.

Compounding this, Arrow noted that medical care, like most professional services, is almost purely an information economy insofar as it relies upon professional training and expertise.³ This means that consumers know neither the value of potential care nor the cost of assessing that value. This may be identified as an important role of third-party mediators, such as insurers.

From there, Arrow identified issues which are peculiar to the medical services market and which have bearing on the capacity to develop a market for risks. These include:

- The uncertainty of individual demand, which in turn means individuals cannot effectively value medical care in the household budget. An important corollary to this is that there is no propensity to accurately value the

² Kenneth J Arrow, "Uncertainty and the Welfare Economics of Medical Care", *The American Economic Review*, 1963 (53:5), pp.941-73.

³ Arrow, "Uncertainty", p.946.



protective benefits of health insurance: typically, any expenditure in a year of good health is seen as overpriced;

- Historically, it has been assumed that the ethics of medical care providers are different from those of business people in general. The effect of competition and other economic incentives depends upon the objectives and motivations of health care providers. Studies have shown that both preferences for net



income and the health outcome or utility for a patient impact physician and provider responses.⁴ How these factors are traded off is a key source of variation in pricing and other behaviours;

- Medical care has a unique dimension of product uncertainty. Leaving aside normal buyer-seller information asymmetry, there is particular uncertainty as to the consequences – rather than simply the quality – of medical services. As an illustration, two people presenting the same disease to the same physician, and receiving the same treatment, may experience radically different outcomes;
- Highly rationed supply of core intellectual property or medical expertise. This is particularly difficult to alter given the timeframes for specialist training, although professional migration may ameliorate this when not subject to unreasonable restrictions. The consequence of this is that all payers in the ‘market’ (governments, insurers, private individuals) are to a greater or lesser extent price takers. Noting the prior observations, they are price takers for a service whose value they cannot assess in any case; and,
- Extensive price discrimination, typically by the patient’s perceived capacity to pay. This is most visible in out-of-pocket (OOP) costs charging in Australia.⁵

What is clear from this analysis is that there are multiple departures from the standard competitive model in which an efficient market would form. In particular, the barriers to entry for suppliers make individual purchasers price-takers. A similar phenomenon occurs with respect to the intellectual property attached to medicines and devices given that, as these become more technologically complex and the costs of health technology assessment (HTA) and associated approvals increase, the barriers to competition continue to rise.

The consequence of this is what economists call ‘non-marketability’ of individual health risk: that an efficient and informed market cannot form between consumers and suppliers. This is the problem that both social and private health insurances seek to address. Along with the need to provide a safety net for poorer Australians, it is a key reason why the universal Medicare and public health systems were established.

Taking this all into account, the central distinction which this paper then seeks to make is between:

1. Rules and structures which are necessary to, or which have value in addressing the limits to formation of a traditional market, particularly those caused by information asymmetry. These will have the desirable effect of increasing aggregate welfare;
2. Those which have been imposed to address specific problems in an imperfectly designed system and which may contribute more inefficiency of the health market than they resolve; and
3. Gaps in the composition of rules which in turn drive inefficiency, for example, when one party to a contract is constrained and the other is not. This particular problem is addressed in tabular form below.

The purpose of insurance is to provide a method of risk sharing and financial settlement where a direct market cannot efficiently arise between multiple buyers and sellers (as is apparent in healthcare). The overriding question is therefore whether Australia’s regulatory structure addresses the market limitations of healthcare via insurance or

⁴ Anthony Scott and Peter Spivey, “Motivation and Competition in Healthcare: Melbourne Institute Working Paper No.5/17”, Melbourne Institute of Applied Economic and Social Research, 2017. ⁵ Arrow, “Uncertainty”, pp.948-54.



simply reallocates them from individuals to private health insurers. This question informs the thinking in the remainder of this paper.

The subsidiary questions which follow from this then become:

1. Are the necessary rules balanced, which is to ask whether the interventions to address market asymmetries apply to all participants;
2. Do they address fundamental challenges to the marketability of health risk as described above, or do they simply address cumulative inefficiencies in the regulatory environment? Another way to ask is whether they are appropriately flexible to a changing demographic and economic landscape; and
3. How might removing or changing one rule affect the others?

Contextually, it is also important to consider to what extent a ‘greenfield’ approach might be taken to private health insurance. Political constraints mean that some level of grandfathering would be necessary for current participants and challenges exist in running parallel systems. The effective amnesty prior to the introduction of Lifetime Health Cover is instructive here.

The problem, looking to history, is that political considerations have meant radical action has only been taken when insurance systems are close to collapse. While the PHI system at the moment is certainly stressed, reports of its demise are at the same time premature. As a general observation, regulatory change is most efficient when it is preventive, rather than corrective, and the costs of leaving action until it is unavoidable will be much higher than investing to stabilise PHI at the moment.

Are non-marketability problems specific to healthcare?

The non-marketability of individual health risk – due to its profound information asymmetries and the market conditions described above – is the principal argument for a third-party manager of risk.

In a broad sense, this is no different from other insurances. Information asymmetry exists in relation to the capacity to calculate the probability and probable cost of dying or crashing a car and, consequently, this risk is typically insured. However, the costs of remediating those events are either capped, as in the case of life insurance or subject to normal competitive pressures, such as in the case of motor vehicle repairs.

What is peculiar to private health insurance (PHI) in Australia is that insurers face many of the same information asymmetries and competition limits as an individual. While there are certainly fundamental insurance benefits in PHI, which stem from grouping and actuarially managing risk, PHI funds remain in many cases price-takers for their own payments, with any discounts limited by professionals’ willingness to treat and by default rates for hospital compensation amongst others, while fund members are unclear about their exposure to risk due to variable OOP costs.⁶ This is in part due to regulatory and underlying Constitutional limits which prohibit the contracting of doctors.⁷

⁶ This is predominately due to the prohibition on forcing doctors to provide services at a capped price. See: [https://en.wikipedia.org/wiki/Attorney-General_\(Vic\)_ex_rel_Dale_v_Commonwealth](https://en.wikipedia.org/wiki/Attorney-General_(Vic)_ex_rel_Dale_v_Commonwealth) Accessed June 2021

⁷ Section 51(xxiiiA) of the Constitution provides that the Commonwealth can pass laws for the peace, order and good government of the Commonwealth with respect to “*The provision of maternity allowances, widows pensions, child endowment,*



unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil

conscriptio), benefits to students and family allowances”. This power is limited in that civil conscription in relation to the provision of medical services is prohibited and it has been argued, and largely accepted, civil conscription extends to any compulsion on a medical practitioner in relation to the provision of medical services.

Sharon Scully, “Does the Commonwealth have constitutional power to take over the administration of public hospitals?”, Research Paper 36 2008-09, *Parliamentary Library*, 30 June 2009.

This latter point contributes to the undermining of the perceived value of health insurance. Because consumers have incomplete understanding of their future demand for and financial liability for healthcare, it is too easy for them to discount the protective benefits insurance (even at an inefficient price point) gives them. While costs are unpredictable, they would be more wildly unpredictable without the presence of PHI.

In contrast, when purchasing vehicle insurances, individuals are fully informed about any costs for which they may be personally responsible through the operation of excesses. This may be regarded as similar to a co-payment for health insurance. However, despite private health insurers’ best endeavours to work cooperatively with preferred surgical and other specialist suppliers, private health insurers are unable to fully specify or contain the level of co-payments.

Once the issue of price discrimination is included, the problem increases. This is because:

- As income rises, the public subsidy for PHI membership – the PHI Rebate – reduces;
- At the same time, medical practitioners may increase their fees to reflect greater capacity to pay; and
- As these move in opposite directions, net household income is doubly affected by health costs, which PHI is supposed to cover. This means particularly that for higher income earners, the normal economic expectation that the value of PHI in the household consumption function (household budget) will increase with income is eroded.

Consumers will inevitably feel this in terms of reduced perceived value of insurance, not least because it behaves differently from other insurances they routinely purchase.

Is Community Rating also a problem?

A further issue peculiar to Australian PHI is the requirement for community rating of health insurance. Importantly, this does not mean every consumer pays the same premium. What it does mean is that:

- Each fund can offer multiple policies with different levels of cover, typically hospital cover with specified exclusions; but,
- Each of these policies must be offered at a single price, regardless of the characteristics of individual consumers, which in turn means there is no price discrimination according to:
 - Individual characteristics, such as gender, age, disability, marital status or similar; ○ Health conditions, including smoking, obesity, chronic diseases or those in high-risk occupations; or ○ Prior use of insurance, e.g., previous surgery or hospital admission for chronic disease.



The only price discrimination options are:

- On geographic grounds where the same policy can be sold at different prices in different states but must still be available to all eligible individuals within each state at the same price; and

https://www.aph.gov.au/about_parliament/parliamentary_departments/parliamentary_library/pubs/rp/rp0809/09rp36 Accessed July 2021.

- The modest variation in discounting rules, which assist funds in competing for new customers (24% if new to fund, compared to 12% otherwise).

The consequences of this – particularly in an ageing population – are a form of intergenerational inequity where younger, healthier consumers – if they wish to cover their health risk in the insurance market – are required to compensate older consumers. There is a natural assumption that this balances out over a lifetime although this is compromised by a number of factors. The inexorable increase in health costs – reflected in premium prices - above inflation magnifies this inequity year on year.

The principal benefit of community rating is that it makes health insurance affordable to many who would not otherwise be able (should they, for example, be alternatively rated according to their health risk profile) to access it and, in doing so, takes pressure off the public health system. This is a significant part of the policy justification for the PHI rebate, in that there are both private and broader economic benefits from reduced waiting lists. However, this is a public policy benefit which suffers from cost-shifting to consumers as:

- The cross-subsidy (intergenerational inequity) is borne by private consumers;
- While the PHI rebate subsidises the premium costs of older consumers, it subsidises the community-rated price rather than the real cost of their insurance. This is a compounding problem in that:
 - It makes insurance relatively cheaper for those who contribute more to expenditure demand (and therefore increases the problem of adverse selection); and
 - In contrast, penalises those who are already being required to pay too much for their insurance.

When combined with means-testing of the rebate,⁵ the latter point intersects with the observation above regarding price discrimination, insofar as:

- Those who are younger, healthier and have higher incomes are not only paying higher premiums, but those premiums exceed expected cost (or value); and
- At the same time, supplier price discrimination leading to greater OOP costs for those perceived to have the capacity to pay more further decreases the experienced value of having insurance.

For the most part – and *ceteris paribus* – this is a technical argument which supports the Medicare Levy Surcharge

⁵ The steepness or bracketing of the means test is an area where the rebate might be refined.



(MLS) which rises with income and provides an incentive to purchase insurance regardless of perceived value.⁶

The problem which stems from community rating is the issue of adverse selection: that those who expect to use insurance more are more likely to purchase it. This is a form of information asymmetry on the buyer side of the equation, where there are relative differences in risk which cannot be fully calculated.

The seminal work on this problem in modern health economics is from Cutler and Zeckhauser who first described the ‘adverse selection death spiral.’⁷ This is initially described as a situation in which there is still risk-rating, but

consumer selection still leads to adverse selection. It is worth noting that this is typical to some extent of all insurances and is partly an effect of competition.

The authors of this paper identified three inefficiencies which arise from adverse selection as follows:⁸

1. Prices to participants do not reflect marginal costs – higher for some, lower for others – so individuals select the wrong policies. It is important to note that price is not an efficient indicator in the selection of policy, as very different sets of inclusions and exclusions may deliver the same price;
2. The desirable risk spreading which is the purpose of insurance is lost to some extent. This is obviously even more so the case with community rating; and
3. Some insurers manipulate their product offerings to attract/preference healthy customers.

The last of these is an example of positive selection, which is the sell-side version of adverse selection in insurance.

There is evidence of this type of behaviour amongst certain Australian health insurers whereby policies are designed which are more likely to be attractive to younger people and can therefore be ‘group-rated’ without violating the community rating requirement.

This is a short-term approach to maximising returns but it does not really optimise plan allocation. To take an example of such behaviour:

- A product which excludes joint replacements may be very unattractive to older Australians and therefore may be priced to the general risk of a younger demographic; but,
- This is individually inefficient in that the cost of such surgery – or the delay in waiting for public treatment – may be catastrophic for a younger person, affecting work and potentially leading to early onset of chronic health conditions. This is the type of low probability, and therefore across the group low cost, intervention which should be insured against; and

⁶ The usual unreasonable claim may arise here that the MLS is a form of countervailing subsidy. It is well-understood that the MLS is designed as an incentive, operating for the consumer as an opportunity cost and for the Government as a partial compensation for increased risk of demand for public health. There is no charge to the Treasury from those who take out PHI.

⁷ David J Cutler and Richard M Zeckhauser, “Adverse Selection in Health Insurance”, in Alan M Garber (Ed.), *Frontiers in Health Insurance, Volume 1*, National Bureau of Economic Research, 1998, p.8.

⁸ Cutler and Zeckhauser, “Adverse Selection”, p.2.



- The economic benefits of participation and general reduction of health burden from providing this treatment to a younger person are much greater than those for an older Australian.

This form of gaming of the community rating standard is therefore undesirable. It is likely only to affect participation and premiums at the margin as it is only a limited proxy for community rating.

A further problem with subgroup rating is that the more groups that exist, the greater the opportunity for adverse selection to occur as members take advantage of inefficiencies in pricing and product design. Insurance generally increases in efficiency as the number of participating consumers increases. The effect of separating them into differently priced cohorts leads to asymmetries between price and perceived value for high-demand consumers with specific needs. This erosion results in reduction in premium income to cover that same risk, as the healthy risks reduce cover and their subsidy for the non-healthy risks.

Other solutions to the adverse selection challenge or solutions which dilute its effect are likely to be more efficient.

Don't exemption periods and Lifetime Health Cover address these problems?

It should be noted here that other factors, such as the prevailing rate of Medical Levy Surcharge affect policy selection: this issue is discussed separately below.

Both waiting periods for certain services and the Lifetime Health Cover (LHC) loading increase the ratio of cost to expected return for new entrants to PHI. Waiting periods are a blunt instrument which increase cost for those with pre-existing health conditions. LHC is a progressive cost which seeks to compensate for the inequity borne by those who join health funds at earlier and healthier stages of their lives and who must pay for the costs of those who join later.

However, these do not principally address adverse selection. More generally, they seem to act against free rider problems: in this sense, they are catch-up costs for those who opt out of PHI until they think they will need it whereas the adverse selection problem is one of a more general phenomena that people with poorer health are more likely to participate in health fund membership. It is the temporary nature of these costs which distinguish them.

It might be further argued that these measures increase the adverse selection problem. The logic of this argument is threefold:

1. LHC and waiting periods are intended as incentives to consumers for early participation in PHI;
2. However, they have a converse effect of acting as a stumbling block to those who may wish to purchase PHI later in life, e.g., because their income has risen, but for whom the delayed value (waiting period) or increased premium (LHC) discourages; so
3. There will be a greater proportion of those entering later who place a higher value on PHI because their health is worse than the average, thereby distilling the adverse selection problem.

This is not in itself an argument against either of these instruments but other solutions are required to address adverse selection.



Would premium competition solve sustainability problems?

Under the current rules, the Australian Government must approve average premium price changes for each fund, on an annual basis. The three principal effects of this are:

1. It constrains the profit-maximising goal of participants in private markets. Given Arrow's view of market limits for healthcare – and particularly the information asymmetry problems – this is not unreasonable; but
2. In doing so, it also limits capacity for innovation as central price-setting crowds out competition in the market. This is not a limit on the 'innovation' of product design but rather a reduction in the capacity of firms to allocate capital to inframarginal improvements, such as longer-term investments in preventive medicine; and
3. It has a (unintended) consequence of increasing the prudential deposit requirements of PHI funds, as there is no capacity to vary premiums throughout the year. This is an inefficient use of capital which might otherwise be invested, and the opportunity cost of this must be borne within the fund, and therefore ultimately by consumers and the Federal government via the rebate.

The requirement to approve and manage premiums at the Federal government level is a political constraint. And it is a particularly unproductive one, in that it tends to only ever increase criticism of the responsible Minister, and consequently unduly politicise PHI.

Equally, there is no doubt that there is for many consumers a growing gap between pricing and perceived value in health insurance. This is particularly clear from data around downgrading of policies, which shows that healthier members see insufficient value in full cover at the prevailing price. This view is reinforced by annual 'bad news' coverage of the average premium increase, however modest. If such coverage were accompanied by a proper dissection of the underlying health inflation (demand increases and supply prices) it might be more benign, but this is likely too much to hope for.

It should be noted here that one consequence of the current market pricing arrangements is substantial annual downgrading after the annual premium increments are approved, which means that the actual mean rise will be less than the announced increase.⁹ Worryingly, this is unlikely to capture the full measure of consumers' dissatisfaction with PHI value as the MLS will prevent a certain number of those who may otherwise abandon health insurance entirely from doing so.

What about hybrid price regulation?

Evaluate is of the view that the current model of central price setting is fundamentally inefficient. While there is an argument – stemming from the non-marketability of health risk – that competition will be limited in offering consumers reasonable prices, other non-fixed and highly asymmetric markets suggest that the competition between a reasonable number of large funds will be effective in driving down prices. Superannuation is a good example here. Nonetheless, removal of central price setting is likely to present too high a political cost. Therefore, it is proposed that two options might be investigated in greater detail:

⁹ <https://actuaries.asn.au/Library/Miscellaneous/2018/DriversOfPremiumIncrease.pdf>, p.5. Accessed May 2021.



1. Reallocation of responsibility for price-setting to a suitable competent authority, ideally to APRA, who are already well-prepared to analyse PHI data. This would at least mean the price regulation reverts to some fixed rules and reduces the risk of caprice due to political pressures on the government of the day. As with products such as electricity and telecommunications, or price-capped products such as third-party motor vehicle insurance, this would mean the most competent regulator (in this case APRA) would set premium variations according to a set of rules, unencumbered by shorter-term political considerations. Importantly, it would align the public policy goals of insurance affordability and prudential regulation, rather than placing them in competition with each other.

It is important here to note that such regulation would be limited to the premium paid by consumers: there is no merit in extending general regulation of the price interactions of PHI funds, particularly with respect to suppliers, as the effect of this would be protectionist, and present no benefit to fund members; and,

2. Variation to permit repricing during the year to address changes in costs. This would smooth out lumpy intrayear health inflation and would allow for more efficient allocation of fund investments. In practice, this would involve:
 - a. Starting prices agreed for the year; and

-
- b. A set of rules to permit variation (essentially change to cost-basis of particular products).

This is not a simple change. However, it would lead to a more organic (rather than stepped) change in premium prices between years, and the data underlying price variation during the year would be invaluable in setting the starting price for future years.

This option requires further research and modelling.

Is PHI under the current model a source of health price inflation?

The recently updated Grattan Report identifies a range of items and services covered by PHI which contribute to a higher than necessary price for those accessing private health care, including: some excessive OOP surgical costs; exceptionally high prostheses prices (by global benchmarks); unnecessarily lengthy hospital stays; and low-value care.¹⁰

These are reasonable criticisms, and – via departure of healthier members - indirectly add to the phenomenon of adverse selection described by Cutler and Zeckhauser. While Evaluate concurs with much of the Grattan critique, the inclusion in its recommendations that the Federal Health Minister should resist premium rises has the potential to reduce sustainability of PHI rather than enhance it. This is because PHIs have limited capacity to control input prices, prostheses prices and low-value care providing two examples. The alternative view would suggest that PHI fund managers prefer increased adverse selection which, even in the short term, defies logic.

¹⁰ Stephen Duckett and Greg Moran, “Stopping the death spiral: creating a future for private health”, Grattan Institute, 19 May 2021. <https://grattan.edu.au/report/stopping-the-death-spiral/> Accessed May 2021. ¹⁴
<https://www.theaustralian.com.au/nation/new-start-is-needed-for-health-insurance/newsstory/d42dd0db157e8f1fb2078435d932a4f6> Accessed May 2021.



Equally, the suggestion that the MLS causes consumers to choose lower-value policies cannot be substantiated.¹⁴ The more credible conclusion is that, if consumers are choosing cheaper policies in order to avoid a tax penalty, without the existence of the MLS their preference would be to not purchase insurance at all.

However, it is fair to argue that any savings from reducing supply costs in PHI might be delivered to consumers through premium reductions as the health insurers have committed in various rounds of government reforms. In turn, insurers should benefit from increased participation which, at current margins, should increase profits.

There is a complementary consideration here as to whether governments should reduce the PHI rebate accordingly. Evaluate's view here is that, given the public subsidy for PHI is more efficient than buying the same care in the public health sector, it would be better to maintain the total cost of the rebate and allow the full benefits of reduced costs to flow to consumers. This has the additional benefit of being consistent with the regulatory imposition of community rating and will maximise medium-term sustainability.

One question which emerges here is whether it is PHI which is driving health inflation in Australia's private sector. There are at least four potential answers to this, including:

1. In a private market with price discrimination, it is likely that uninsured consumers would be asked to pay a lower price than the current aggregate of PHI and OOP costs. This is both because: in the absence of PHI, total private demand would fall; and because, without insurance, the expected capacity of the individual to pay would be lower;
2. The observation that because public expenditure at the margin is more efficient than direct expenditure in the public health system,¹¹ a fixed budget which includes PHI will increase overall demand, which – given supply constraints – should be at least somewhat inflationary;
3. Similarly, incentives such as the MLS which move people out of the public health system into private care will further increase demand, particularly in diagnosis-related groups (DRGs) which are dominated by private supply, such as prostate treatment, some mental health services; but
4. Any inflation which is caused by the addition of private insurance to the market is proportionate to the rules which govern the operation of the product.

Looking to the last point, if the factors typically identified – and well-described by Grattan – are considered, a series of critical asymmetries may be identified as follows:

- While the prices of insurance products are regulated according to cost of goods supplied, there is no corresponding test for the items supplied to consumers and funded via a combination of PHI and OOP costs. This results in both PHI funds and insured consumers being price takers, which is incompatible with both capped prices and constrained household budgets.¹² It is a curiosity that policymakers see value in capping

¹¹ See Alastair Furnival et al, "The Relative Efficiency of the Private Health Insurance Rebate v. Direct Public Health Expenditure", Evaluate Consulting, 2017.

¹² As discussed above, price discrimination means that the benefits of premium price capping are greater for some consumers than others



PHI prices to any increase in charges to funds, while taking limited interest in the total cost of healthcare to the consumer (including OOP costs)¹³;

- This is compounded by a series of rules which limit funds' capacity to discriminate on purchases, including:
 - The Prostheses List itself, which guarantees an oligopoly for these items. Once items are added to the List, funds are forced to pay for them and are not able to request a substitute if a relevant procedure is covered by a consumer's policy;
 - Because physicians, surgeons and other specialists are the sole prescribers of care, the fund cannot identify any activity as being of inadequate value; and ○ The default price for private hospitals.

The key takeout here is that health inflation occurs in all of the underlying costs covered by PHI, because there is either no appetite or no legal capacity to constrain these prices.

The counterpoint to this issue of health inflation is elasticity of supply. It is assumed given the fixed supply of professional services that this is insignificant and, in the case of accommodation, any reduction should be associated with better allocation of care.

The set of rules governing PHI are outlined in Appendix One. It is worth emphasising three peculiar consequences of these rules. The first of these is that, whereas the supply of professional medical expertise is constrained by training limits and registration policies,¹⁴ the supply of hospital accommodation and associated services is not. Instead, it operates in a comparatively free market, where cost of capital is the principal governor.

Because States are responsible for licensing hospitals and PHI funds must pay at least a default rate to any approved hospital,¹⁵ there is a strong incentive to build more capacity and to maximise the number of patients for a minimum number of professional staff. In the main, hospital operators are indifferent to MBS and OOP medical fees and practitioners are viewed principally as sources of custom. This means that, if the ratio of customers to practitioners can be increased, then total hospital income increases accordingly.

This approach is visible in the growth of services such as drug and alcohol treatment, eating disorders, admissions for the treatment of anxiety and depression, and in-patient rehabilitation. These require both minimal professional attendance and minimal facilities given that no surgical procedures are involved. There are a range of views on the extent to which these services are strictly necessary or are poor and expensive substitutes for community treatment but, while the current rules are in place, their provision will continue to grow.

As such, second tier default benefits are a driver of investment in low-value care, because floor price is fixed, whereas supply is unconstrained.

The second perverse aspect of PHI supply pricing is found in the Prostheses List. Leaving aside the comparatively high prices paid for these items in Australia, technically it is only the use of health insurance which guarantees these fees.

¹³ As noted earlier, this disparity is likely an artefact of the inability to directly constrain medical pricing

¹⁴ This includes MBS access, which is the primary limitation to supply growth by immigration or overseas training.

¹⁵ The Second Tier Default Benefit



In theory, an uninsured patient having a knee replacement could negotiate the price of their prosthesis but, if they are insured, this is not possible and the listed price must be paid by their insurer.

The 2020 book *Deaths of Despair* provides a comprehensive example of what happens in a real-world market when Arrow's arguments about asymmetry are ignored. In this work, Professor Anne Case and her Princeton Colleague - the 2015 Nobel laureate Angus Deaton – describe a market where there is no supply price constraint, no community rating and no limit to the debt which can be incurred by those in the US health system.¹⁶ This is a practical illustration of what happens where there is *inadequate* regulation to address the non-marketability of healthcare.

Looking at the Australian system through this lens and noting that neither this paper nor the above authors are suggesting moving towards a US managed care system, it can be observed that many asymmetries have been corrected, not least by our systems of regulated insurance pricing and community rated access to care. However, at the same time, Australia has exceeded the US in some areas, particularly in prostheses where putting a floor on prices has freed importers from market pressures while presenting a new problem to insurers and consumers.

This brings us to the third peculiarity of the Australian system which is that governments, who regulate private market insurance pricing and consequently benefit from the capacity to budget more frugally in the public system, would not tolerate the supply rules in public hospitals that they enforce in the MBS. This is demonstrated by activities such as:

- The tender system used in the public health system to put downward pressure on goods, including prostheses, and which resulted in much cheaper procurement. This is achieved without noticeably worse outcomes, and in some cases with measurably better outcomes;
- State governments and their Local Health Networks (LHNs) selecting hospital service suppliers rather than being forced to compensate any registered provider; and

-
- The exclusion of low-value care in the public health system through a DGR-based system of rationing.¹⁷ In practice, this is a form of risk-based managed care in the public system, even though the premium is nominally an independent artefact of the tax system.

In practice, the ability to directly negotiate with suppliers rather than to do so with externally-set and artificial price limits permits the public sector to engage in regular comparative benchmarking of prices, which is more akin to a normal market.

Having private health insurance ensures that insured patients do not face the waiting lists prevalent in the State and Territory health systems. The full benefits of this are difficult to quantify, but there are also externalities from

¹⁶ Anne Case & Angus Deaton, *Deaths of Despair and the Future of Capitalism*, Princeton University Press: Princeton, 2020.

¹⁷ In this system, the allocation of medical expertise is rationed in two ways: by priority for certain conditions (DRGs); and further by priority for certain patients within those DRGs. The introduction of activity-based funding, which in part sets prices according to value, presents an external set of incentives for the design of this rationing.



individual and group investment in private care which are consumed both by individuals who experience shorter waiting times in the public system, and by the economy as a whole.

However, this key difference between private and public care leads to an important distinction in the question of reducing low-value care which is that, as a guiding principle, low-value care is that care for which insured consumers should not need to wait because it does not present sufficient value to be provided at all. The conclusion here is that, to the extent PHI is at all inflationary, it is because current settings fail to allow constraint in the growth of low-value care.

Is inpatient care an unnecessary limitation?

Historically, PHI has been restricted to admitted care, because: this provides the benefit in terms of State and Territory public waiting lists; but removes the inflationary risk of gap insurance for primary and outpatient care.

It is commonly observed that the inability for private health insurers to pay for treatment delivered outside a hospital removes their capacity to offer members lower-cost but equally effective substitutes. This is true but, understanding the extent to which this might affect care choices, costs and ultimately premiums, requires investigation of three questions:

1. The extent to which customers/patients and GPs/specialists might have preferred clinically-appropriate treatment in the home or community but are limited in their choice due to the inability of private health insurers to pay for patient care in these settings. This is the base rate of any prospective substitution;
2. Patients' awareness of options. There is likely to be a strong view that, due to the historical limits of PHI, hospital admission is a normal practice for any insured care. It is worth noting in contrast however, there will be a certain cohort – particularly post-COVID – who will want to avoid any hospital admission at all;
3. Removal of any incentives which might compromise the strictly professional preferences of health care providers. These may be financial incentives but are more likely to be involve preferential access to operating theatres or other hospital facilities when required, and the capacity to consult with the majority of patients at a single site; and
4. The clarity that any funding of outpatient care should only be as a substitute for admitted care, rather than an addition.

Evaluate is of the view that most of the savings in this space are likely to take place in residual accommodation, which may be defined as including both:

- Continued hospital stay after necessary urgent admission, for example for rehabilitation which could occur in an outpatient setting; and
- Initial admission for activities which can be equally effectively provided in community settings (e.g. mental health, including drug and alcohol, treatment).



As well as the potential savings, there are consumer benefits from such activities as rehabilitation, chemotherapy and dialysis in the home. These are predominantly about psychology and happiness, but the reduction in risk of nosocomial infections is also important.

The international evolution of tertiary care suggests that at least initial admission in day surgeries remains normal practice and there is a compelling argument that proximity to emergency facilities remains crucial for many DRGs. However, there will be resistance to replacing overnight admissions and longer stays with day surgery and this will require an incremental approach.

Being able to fund services such as mental health interventions in the community will remove what is effectively gaming, particularly the medicalisation of such activities as group drug and alcohol counselling which do not necessarily need to take place in an admitted setting. However, the replacement of specialist care with alternative options in allied health care will need to be considered on a case-by-case basis.

A key conclusion here is that much of the gaming described takes place because of the restriction on outpatient funding: if PHI were able to be applied more efficiently to outpatient services, some of the capital invested in unproductive accommodation would likely flow to such services.

What else might be done about low-value care?

In principle, it is desirable that the prescription of medical services, including hospital admission, surgical and other treatments, should be left to the expertise of appropriately trained and experienced professionals.

In practice however, the market incentives which prevail in the absence of a price-regulated supply side mean that allocation of care expenditure is not *purely* driven by medical outcome. At the same time, there is no short-term incentive for medical practitioners working within the private system to have regard to the cost of any procedure.

Again, this situation may be unfavourably compared to aspects of the public system which insist on pricing according to value, an example of which is the Pharmaceutical Benefits Scheme (PBS). At its heart, the PBS uses a comparative value model based on incremental cost-efficiency ratios (ICERs) to decide at what price a new market entrant may be compensated by the Government.

However, and more significantly for comparison with PHI, the PBS limits total cost growth by rationing some expensive products according to value for individual patients. Biologics, such as Humira for rheumatoid arthritis, require not only evidence that an individual patient suffers a sufficiently high level of inflammation, but that other, less expensive medicines have previously failed to address this. This serves to reduce unnecessary expenditure and avoid what would otherwise represent low-value care.

At the same time, a large proportion of PBS pricing agreements include risk-sharing between the manufacturer/importer and the government, to limit the impact of higher-than-expected demand. Risk-sharing is a tool which could also be used to manage costs either between PHI and suppliers, or more likely between funds and hospitals.

It is acknowledged here that what constitutes low-value care is a complex question, and one which is best guided by qualified medical practitioners: this acknowledgment is incorporated into recommendations below.

The standard approach to the low-value care problem in overseas insurance markets is via some form of managed care. Managed care typically involves three interlinked approaches to cost management as follows:



- Contracts with a limited number of care providers, who provide certain interventions for agreed diagnoses at fixed prices. This approach – where the insurer can choose to contract with specific providers – allows suppliers and insurers’ interests in cost containment to be aligned;
- Insurance models with individual risk rating, which allow insurers to be involved in decisions as to whether proposed interventions represent reasonable value for individual patients; and
- Substantial co-payment arrangements, which substitute for OOP costs but are:
 - Known in advance; and
 - Part of the contract for total costwith contracted providers.

Some observations as to the limits of Australia’s social compact are necessary here. First, community rating, which is at the heart of PHI in Australia, represents an inalienable element of the public good of health insurance even where it may be refined as noted above.

Second, there is a substantial infrastructure of private hospital supply in which investments have been made in good will and under current arrangements. Managed care as it is generally practised overseas would represent an excessive rebalance between the interests of insurers and suppliers and, rather than simply addressing the problem of PHI funds being price takers, would simply upend this and make suppliers price takers instead.

Some contracting does of course occur in Australia already. In the case of hospitals however, the default rate of payment erodes any basis for proper negotiation as insurers can neither negotiate a market price nor walk away with no cost.

With respect to health care professionals, preferred provider arrangements work reasonably well, particularly where the insurer agrees to a market rate which obviates all OOP costs. While this is purely a voluntary agreement for clinicians, Evaluate is aware that it is still gamed at the margin – for example with ‘booking fees’ – and there is imperfect transparency with this arrangement. This should be addressed through improved reporting and oversight between insurers and practitioners, however, and does not require regulatory intervention.

However, several options might draw on the approach of overseas jurisdictions, and these are outlined below. Each would benefit from further investigation.

Private Health Insurance: the economic impact

The Australian Government has long provided support to the private health insurance sector, demonstrating their long-term view of the value that the sector delivers to Australia, both in terms of our health system and its economic impact.

The economic impact of PHI might be expressed in several ways as follows:



1. The scale of the PHI sector itself, and the services it funds, in terms of turnover¹⁸ and employment, though this may fail to properly consider the alternative consumption of inputs in the absence of PHI funds. This requires calculation of specific multipliers as these are no longer published by the ABS;¹⁹
2. The amount of healthcare which is purchased, which would otherwise need to be provided by the public system in order to maintain waiting lists at current levels. This is captured in data by the Australian Prudential Regulation Authority.²⁰ While this is efficient in terms of government expenditure,²¹ it may lack some efficiency in terms of total expenditure. Importantly, replacing public with private expenditure would incur an increased deadweight loss through the marginal excess burden of taxation (which means the cost of public care to the overall economy is greater than the actual taxes allocated to pay for it);
3. The broader economic benefits of providing this healthcare, which include:
 - a. Actual economic activity benefits in terms of employment, taxes and other consumption;
 - b. The capacity of individuals and their carers to productively participate in the economy, either in the formal or informal labour markets due to better health. This uses standard healthcare expenditure multipliers, which are qualitatively different from more general activity-based input-output (I-O) multipliers;
 - c. Reduction in demand for other services due to provision of healthcare. These would variously include:
 - i. Formal and informal care associated with continued illness or disability if it were not remediated via care funded by PHI;
 - ii. Consumption of alternative primary care supports funded by government or individuals, which would also be displaced by care funded by PHI; and
 - d. Privately consumed increases in health-related quality of life (HRQoL) due to alleviation of discomfort and disability, and reduction in uncertainty regarding future health state.

The last of these is notoriously difficult to calculate as it is both subjective and individual. It will require greater depth of investigation than is possible in this paper. The other elements are generally easier to calculate on a per-DRG basis as they are compared to reduction in burden of disease by category. This would be a useful exercise for further investigation.

¹⁸ See for example the Australian Prudential Regulation Authority's March 2021 *Quarterly Private Health Insurance Statistics*, published 18 May 2021. <https://www.apra.gov.au/sites/default/files/2021-05/Quarterly%20private%20health%20insurance%20statistics%20highlights%20March%202021.pdf> Accessed May 2021.

¹⁹ For a discussion of this argument, see:

<https://www.abs.gov.au/ausstats/abs@.nsf/Previousproducts/5209.0.55.001Main%20Features4Final%20release%20200607%20tables> Accessed May 2021.

²⁰ APRA, May 2021.

²¹ See Alastair Furnival et al, "The Relative Efficiency of The Private Health Insurance Rebate v. Direct Public Health Expenditure", 2017. <https://www.evaluate.net.au/reports-feed/the-relative-efficiency-of-the-private-health-insurance-rebate-v-direct-publichealth-expenditure> Accessed June 2021.



Data Sources

Evaluate has reviewed a body of literature on health insurance activity and impact and will provide a list of sources separately.

The principal data sources on which any measurement of the impact of health insurance will rely include:

- Australian Prudential Regulation Authority data on health insurance membership and financial performance;²²
- Aggregate and delineated health expenditure from the Australian Institute of Health and Welfare;²³
- Information on PHI by income, including MLS and LHC statistics, from the Australian Taxation Office;²⁴
- Broader coverage data by demographics from the Australian Bureau of Statistics;²⁹ and
- Various historical inquiries regarding costs and benefits between the public and private system, for example, from the Productivity Commission in 2009.²⁵

Each of these and other sources, both Australian and international, provide data which will be useful for specific modelling around the various concerns and recommendations raised in this paper.

Calculation of Economic Impact (1)³¹

Public and private expenditure in the health care sector, through capital investment or recurrent expenditure, contributes to the Australian economy both directly and through flow-on impacts on the activities of other industries. These impacts are measured by economic multipliers.

Such economic multipliers, if used wisely, can provide policy makers and planners with estimates of the employment and income that will result from new economic activity. This can allow alternatives to be compared more effectively, by recognising all the benefits of an investment. Note, these economic multipliers do not measure the behavioural impacts on the economy of health investments – such as the increased productivity and participation – that may arise from health investments.

The economic impact of investment in the health care sector can be measured through three sets of multipliers as follows:

²² <https://www.apra.gov.au/statistics> Accessed May 2021.

²³ <https://www.aihw.gov.au/reports/australias-health/private-health-insurance>.

²⁴ Supplied.

²⁹

<https://www.abs.gov.au/ausstats/abs@.nsf/7f9c63244d12d1d0ca257090001cd4cc/f4c561feb0dd3283ca256bd00026927b!OpenDocument> Accessed May 2021.

²⁵ <https://www.pc.gov.au/inquiries/completed/hospitals/report> Accessed May 2021. ³¹

Evaluate is grateful to Dr David Cullen for input into this section of the report.



- output multipliers – these measure the impact of additional investment and expenditure on the output of industries to the economy;
- income multipliers – these measure the additional income earned by households because of additional investment and expenditure; and

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- employment multipliers – these measure the additional employment that is expected to be generated because of additional investment and expenditure.

Each of these sets of multipliers has the following components:

- the initial effect – an initial extra output of the health care sector, and related employment in the sector to produce that output;
- a production induced effect – which combines:
 - the first round effect – the amount of output and employment required from all industries that supply goods and services to the health care sector in order for it to produce the initial extra output;
 - an industrial support effect – the induced extra output and employment from all industries to support the production of the first round effect; and
 - a consumption induced effect – the subsequent inducement for extra output and employment due to increased spending by the wage and salary earners in the health care sector across all industries arising from the compensation received for their labour as part of the other effects above.

The past two years do not provide good indicators for the normal operation of the Australian economy. However, input and output multipliers are relatively stable in Australia, so an indicative long-run set of data has been used. Table Two outlines the multipliers for the health sector.²⁶

Table Two: Australian Health Sector Multipliers

	Initial effects (1)	First round effects (2)	Industrial support effects (3)	Production induced effects (4 = 2+3)	Consumption induced effects (5)	Total Multiplier (1+4+5)
Health care						
Output	1.0	0.3	0.2	0.5	1.4	2.9
Income	0.5	0.1	0.1	0.1	0.4	1.0
Employment	7.3	1.0	0.7	1.6	4.5	13.5
Construction						
Output	1.0	0.7	0.7	1.4	1.0	3.4
Income	0.1	0.2	0.2	0.3	0.2	0.7

²⁶ Derived from data at: <https://www.abs.gov.au/statistics/economy/national-accounts/australian-national-accounts-input-outputtables> Accessed May 2021.



Employment	1.1	1.9	2.0	4.0	3.1	8.2
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It is notable here that construction investment in the health care industry (and for all non-residential construction) is the highest multiplier in the Australian economy. This means that for every \$1 million invested in health infrastructure, there is an increase in economic output of \$3.4 million. While it is difficult to identify the extent to which PHI is directly responsible for new healthcare infrastructure, this is an important effect.

More relevantly, the healthcare services multiplier is 2.9. This means:

- Looking at the APRA PHI report for the most recent normal year,²⁷ total expenditure on healthcare services includes:
 - Expenditure under hospital coverage of \$15,651,112,000; ○ General treatment of \$5,233,707,000; and
 - State (ambulance) levies, which are presumed to be hypothecated to health expenditure of some \$233,634,000.

This represents a total expenditure via PHI for a snapshot ‘normal’ year of \$21,118,453,000.

Table Three shows these data along with their implied effect on total economic output using the 2.9 multiplier.

Table Three: PHI Expenditure 2018-19 (AUD thousands) and Attributable Economic Output

Activity	Expenditure	Output
Hospital Insurance	\$15,651,112	\$45,388,225
General Treatment	\$5,233,707	\$15,177,750
State Levies	\$233,634	\$677,539
Total	\$21,118,453	\$61,243,514

If GDP is a nominal \$1.97 trillion, the total output attributable to PHI is 3.11% of the economy.

Further analysis of these data would be useful on a DRG basis as it would facilitate the breakdown of the economic impact of PHI in relation to higher value of expenditure by impact on health-related quality of life (HRQoL).

Calculation of Economic Impact (2)

The previous section describes the impact of health expenditure in terms of direct and indirect economic activity associated with its provision, which is contribution to GDP.

²⁷ Australian Prudential Regulation Authority, “Operations of Private Health Insurers Annual Report: 2018-19”, June 2019. ³⁴ David J Cullen & Henry Ergas, “Efficiency and Productivity in the Australian Health Care System”, Australian Centre for Economic Research on Health, Australian National University, 2014.



However, the other key question about how health investment affects the economy relates to its impact on GDP growth. The argument here is that healthier citizens are more productive participants in both the formal and informal economies, thus contributing to growth in national output.

What this further implies from an economic perspective is that health – like other social goods such as education – has an investment dimension which complements its expenditure. Formally, it leads to positive externalities, which is to say that not all benefits are consumed by the payer and the patient.

The key datum here is a calculation which identifies health – through both life extension and increase in individual productive capacity, contributes 3.3% of all economic growth in Australia, annually.³⁴ This is on top of standard GDP growth factors such as population growth, increased participation, improved technology and generally increased productivity.

The most recent breakdown of national health expenditure by payer allocates 9.0% of total payments to PHI.²⁸ This in turn implies that PHI is annually responsible for 0.3% of GDP growth.²⁹

This likely underestimates the real effect as OOP costs and other complementary expenditure means PHI is likely responsible for part of the 16.5% private expenditure by individuals.

Two important observations can be made here:

1. This is a matter of productivity effects, not fiscal activity. This in turn means that if the mean cost of overall health expenditure is reduced via broader membership in a sustainable PHI model, or is reduced by removing low-value care, then the same economic growth effects are available at lower prices; and
2. Looking to the future, if PHI becomes increasingly dominated by older and sicker Australians, the increased life expectancy and work productivity benefits will decrease which will reduce economic growth while healthier Australians remain on public waiting lists.

The latter point is particularly significant as it demonstrates that the sustainability of PHI is critical to the sustainability of at least one component of economic growth. Underpinning this is the simple fact that healthier people are more productive.

A sustainable private health sector: principal goals

The PHI reform narrative is complex because the effects of the various rules and incentives described above intersect and create complexity. However, it may be simplified if three primary goals are identified as follows:

1. Membership should be increased and broadened, which is the key to sustainability;

²⁸ <https://www.aihw.gov.au/reports/australias-health/health-expenditure> Accessed May 2021.

²⁹ This is 9% of 3.3%.



2. Instead of pursuing minimum price increases, which will not lead to increased membership, solutions should be sought that will substantially reduce the mean cost of PHI, particularly those which reduce price-taker problems for both consumers and their funds; and
3. These solutions should not undermine the core value proposition of PHI which is that it offers immediate treatment where needed.

As an observation, the value proposition for PHI is shared by both consumers and governments and is that it provides more benefits than costs. For consumers, this involves peace of mind by eliminating uncertainty regarding health care at a reasonable cost. For governments, this involves spending a reasonable share of the health budget to capture a series of economic benefits as described in the model below. If PHI is efficient, it will help maximise both individual utility and aggregate welfare.

It may also be observed that one test of PHI's value is the effect of the MLS. At the moment, one option is always to raise the MLS rate³⁰ in concert with annual price rises in order to keep the two indicators aligned. The reasoning behind this is that the discretionary cost of PHI is the difference between each person's premium and the amount they would spend on the MLS if they ceased PHI membership. This has an effect of retaining some members who

would otherwise depart PHI. The extent of that effect depends on the observed elasticity of demand for PHI at the residual cost of the premium minus MLS.

However, raising the MLS is in practice a recognition that the perceived value proposition of PHI is reducing annually. Unfortunately, while this may be a necessary solution to maintaining membership in the absence of other reforms, it has the undesirable effect of decreasing perceived value, rather than increasing it. Returning to the original question as to what regulations are needed to address the non-marketability of PHI, this would currently fail the test as it is a direct intervention that forces some people to buy insurance when they would not otherwise choose to.

This does not mean that the MLS is entirely lacking in merit. When insurance is perceived as good value, there will be those who still choose to be free riders in the public system despite their capacity to pay for PHI. This was the case when the Howard Government first introduced the MLS and the LHC along with a temporary LHC amnesty. The goal here should be to return the PHI value proposition to a circumstance where the MLS is a compulsion at the margin, not an inefficient brake against mass departures. This is not an argument against either increasing the MLS rate, or taking advantage of 'bracket creep' to bring more people into the MLS-liable cohort: rather it is an observation that this is less efficient than improving the overall perceived value proposition.

As a final observation here, it would be better if the MLS required purchase of particular levels of insurance. The argument here is that because there is something of an annual race to the bottom to provide the cheapest product which satisfies MLS exemption, consumers are encouraged to purchase much less insurance than they can afford, and less than they may need. Particularly for higher income consumers, it would be better if there were a specific requirement to purchase silver or gold policies, rather than just any hospital cover policy. As the price of the MLS penalty will still exceed the premium for these consumers, this is not an unreasonable change.

³⁰ Or reduce the MLS income band.



Restoring the PHI value proposition

Drawing upon the analysis above, there are five general paths to restoration of the value proposition which are:³¹

1. Removing the asymmetry whereby PHI funds are price-takers including from hospital accommodation and device suppliers;
2. Addressing the OOP costs issue;
3. Reducing expenditure on low-value care;
4. Allowing market completion by allowing health insurers to fund care options involving hospital substitution within hospital cover; and
5. Investing in consumer education to reduce information asymmetry and address some of the myths about healthcare in Australia.

Each of these is aimed at reducing the overall costs while maintaining the core benefits of PHI. This will in turn allow reduction of only one side in the value proposition ratio which should be attractive to both consumers and governments.

Each of these options is broken down further below.

Changing the market power balance

A great deal of work has been done in recent years by Private Healthcare Australia with input from Evaluate and other consulting groups on reform of supply arrangements. This has led to a number of welcome proposed changes to the Prostheses List, announced in the 2021 Federal Budget, including price oversight by the Independent Hospital Pricing Authority (IHPA),³² the same regulator which sets prices in the public system. This will hopefully be a significant source of downward price pressure though the guaranteed access granted by the Prostheses List as it currently operates will limit the scope of price reform.

Options beyond the current reforms which would benefit from more in-depth investigation include:

1. Formal alignment of the PL or a similar mechanism to prices in the public health system. While there may be some marginal reasons of scale or distance which mean prostheses can never be perfectly benchmarked to international prices,³³ there is no credible reason why there should be different prices for devices between the public and private systems. In fact, for the many devices which are used substantially more in the private

³¹ These exclude the potential impact of prospective risk equalisation which is also an important reform option but is being addressed elsewhere.

³² <https://www.health.gov.au/health-topics/private-health-insurance/the-prostheses-list/prostheses-list-reforms-and-reviews> Accessed May 2021.

³³ Though any incremental costs should at least be higher in NZ, given lower scale and greater cost of delivery. ⁴¹ Independent Hospital Pricing Authority, "National Pricing Model Technical Specifications 2021–22", 5 May 2021. <https://www.ihsa.gov.au/publications/national-pricing-model-technical-specifications-2021-22> Accessed May 2021



system, the private price might reasonably be expected to be lower. This is the ultimate goal if IHPA's oversight of device pricing is allowed to operate freely;

2. Extension of IHPA's oversight to the total cost of care on a DRG basis. On this, it is accepted that private hospitals may not be as cheap as public hospitals for equivalent patients. However, the same relative complexity factors should be able to be used to develop a model based on variations to a National Efficient Price (NEP) and National Efficient Cost (NEC – for smaller providers)⁴¹ in the private sphere;
3. Introduce a series of measures which permit a more symmetric negotiation between insurers and hospitals, including:
 - a. Either removing the default rate or substantially reducing it to bring hospitals to the negotiating table and lowering the guaranteed profitability of low-value care;
 - b. Amending the *Private Health Insurance Act 2007* and its regulations³⁴ so that the Commonwealth, which is also a funder of PHI, is responsible for approving hospitals with access to the Commonwealth-specified default. This would allow for exclusion of facilities which specialise in lowvalue care or which excessively game the system. The legal basis of this would need to be investigated but it should be possible to have a gazetted schedule of approved hospitals in the same way as the PL currently operates; and
 - c. In concert with the proposal for DRG-based pricing, allowing insurers and hospitals to contract on total cost of services, potentially with the exception of professional fees.³⁵

One consequence of any attempt to rebalance asymmetries of market power is that it might go too far, in this case giving insurers excessive market power over their suppliers. Given the lack of specialist health pricing expertise at the

Australian Competition and Consumer Commission (ACCC) and the onerous and expensive nature of general competition enforcement, it might be better that this risk is again managed by IHPA.

This could involve either a complaints resolution process or a requirement that each contract be registered with IHPA. A further condition might involve justification if contracts vary from IHPA's DRG-based price calculations beyond a certain percentage.

Dealing with OOP costs

OOP costs from hospitals, which are typically relatively minor, should be addressed via the contracting model described above. The industry association Private Healthcare Australia has described the challenges of this problem at length.³⁶

³⁴ <https://www.health.gov.au/health-topics/private-health-insurance/about-private-health-insurance/private-health-insurancelaws> Accessed May 2021.

³⁵ See below for further discussion on this exclusion.

³⁶ Private Healthcare Australia, "Submission: Senate Community Affairs References Committee Inquiry into the Value and Affordability of Private Health Insurance and Out-of-Pocket Medical Costs", July 2017. https://www.privatehealthcareaustralia.org.au/wp-content/uploads/sub18_PHA.pdf Accessed May 2021.



The principal limit on dealing with this problem is that the Commonwealth cannot compel registered providers of medical services to do so at any price and, consequently, cannot introduce a mechanism which indirectly permits such compulsion.

As a result, the main pathway to reforming this problem – other than transparency mechanisms³⁷ – will involve providing incentives to practitioners to participate in, and comply with, no-gap and known-gap arrangements.

The non-financial incentives mentioned above for private hospitals to refer patients for admission are instructive here. If the revised contracting arrangements proposed in the previous section can also include fixed professional fees within a single DRG price, then OOP costs can be proactively managed. Reversing the current cost-positive incentive of access to operating theatres and similar and making this a downward cost pressure would be ideal.

The ultimate extension of this would be that hospitals would have an incentive to participate in a known price scheme, because – if there were also a lower (or no) default rate – then there could be an environment in which only those hospitals who did agree to fixed or known costs per DRG would be accessible by consumers using PHI. Because this would be per-DRG, it requires extensive further modeling.

Low-value care

There are various potential versions of low value care. These include:

- Purchase of health services for which there is no or inadequate evidence of benefit;
- Purchase of services for which the expected benefit for *any* patient is very small compared to the price; and
- Purchase of services which represent low value for *individual* patients.

These three definitions are likely to grow in contention within each DRG, and it would be useful to quantify their impact on a per-DRG basis, at least for selected examples. It would nonetheless be difficult to argue that treatment which lacks evidence should be included.³⁸

In contrast, the requirement for expenditure to match and support the expectation of a value proposition for the consumer of insurance, while entirely logical, presents a greater threat to current economic interests, including for hospital investors and the medical profession. Nonetheless, it is proposed that there be some more detailed investigation of what might fall into both of these first two categories.

The question of treating individual patients differently is more controversial as it should be. Given the earlier observation that the benefits of private insurance are substantially due to displacing the need for public expenditure to deliver a total amount of care while maintaining current waiting list levels, low value care may usefully be identified as treatment which would not move to the front of a waiting list under any circumstance. This is mostly because it has poor evidence or poor economic efficacy but, in some patients, it may particularly be inefficient or inappropriate.

³⁷ And potentially the modern element of ‘shaming’ which often accompanies them.

³⁸ This should not prohibit funding – including via PHI – of clinical trials for treatments where the evidence is not yet clear or complete.



Given the role of PHI providers in funding treatment, it is inappropriate that they should unilaterally intercede in decisions regarding patient treatment. Accordingly, the introduction of an independent third-party panel staffed by appropriately professionally-qualified reviewers should be considered. This would allow for rapid referral and decision-making where insurers feel prescribed high-cost options are of low prospective value. An issue which arises here is that health funds are generally only advised of prescribed treatment in Australia *post hoc*. This approach would require investigation of options which change the timing of notification, either:

- Generally, for non-urgent cases, which would be beneficial in providing oversight of the system; or,
- For specific instances, either of high-value expenditure or for particular procedures which are often identified as low-value, in a way similar to that required by the PBS.

PHI funds excel at pattern-based identification of appropriate expenditure. Currently, this is principally used to monitor and identify fraud but can also be utilised as an early warning system for inappropriate medical practice. It would be useful generally if private health insurers were notified in advance of proposed interventions – except actual emergencies – as the current quality of information regarding treatment is inadequate. This would also permit algorithm-based identification of possible low-value care which funds might refer to an independent reviewer.

There would also be merit in allowing transparency of statistics on a per-fund basis of such reviews, which would provide a reputation risk-based limit to excessive referrals. Evaluate also notes that there are some examples of what may in a strictly clinical sense be seen as low-value care, such as some admitted mental health services, but which are highly valued by consumers as part of the PHI proposition: these which would not likely be affected by initiatives to reduce lower-value care.

Dealing with low-value care is the most challenging but probably the most productive option to reduce PHI premiums over time. While it may initially be seen as anathematic to the general principle of PHI, it is no different from the rationing which takes place elsewhere in the health system. The public system does this indirectly in two ways, both of which are delivered through waiting list mechanisms:

1. First, it prioritises resource allocation toward particular DRGs associated with the greatest risk to life and quality of life (cancer care, cardiac surgery); and
2. Within each DRG waiting list, patients are prioritised according to urgency.

Neither of these is available to PHI, which must serve all customers promptly, but removing the care which the public system would never let reach the front of any waiting list would provide some alignment between the systems.

In the absence of a mechanism which limits low-value care, the price of Gold policies will only continue to rise and the need for restrictions on lower price products can only increase accordingly. None of this should get in the way of necessary and clinically appropriate, high-value healthcare funded by PHI.

The next step for this proposal is to undertake a comprehensive investigation to describe and quantify what might be included in various definitions of low-value care.

Market Completion

Currently the private healthcare market is incomplete, because insurers are restricted from various activities which would make PHI more efficient and affordable. Market completion that allows private health insurers to pay for



services provided in non-hospital settings under current hospital cover is only useful if it will reduce overall costs and therefore premiums.

This can occur in two general ways as follows:

1. Extending the capacity of PHI funds to invest in health promotion activities, particularly in terms of behavioural improvement and chronic disease management, within hospital policies. Options around these require identification and a detailed cost-benefit analysis; and
2. Allowing funds to fund treatment without hospital admission for more than general treatment items, including both preventive and hospital substitute treatment.

Notably, both of these are exercised as a method of hospital avoidance in the public system, which utilised this as a means to reduce waiting lists.

Unfortunately, the experience of gaming in hospital admissions indicates a countervailing risk of similar gaming in non-tertiary settings. Accordingly, it is proposed that funds would be able to offer these types of services on a discretionary basis where they are a clear substitute to hospital admission. There should be no automatic right to non-hospital care.

In the context of the low-value care referral mechanism, it is possible that this initiative might be usefully extended to allow the option to propose alternative care outside a hospital setting. However, this is likely to be more readily negotiated rather than mediated.

Market completion offers the choice between either reducing supply costs and thus premiums or offering more treatment at the same cost. It also offers a further option for refinement of specific PHI products, which may increase competition and innovation. Each option needs to be quantified on a DRG basis.

An alternative approach: floating the rebate

This is not formally proposed as an option but as a useful intellectual exercise in describing the asymmetry caused – rather than removed – by some PHI regulations.

It has already been observed that there are legislative and regulatory impediments to market equilibria in PHI, which results in prices that governments are not willing to bear in the public system. The only way in which this situation could be ethically supported is if the Government were willing to pay for the incremental costs of these impediments.

In practice, this would mean that the rebate would not be merely means tested but that it would be adjusted annually to cover the full costs of any above-market supply margins.

This could be managed through the same mechanism through which IHPA would compare the costs of public and private care. Further, it would promote sustainability by removing the distortions caused by non-productive regulatory intervention, that is, intervention which increases cost without addressing the fundamental asymmetries of healthcare markets.



The NDIS has clearly demonstrated to the Commonwealth how poor regulation can increase cost pressures in private insurances.³⁹ It would be useful to quantify what equivalent exposure would look like if the Government were required to guarantee PHI sustainability.

A further alternative – re-targeting the rebate

A corollary proposal to the above is that to restore the value proposition of PHI for younger, healthier participants, the Government might do well to change the rebate settings: instead of compensating older and sicker customers, it would compensate younger, healthier consumers, whose value proposition is undermined by community rating.

This is again hypothetical and would, in any case, require grandfathering of current age-related rebate settings for existing fund members for political reasons.

However, even as a thought experiment, what this does is emphasise that the costs of the current regulatory structure are borne by PHI funds and their members, with no productive benefit. At the very least, a youth rebate increment would bring in some consumers who are excluded by the gap between price and perceived value. This would in turn reduce all premiums, as a healthier cohort is brought into the mix.

It is not expected that the government would be willing to make this change. But in its absence, other proposed initiatives to decrease the perceived value gap are made only more compelling.

Private patients in public hospitals

Again, the issue of public hospitals providing services funded by PHI has been addressed at length by Private Healthcare Australia.⁴⁰ The issue here is essentially that some people may feel they have been forced to underutilise their PHI by selecting public accommodation although it is unclear to what proportion of private in public patients this applies.

The current approach to this issue is that IHPA should ensure there is no double-dipping by hospitals charging the Commonwealth for procedures which are also funded via PHI. Anecdotally, there may be some compliance failures in this space.

The most direct alternative solution would be to limit access to MBS item numbers in public hospitals as part of the incentive to increase private in public is for public hospital employers to top up practitioner salaries via the MBS. However, this introduces some complexity as:

- Some insured patients may simply prefer a public hospital environment;
 - There remain some legacy PHI products which only cover accommodation in a public setting; and
-
- Most critically, patients in regional Australia may simply have no easy access to a suitable private facility.

³⁹ <https://www.theaustralian.com.au/nation/politics/ndis-bill-to-jump-10bn-over-budget/newsstory/21a3aa7f73b194a109b72cad2293aef9> Accessed May 2021.

⁴⁰ Most recently at: <https://www.privatehealthcareaustralia.org.au/abc-radio-adelaide-mornings-program-interview-with-drrachel-david-on-cost-shifting-in-south-australias-public-system/> Accessed May 2021.



This issue is predominantly one of behaviour rather than as a regulatory problem of PHI. While access to private accommodation and care is part of the PHI value proposition, this is not undermined as long as patients choosing to be treated in public hospitals do so willingly and with appropriate levels of information.

This is best dealt with via greater education and transparency and is not recommended as a priority for further investigation.

The above pose questions that would benefit from further modelling. This would also permit consideration of the various solutions proposed above.

Operating constraints in the private health sector

As flagged in the section outlining the regulations governing private health insurers, various regulations constrain the operations of PHI. Likewise, constraints exist for other participants in the private health sector and these are briefly outlined in Table Four.

Table Four: Operating Limits between participants in the private health sector

Stakeholders	Private Health Insurers	Suppliers	Consumers	Commonwealth Government	Public health	
Constraints		Hospital Providers	Medical professional			
Price of cover	Government regulation/approval: <ul style="list-style-type: none"> price caps no capacity to control or price for risk 			Value proposition: <ul style="list-style-type: none"> Price to value ratio Price minus MLS Understand risk 	Exposure to rebate Number of people covered	Funded via tax system, with pricing set by activity based funding (ABF) model managed by IHPA
Payments for accommodation	Hospital contracting but minimum defaults in place	Minimum default payments		Excesses in place	Exposure to rebate	Set under the ABF arrangements
Payments for MBS services	Government regulation: MBS Hospital contracting		Contracts with PHI Consumers' willingness to pay OOP	OOP – often unknown	Exposure to rebate	Levied where private patients are treated in public hospitals
Prostheses and device prices	Prostheses List	Prostheses List minus actual cost		No negotiating power		Purchased on open market by tender
Provision of lowvalue care	No control over provision		Few limits to provision	Limited by information asymmetry		Excluded by DRG-based waiting lists



Conclusion and potential next steps

Looking to the future, if PHI becomes increasingly dominated by older and sicker Australians, the increased life expectancy and work productivity benefits provided by the sector will decrease. This in turn will reduce economic growth while healthier Australians remain on ever-increasing public waiting lists. This scenario is obviously detrimental compared to the current or ideal environment which only emphasises and underpins the need for the above options to be modelled, considered and, where appropriate, adopted.

Reforms underway in the PHI sector, such as those to the Prostheses List pricing, will deliver clear benefits. This work explores a number of options for the next round of reforms which would make the private health insurance system more sustainable, benefiting patients, the health system and the economy more broadly. The options outlined in this paper seek to reframe the system for long term sustainability not simply for the sector but to maximise the health and wellbeing of Australians, support the sustainability of government expenditure on both public and private healthcare and to remove pressure from public hospital waiting list.

Further work is needed to flesh out some of the details and potential impacts of the proposed reforms. This would enable identification of those most valuable and their prioritisation for adoption.

Appendix One: Overview of private health insurance – market and regulations

Licensed private health insurers

Only registered health insurers can provide private health insurance. These insurers are regulated by APRA in accordance with the [Private Health Insurance \(Prudential Supervision\) Act 2015](#). There are currently thirty six registered health insurers in Australia.

To be registered, it is necessary to comply with the [Private Health Insurance \(Registration\) Rules 2017 \(No 2\)](#).

Possible business structures

If a health insurer is 'not-for-profit', it is a mutual organisation. Premiums paid to the insurer must be used to operate the business and cover benefits for members. 'For-profit' insurers aim to return a profit to their owners, which may be another health insurer or corporation, or shareholders. Both are required to maintain sufficient funds to operate the company and pay benefits to their members.

Restricted and open memberships

Health Insurers have either an 'open' or 'restricted' membership. Open membership organisations provide policies to all members of the public while restricted membership organisations only sell policies to specific employment groups,



industry sectors or unions, for example Defence Health provides insurance to Defence personnel and their families only but remains governed by the same regulatory framework.

Prudential standards and capital requirements

Private health insurers are required to be able to meet, out of the fund's assets, all liabilities that are payable by the fund at the time they fall due. The prudential standard requires private health insurers to demonstrate this, including in adverse circumstances.

Capital requirements for private health insurers mean that they are required to hold sufficient assets to meet their liabilities for a twelve-month period, including allowing for future business plans and adverse circumstances.

Brand names

Insurers can sell private health insurance through other organisations, such as QANTAS and Kogan, through underwriting the policies provided by those organisations.

Corporate policies

Some health insurers provide health cover policies tailored for specific companies or organisations, which may be part of the company's benefits package.

Regulatory framework⁴¹

Today, a significant body of regulations underpins private health insurance. This acts to support Australia's private health insurance in many ways whilst, at the same time, creating a variety of barriers to what would, in other markets, represent effective competition and market operation. It is Evaluate's view that the particular asymmetry between the vast level of compliance and restrictions placed on PHI funds and the light touch on all levels of suppliers cannot produce a sustainable PHI sector in the medium term.

The [Private Health Insurance Act 2007](#) is the main piece of Australian legislation that outlines the legal requirements for private health insurance and health insurers.

[Private Health Insurance Rules](#) sit under this legislation and provide further detail about numerous areas of private health insurance.

The following legislation relates to the supervision of the Private Health Insurance industry together with links to the Federal Register of Legislation:

- [Private Health Insurance \(Prudential Supervision\) Act 2015](#)
- [Private Health Insurance Act 2007](#)
- [Private Health Insurance \(Prudential Supervision\) \(Consequential Amendments and Transitional Provisions\)](#)

⁴¹ These are the regulations under which PHI funds operate in Australia as opposed to the rules established by each PHI to govern their own fund.



[Act 2015](#)

Data collection

- [Financial Sector Collection of Data Act 2001](#)

Levies

- [Private Health Insurance Supervisory Levy Imposition Act 2015](#)
- [Private Health Insurance \(Risk Equalisation Levy\) Act 2003](#)
- [Private Health Insurance \(Collapsed Insurer Levy\) Act 2003](#)

Rules and guidance

APRA rules and guidance that apply to private health insurers include:

[Private Health Insurance \(Prudential Supervision\) Rules 2019](#)

[Private Health Insurance \(Registration\) Rules 2017 \(No 2\)](#)

[Private Health Insurance \(Risk Equalisation Administration\) Rules 2015](#)

[Private Health Insurance \(Health Benefits Fund Enforcement\) Rules 2015](#)



Pricing and consumer information

Premium changes

Under the *Private Health Insurance Act 2007*, health insurers to submit proposed premium increases to the Minister for Health before premiums for any policies can be increased. The submission to the Minister needs to include financial information and cost and benefit projections and a health fund's appointed actuary must certify the submission.

Proposed increases are examined by the Department of Health and by the Australian Prudential Regulation Authority (APRA). APRA can require insurers to report on their finances and operations and also independently audit private health insurers' finances.

Before a premium increase can occur, the Minister for Health must approve it which occurs once a year. If the Minister does not believe the increase can be supported by evidence provided by the health fund, they can refuse the proposal.

Private Health Information Statement (PHIS)

Health insurers are legally required to provide these Statements to members. This enables them to review their existing policy or compare private health insurance policies. A PHIS for every available policy in Australia is available at https://www.privatehealth.gov.au/health_insurance/howitworks/phis_guide.htm

Communication of changes to premiums or rules

Any change to a health insurer's rules that might be detrimental to a member must be communicated, including all premium changes. The Private Health Information Statement for the policy must also be updated.

PHI products

There are two types of PHI - hospital policies which cover an individual when they are admitted to hospital; and general treatment or extras policies which cover ancillary treatment, such as dental and physiotherapy and which can also cover ambulance transport.

Most health insurers offer combined policies that provide packaged cover for both hospital and general treatment services, or members can buy separate hospital and general treatment policies to 'mix and match'.

Health insurers may not cover non-surgical MBS items on behalf of their members, such as visits to the GPs, specialist appointments in their rooms and most diagnostic tests and services.

The focus on this analysis is hospital cover. Extras cover is a sub-section of this market and only indirectly involved in the analysis and recommendations.

Hospital cover – what can be covered?

A hospital policy covers a member for in-hospital services when they choose to be treated as a private patient. This includes some or all hospital costs, such as accommodation, theatre costs, nursing care and so forth; and some of the doctors' costs.



an economic study

One of the benefits of private health insurance is that private patients can choose their hospital, doctor and specialist.

PHIs do not have to fund in-hospital services that do not attract an MBS rebate although they have the option to do so. Podiatric surgery is an example of this where some insurers choose to fund services provided by podiatric surgeons whilst others do not.

Gold, Silver, Bronze and Basic

On 1 April 2020, four new tiers of hospital cover – Gold, Silver, Bronze or Basic – became mandatory for all private health insurers and all their products are required to align with the requirements of one of these tiers.

To qualify to be included in a specific tier, a policy needs to include the minimum requirements of that tier as set out in the table in Appendix One. All treatments in the table indicate a treatment that would be delivered, and paid for, as part of a hospital admission.

If a policy meets the minimum requirements of a tier but also includes additional services, it can be referred to as a 'Plus' policy, for example, Silver Plus or Bronze Plus.

What is or is not covered in these product tiers is based on clinical categories. Each category – for example, the 'dental surgery' or 'ears nose throat' category – includes the hospital treatments that private health insurers must cover. If an insurance policy includes a certain category, then everything listed within that category is included in the insurance policy, not simply some items. **Prostheses covered**

If a policy covers the procedure to implant a prosthesis, it will also cover some or all the cost for the prosthesis itself.

Private health insurers must pay a benefit for a prosthesis if:

- it is listed on the Prostheses List;
- it is delivered as part of hospital or hospital substitute treatment;
- it is covered by the policy; and
- a Medicare benefit is payable for a service associated with the use of the product.

The prostheses covered are determined by the Prostheses List Advisory Group and their prices are established independently of the private health insurers. Private health insurers are required to pay benefits for products listed on the Prostheses List, if the product is provided to the patient with appropriate cover as part of hospital or hospital substitute treatment.

Prostheses not able to be on the Prostheses List include:

- external prostheses, such as prosthetic limbs;
- surgically implanted devices that are not designed to replace an anatomical body part or, alternatively, to combat a pathological or modulate a physiological process, such as some cosmetic implants; and
- devices used for diagnostic purposes.



Complications and unplanned hospital treatment

If a patient is admitted to hospital for a planned treatment included in their policy and complications occur that are outside the scope of the policy, private health insurers are required to cover the cost of treating the complication. This is the case even where, under the policy, the clinical category involved may not be included.

If a patient is admitted to hospital for a planned treatment and, during the course of admission, another condition that requires urgent treatment is identified, this 'associated unplanned treatment' must be covered by their insurer. This is regardless of whether the associated treatment involved is covered by the patient's policy as long as the treatment is provided within the same episode of care as the original treatment. The associated unplanned treatment must be considered medically urgent and necessary in the view of the medical practitioner providing the treatment.

Insurers are required to cover elective procedures that are covered by a policy together with all associated services or complications arising from that procedure. An insurer does not have to cover any planned elective procedures not covered by the policy, regardless of whether another procedure is provided during the same admission.

Hospital treatment waiting periods

The Government sets the maximum waiting periods that insurers can impose for hospital treatment. Private health insurers can determine the waiting times for services within extras cover. For hospital treatment, waiting times are set as:

- 12 months for pre-existing conditions;
- 12 months for obstetrics – obstetrics is only available under family or single parent cover, not within a single membership;
- two months for psychiatric treatments, rehabilitation or palliative care, even for a pre-existing condition; and
- two months in all other circumstances.

In some cases, it is possible to upgrade a policy to include mental health treatment in hospital without a waiting period.

Assessments as to whether a condition is pre-existing must be made in relation to that individual's personal circumstance. Insurers may not claim that certain conditions are always pre-existing. A medical practitioner appointed by the health insurer must be satisfied that there is a direct link between the condition requiring hospital treatment and the existing signs and symptoms in the six-month period prior to the member joining or upgrading hospital cover. The condition does not need to have been diagnosed during the six-month period, only that signs and symptoms were or would have been evident to either the patient or an examining medical practitioner during that period.

Travel and accommodation for rural consumers

Until 2019, private health insurers were unable to offer travel and accommodation benefits under hospital cover although some offered these benefits under extras cover. From 1 April 2019, insurers are able to offer travel and accommodation benefits as part of hospital cover.

Hospital cover – governance arrangements



Community Rating

Community rating is designed to make PHI affordable to older and sicker Australians and effectively operates as a cross-subsidy by younger, healthier participants.

Australia's system of community rating was established by the *National Health Act 1953* together with the policy of open enrolment.

Under Australia's community rating rules, private health insurers are not allowed to refuse to insure any individual, including on the basis of their age, gender or health status. This has the result that all individuals holding the same PHI policy and living in the same state/territory pay the same premium for that product. In addition, private health insurers cannot refuse cover to any eligible individual, i.e., Australian citizens and permanent residents, regardless of their risk or likelihood of claiming against their policy.

The prohibition of risk-rated premiums, and preventing insurers from refusing customers, has meant that certain insurers engage in potentially inefficient 'risk selection' whereby they seek to discourage high risk customers and attract low risk consumers through product design. This is an unfortunate approach but is a credible strategy given the level of regulation and restriction on innovation to improve value. Maintaining a viable PHI industry in the presence of the distortions created by community rating and open enrolment has required numerous other policy interventions and regulations from rebates to Lifetime Health Loading.

Geographical pricing

Insurers are allowed to differentiate their policies for different states or territories. Likewise, they are permitted to offer the same policies at different premiums in different states and territories. This is designed to take account of differences in costs and benefits between states, including some state government health arrangements.

Risk equalisation

Risk equalisation underpins community rating by transferring funds from insurers with lower than average costs to those with higher than average costs. Importantly, this does not include all high-cost patient activity and only partially defrays the excessive costs borne by individual insurers.

Over 40% of all hospital and medical claims are managed between insurers in this way with the pooled claims being allocated equally to every insured adult in each state with a basic policy contributing as much as a more comprehensive policy. Currently risk equalisation equates to around \$750 on an average adult policy and has increased 7.5% per year for the last ten years.⁴²

Medicare Levy Surcharge

As of July 2012, people who do not hold eligible private health insurance hospital cover income above three tier thresholds pay an additional 1.00%, 1.25% or 1.50% income tax. This means that people without eligible hospital cover whose income is more than the specified single and family income thresholds will pay Medicare Levy Surcharge with their income tax without receiving any additional health cover beyond Medicare.

⁴² Jamie Reid et al, "Risk Equalisation: time to think differently?", Finity Consulting, 2017. <https://www.actuaries.asn.au/Library/Events/SUM/2017/SUM17ReidEtAlPaper.pdf> Accessed May 14 2021.



Federal Government Rebate on Private Health Insurance

On 1 January 1999, the Federal Government introduced a universal 30% rebate on all health insurance premiums for both hospital cover and extras cover. Individuals could access this rebate either as a reduced premium or as a tax rebate. In 2005, the PHI rebate was increased to 35% for people between 65- and 69-year-old and 40% for those over 70.

As of 1 July 2012, the rebate has been means tested and reduces and as income rises above specified tiers. Depending on income level, individuals no longer receive the universal 30% rebate originally introduced but instead are receive a 30%, 20% or 10% rebate or, for those over the highest income threshold, no rebate at all. This change was estimated to save \$6.78 billion over 4 years.

At the same time, the Government announced that the rebate would no longer be payable on policies with Lifetime Health Cover loading.

Further, the rebate percentages became indexed annually relative to industry premium increases or the Consumer Price Index, whichever was lower. This initiative, which commenced on 1 July 2014, affects lower- and middle-income earners and, as a result, the value of the 30% rebate decreases every year and will continue to do so while health inflation and premium increases remain above CPI.

Lifetime Health Cover

Lifetime Health Cover (LHC) started on 1 July 2000 and is intended to encourage people to take out hospital cover when they are younger and to maintain it throughout their life as a principle that underpins community rating. This was achieved by enabling private health insurers to charge differential premiums based on the member's age at the time they first took out private hospital cover.

Lifetime Health Cover regulations mean that anyone who takes out PHI pays a loading of 2% on their premium for each year of age they are over 30. No loading exists for those who hold private health insurance prior to their 30th birthday.

The maximum LHC loading that anyone can pay is 70%. A LHC loading is removed after 10 years of continuous hospital cover. Someone taking out PHI for the first time after their 45th birthday would therefore attract a 30% loading on their premium and pay an incremental 30% of the listed premium price for each year for the following ten years.

Those who held cover before 1 July 2000, later extended to 15 July 2000, were exempt from paying the Lifetime Health Cover regardless of their date at that age. This effectively offered an amnesty or grace period for those taking out new cover before the 15 July date.

Some special circumstances apply to new migrants or Australians who have been living overseas.

Gaps in cover and Days of Absence

To cover gaps in coverage, such as switching from one insurer to another, an individual can be without hospital cover for a total of 1094 days, so three years less one day, during their lifetime without affecting your LHC loading. These are known as 'Days of Absence'.

If you exceed your Days of Absence, LHC loading will be paid on re-joining hospital cover. The loading is an additional 2% on top of any previous loading and will increase by 2% for every year after the 1094 days without cover.



Suspension of membership

It is possible to suspend hospital for a short period with the agreement of a private health insurer, for example, for a holiday. This period of suspension is not counted towards a member's 1094 Days of Absence. Suspension terms and conditions vary between insurers.

Going overseas

If hospital insurance is cancelled after an individual's Lifetime Health Cover base day to go overseas for at least one continuous year, the days spent outside Australia are not counted towards the 1094 Days of Absence. Individuals can return to Australia for periods of up to 90 consecutive days per visit and still be considered to be overseas. Any periods of 90 days or more spent in Australia during this time will be deducted from the 1094 Days of Absence.

Age based discounts

Starting on 1 April 2019, private health insurers can offer people 18-29 discounts of up to ten percent of their premium or two per cent for each year that a person joins private health insurance before they turn 30. The discount is a maximum of 10 per cent for 18- to 25-year-olds and the discount will remain in place until the individual turns forty after which time it will phase down.

This age-based discount can be transferred but insurers can choose whether the age-based discounted policies they offer will honour existing age-based discounts when a person transfers insurers.

Other discounts and incentives

Private health insurers are allowed to offer discounts on policies or incentives to customers of a maximum of 12% per annum.

Portability rules

If transferring between private health insurers, getting a Clearance Certificate from the existing insurer can help avoid waiting periods with the new insurer as well as maintaining the current level of LHC.

Certificates must be issued within fourteen days of a member requesting one and include the following: type of cover, e.g., hospital, general treatment, combined; level of cover; join and cancellation dates; Lifetime Health Cover Certified Age of Entry; and a history of recent claims.

Waiting periods may need to be served for any additional benefits covered by the new policy and, where the full waiting period has not been served with the original fund, the balance will be required by the new fund.

Gap of one to two months are allowed by some funds but different fund rules mean that some funds do not permit any gap at all.

These rules are contained in the *Private Health Insurance Act 2007* and only cover hospital policies. Many funds apply some portability to general treatment policies but they are not obliged to under law.

Excesses

Until 2019, excesses were set at a maximum of \$500 for singles or \$1,000 for couples and families in order to avoid the Medicare Levy Surcharge. The maximum excesses were then raised and are now \$750 for singles and \$1,500 for couples and family policies.



Hospital Purchaser Provider Arrangements

Hospital Purchaser Provider Agreements were introduced in 1995, following the passage of the *health Legislation (Private Health Insurance Reform) Amendment Act 1994*. These were designed to enable private health insurers to negotiate with hospitals to pay them above the Medicare Benefits Schedule (MBS) fee where there was an agreement for in-hospital medical services. The intent behind this was to simplify billing practices but also and critically to enable the elimination of out-of-pocket costs for patients. Other factors may include agreements about who pays in the event a patient is readmitted within a particular period.

Further changes were made in April 1998 with the aim of helping achieve the objective of reducing medical gaps experienced by customers and, when there is an agreement between an insurer and a private hospital, members have either no out-of-pocket expenses or are provided with details of out-of-pocket expenses.

Second-tier default benefits

Insurers must pay second-tier default benefits for hospital treatment if they do not have a negotiated agreement with the hospital *and* the hospital is eligible for second-tier default benefits.

Second-tier default benefits are set at least 85% of the average cost of the equivalent treatment under that insurer's negotiated agreements for comparable private hospitals. Comparable private hospitals are those in the same state and in the same second-tier hospital category. Each health insurer must work out second-tier default benefit rates for each category in each state and territory.

Second-tier benefits are higher than what private health insurers are required to pay if the hospital is not eligible.

To be eligible for second-tier default benefits, a hospital must:

- apply;
- be accredited;
- be a private hospital;
- not bill patients the minimum benefit their insurer will pay;
- ensure patients give informed financial consent; and
- provide the hospital casemix data to health insurers for each claim lodged for second-tier default benefits.

The second-tier hospitals list is reviewed annually by the Department of Health.

No-gap or known gap products

No-gap or known gap products were introduced in July 2000 in order to encourage health funds to offer policies that either enabled members to avoid paying out-of-pocket expenses or allowed them to know in advance what those out-of-pocket costs would be. Unless private health insurers introduced one or more policies involving a no-gap or known gap, they were not permitted to offer members access to the 30% PHI rebate as a premium reduction.³²



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Appendix Two: Clinical categories

Clinical Category	Basic	Bronze	Silver	Gold
Rehabilitation	Y (R)	Y (R)	Y (R)	Y
Hospital psychiatric services	Y (R)	Y (R)	Y (R)	Y
Palliative care	Y (R)	Y (R)	Y (R)	Y
Brain and nervous system	O (R)	Y	Y	Y
Eye (not cataracts)	O (R)	Y	Y	Y
Ear, nose and throat	O (R)	Y	Y	Y
Tonsils, adenoids and grommets	O (R)	Y	Y	Y
Bone, joint and muscle	O (R)	Y	Y	Y
Joint reconstructions	O (R)	Y	Y	Y
Kidney and bladder	O (R)	Y	Y	Y
Male reproductive system	O (R)	Y	Y	Y
Digestive system	O (R)	Y	Y	Y
Hernia and appendix	O (R)	Y	Y	Y
Gastrointestinal endoscopy	O (R)	Y	Y	Y
Gynaecology	O (R)	Y	Y	Y
Miscarriage and termination of pregnancy	O (R)	Y	Y	Y
Chemotherapy, radiotherapy and immunotherapy for cancer	O (R)	Y	Y	Y
Pain management	O (R)	Y	Y	Y
Skin	O (R)	Y	Y	Y
Breast surgery (medically necessary)	O (R)	Y	Y	Y
Diabetes management (excluding insulin pumps)	O (R)	Y	Y	Y
Heart and vascular system	O (R)	O	Y	Y
Lung and chest	O (R)	O	Y	Y
Blood	O (R)	O	Y	Y
Back, neck and spine	O (R)	O	Y	Y
Plastic and reconstructive surgery (medically necessary)	O (R)	O	Y	Y
Dental surgery	O (R)	O	Y	Y
Podiatric surgery (provided by a registered podiatric surgeon)	O (R)	O	Y	Y
Implantation of hearing devices	O (R)	O	Y	Y
Cataracts	O (R)	O	O	Y
Joint replacements	O (R)	O	O	Y
Dialysis for chronic kidney failure	O (R)	O	O	Y
Pregnancy and birth	O (R)	O	O	Y



Assisted reproductive services	O (R)	O	O	Y
Weight loss surgery	O (R)	O	O	Y
Insulin pumps	O (R)	O	O	Y
Clinical Category	Basic	Bronze	Silver	Gold
Pain management with device	O (R)	O	O	Y
Sleep studies	O (R)	O	O	Y

Y Indicates the clinical category is a minimum requirement of the product tier.

(R) Restricted cover permitted: insurers are allowed to offer cover for this clinical category on a restricted basis. A restricted benefit means you are partially covered for hospital costs as a private patient in a public hospital. You may incur significant expenses in a private room or private hospital so you should check with your insurer and hospital for details.

O Optional for the insurer to include: insurers may choose to offer these as additional clinical categories.



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