GRATTAN Institute

August 2017

Making health care more affordable and effective for both taxpayers and patients

Grattan Institute submission to the Senate Community Affairs References Committee inquiry into the value and affordability of private health insurance and out-of-pocket medical costs

By Stephen Duckett, Greg Moran and Lucille Danks

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Grattan Institute, August 2017

This submission was written by Stephen Duckett, Director, Health Program, Greg Moran and Lucille Danks, Associates, Grattan Institute. Jessy Wu and Naveen Tenneti provided research assistance and contributed to the submission.

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This submission may be cited as: Duckett, S. Moran, G. and Danks, L., 2017, *Making health care more affordable and effective for both taxpayers and patients: Grattan Institute submission to the Senate Community Affairs References Committee inquiry into the value and affordability of private health insurance and out-of-pocket medical costs,* Grattan Institute

Summary

In this submission we explore several aspects of the current inquiry by the Senate Community Affairs References Committee on the value and affordability of private health insurance and out-of-pocket medical costs.

Our main comments and recommendations in respect of each of the terms of reference are set out below:

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

- Commonwealth payments for growth in private patient activity in public hospitals in any state should be capped at 6.5 per cent, the current cap on overall growth payments.
- The Commonwealth Government should impose severe penalties on states where there is evidence that public hospitals are giving admission priority to privately-insured patients over public patients with a similar clinical need.
- Information about waiting times for public hospital specialist outpatient clinics should be published.
- There is no evidence that support for private health insurance and private hospital care reduces public hospital waiting times. Indeed, evidence shows that a greater public hospital share of activity is associated with shorter waiting times.

b. the effect of co-payments and medical gaps on financial and health outcomes

- Increasing out-of-pocket costs is not a good way to save money in the health care system.
- Out-of-pocket costs hit the vulnerable hardest.
- The Government can help patients reduce their out-of-pocket costs by promoting transparency in fees. For example, Medicare could publish, for general practices and specialists, the proportion of services bulk billed and the average out-of-pocket cost for non-bulk-billed services.

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

- The increased proportion of the insured population with deductibles and exclusions means that some people who use private hospitals receive unexpected bills or find they have no cover. Government should provide more information to help consumers make better-informed choices about the likelihood of particular health conditions, and thus help them understand what conditions might require them to get hospital treatment.

d. the use and sharing of membership and related health data

- This submission does not address this component of the Terms of Reference.

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

- This submission does not address this component of the Terms of Reference.

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

- There should be greater transparency of fees charged by specialists. Government should publish information about fees. Private health insurers should also publish information about in-hospital fees.

g. medical services delivery methods, including health care in homes and other models

- Australia's primary care system needs to be reformed to better cope with the growing burden of chronic disease.
- The Government's trial of Health Care Homes is only part of the change needed.
- Government should:
  - gather more information about what happens in general practice to provide a basis for further reform;
  - strengthen Primary Health Networks and give them explicit responsibility for creating more effective and efficient primary care systems in their local areas; and
  - set specific goals and create joint accountability for better outcomes through Primary Care Agreements with each state, supplemented by localised agreements signed by the Commonwealth, the state and the Primary Health Network.

h. the role and function of:

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

- Over the long term, government should reform Medicare's fee-for-service payment system for GPs. Currently, GPs have no financial incentive to reduce unnecessary patient visits to their practice.
- Government – and possibly private health insurers too – should publish more information about what fees medical practitioners charge. For hospital-based specialists, government should also publish information about whether there is any evidence that a practitioner has better outcomes which might justify a higher fee.
- Government should use rebate-setting and access to rebates to encourage specialists to establish their practices in areas of greatest need.

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

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

- This submission does not address this component of the Terms of Reference.

i. the current government incentives for private health

- The private health insurance rebate is an inefficient use of public money. However, the rebate is factored into family budgets and so policies for reducing it, especially changing the rate for the Base group (families with incomes below $180,000 a year), should only be considered in the context of broader budget changes to ensure families, especially low-income families, are not disadvantaged. Change in the level of the rebate should also be accompanied by deregulatory policies which allow insurers to address their costs – such as enhancing their ability to address low value care – at the same time as any revenue impact of a reduced rebate.

j. the operation of relevant legislative and regulatory instruments

- This submission does not address this component of the Terms of Reference.

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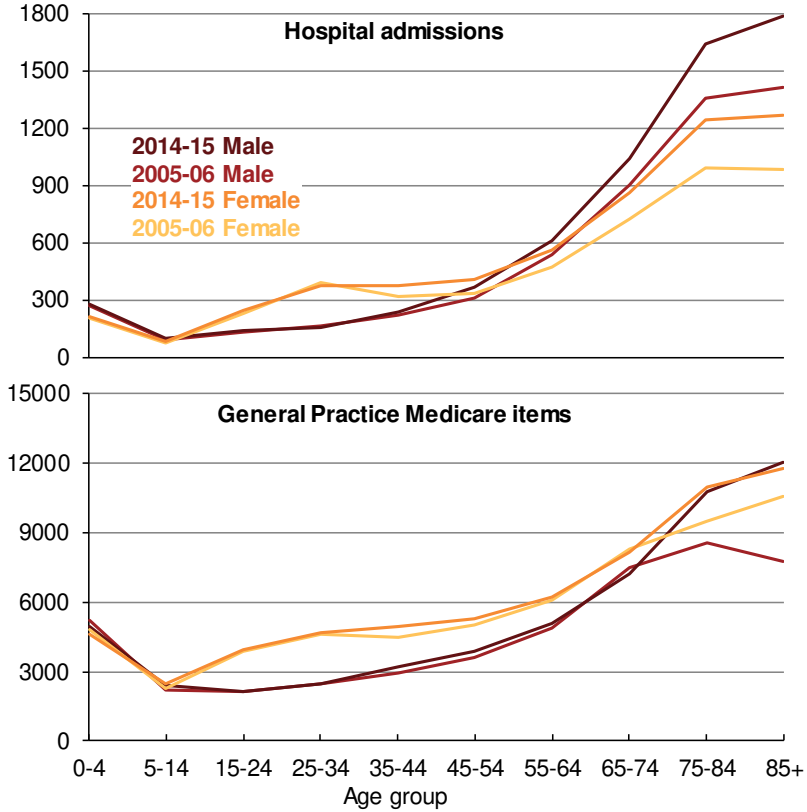
1 Chronic disease poses a significant challenge to constraining the cost of health care

Health care costs are growing faster than the population, inflation and economic activity.[1] The increased prevalence of chronic disease, and the way chronic disease treatment is changing, are the major causes.

In 2014-15, more than 44 per cent of Australians reported having three or more long-term health conditions.[2] In 2012-13, the 12.5 per cent of Australians who visited their GP the most – and were therefore most likely to have chronic conditions – accounted for 41 per cent of non-hospital Medicare benefits expenditure.[3] Australia also has comparatively high numbers of hospital admissions for chronic disease which could be managed in primary care.[4]

Commentators sometimes question the sustainability of the health system because of ageing of the population. Although the number of older people is increasing – and increasing as a share of the population – a bigger challenge is posed by the significant changes in the way older people's health care problems are managed. When Australians become sick, more can be and is being done for them. As Figure 1 shows, people over 65 are going to hospital and seeing the doctor much more than people the same age were a decade ago – these increases in service usage have a much bigger impact on costs than the effect of ageing.

Figure 1: People over 65 are using health care services much more than people the same age were a decade ago
Health care activity per 1000 population



Note: General Practice Medicare items are 3, 4, 20, 23, 24, 35-37, 43, 44, 47 and 51.
Sources: Grattan analysis of Medicare statistics, Australian Institute of Health and Welfare (2016a), Australian Institute of Health and Welfare (2007), ABS (2016a) and ABS (2014).

[1] Australian Institute of Health and Welfare (2016c), tables 2.3 and 2.6.
[2] ABS (2015).
[3] National Health Performance Authority (2015), p.14.
[4] OECD (2015).

Australia needs to do better on primary care

The primary care system – Australians' first point of contact for health care – was designed in and for another era.[5] Reforming primary care to better deal with chronic disease should be a priority.

Better management of chronic disease should help ease recurrent costs to both government and individuals. This is particularly the case if both government and individuals can avoid the cost of hospital admissions that are preventable through better primary care.

The Government recognises there is a problem. It has announced a trial of Health Care Homes, designed to improve the way general practices work with other health professionals to treat patients with chronic conditions. But change to the way general practitioners work – the essence of the Health Care Homes project – is only part of the change necessary. The way the whole primary care system works needs to change. The *direction* of the current policy is sound, but more ambitious changes are needed.

As we recommend in our May 2017 report, *Building better foundations for primary care*,[6] the Government should:

- require PHNs to gather more information about what happens in general practice to provide a basis for further reform. This can be done by capturing data collected in practice software without imposing a red tape burden on practices;
- strengthen Primary Health Networks (PHNs) and give them explicit responsibility for creating more effective and efficient primary care systems in their local areas. PHNs should give feedback to GPs to help them improve the quality of care they provide. The feedback should help GPs see how they are performing compared to other GPs in the area, and respond to poor results in accreditation surveys; and
- set specific goals and create joint accountability for better outcomes through Primary Care Agreements with each state, supplemented by localised agreements signed by the Commonwealth, the state and the Primary Health Network. These agreements should also include plans to strengthen the capacity of the PHNs themselves.

PHNs should also be provided with hospital data and information about specialist use. With this richer data they would be able to provide more useful feedback to GPs and be better able to identify service gaps for their local communities.

We also recommend that, over the long term, the Government reform Medicare's fee-for-service payment system for GPs. Currently, GPs have no financial incentive to reduce unnecessary patient visits to their practice. In recent years, the only proposals to mitigate Medicare's exposure to these costs has been to shift some of the risk to patients through increased co-payments. Yet, as we discuss in the next section, such moves could hit poorer patients hardest.

[5] Primary care is much more than primary *medical* care. The focus in this section is on general practice.

[6] Duckett, *et al.* (2017)

As was recommended by the National Health and Hospitals Reform Commission, payments for primary care should involve a mix of payments for care of people over a course of care or period of time, payments to reward good performance in outcomes and timeliness of care, and fees-for-service.[7]

[7] National Health and Hospitals Reform Commission (2009)

2 Out-of-pockets may restrict health care costs in the short term, but they can hurt health outcomes and the vulnerable

Patients face out-of-pocket costs when the fee charged for a health service exceeds the Government subsidy for that service. Out-of-pocket costs have in the past been considered a policy lever because they create an incentive to use health services less. Yet less use of health services can end up costing more in the long term. And out-of-pocket costs also hit the vulnerable the hardest.

What are out-of-pockets?

Patients can be charged out-of-pocket fees for Medicare services, for example to visit a GP or specialist doctor, or get blood or imaging tests. Such fees are determined by the medical practitioner and are not regulated as part of the Medicare Benefits Schedule. There are also fixed out-of-pocket fees for drugs on the Pharmaceutical Benefits Scheme (PBS).

Once patients spend a certain amount each year, 'safety nets' reduce or eliminate these payments. For people on concession cards, there are lower safety-net thresholds, as well as lower fixed out-of-pocket costs for the PBS. Other aspects of health care, such as allied health services and medical equipment, also involve out-of-pocket costs. There is no safety net for these fees (except where allied health fees are controlled by a Chronic Disease Management Plan). People with private health insurance may get a rebate for these costs from their insurer.

It is important to note that out-of-pocket fees are not the only costs that individual patients pay. Getting care often involves travel or child care costs, or time taken away from paid work, particularly when out-of-hours services are not available.

Out-of-pockets create an incentive to use health services less

Usually when a good or service becomes more expensive, people will buy or use less of it.

But people's use of health services will also depend on factors such as the public's level of health, access to health services, and health service providers' behaviour – for example, a given provider may encourage or discourage further use of health services.

Nonetheless, cost is clearly a barrier for some people to accessing health services. The ABS Patient Experience Survey in 2015-16 shows that due to cost:[8]

- 4 per cent of people delayed or did not see a GP;

[8] ABS (2016b)

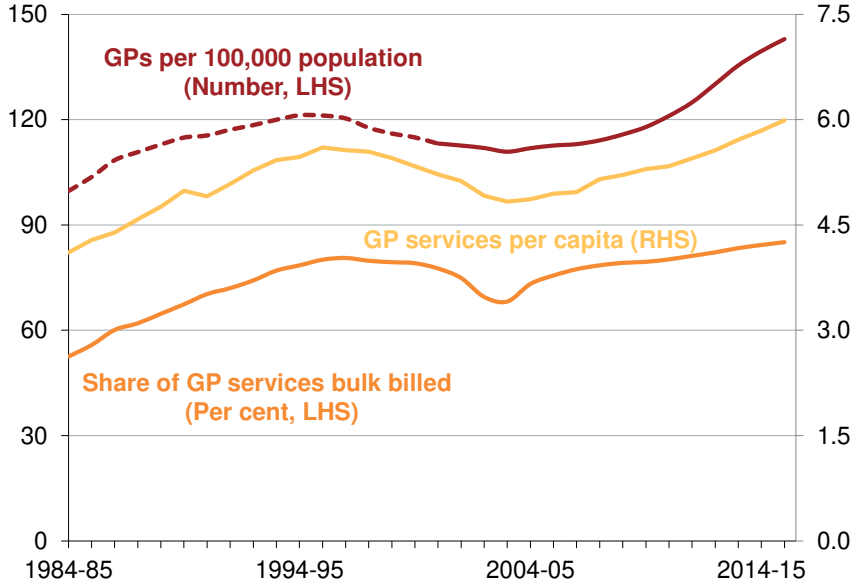
- 8 per cent of people who received a prescription for medication delayed or decided against filling it. People who live in the 20 per cent of areas which are most disadvantaged have a much higher rate of delaying or not filling a prescription compared to those who live in the least disadvantaged areas – 10 per cent compared to 5 per cent;
- 8 per cent of people who needed to see a medical specialist delayed or did not go; and
- 19 per cent of people who needed to see a dental professional delayed or did not go. People who live in the 20 per cent of areas which are most disadvantaged have a much higher rate of delaying or not filling a prescription compared to those who live in the least disadvantaged areas – 27 per cent compared to 11 per cent.

Other surveys, such as the international comparative survey of the Commonwealth Fund, show higher levels of reduced use because of cost.[9] Separate research released this year showed that cost barriers were more common in Australia than in many other developed countries.[10]

Primary care use declined when bulk-billing declined

The issue of cost is also evident in Medicare data on GP services. Figure 2 shows that the trend in the use of GP services per capita has been broadly similar to that in the share of GP services that is bulk billed.

Figure 2: Use of GP services, the bulk billing rate and the supply of GPs have all followed the same broad trend



Notes: Prior to 2000-01, the 'GPs per 100,000 population' series has been estimated using annual percentage changes in 'GP Head Count' in the 2013-14 GP Workforce Statistics. 'GP services per capita' uses 'Total non-referred attendances (Including GP/VR GP, Enhanced Primary Care, and Other)' in the annual Medicare statistics.
Sources: Grattan analysis of ABS (2017), Department of Health (2014), Department of Health (2016) and Department of Health (2017a).

The decline in both bulk billing and use of services between the late 1990s and early-to-mid 2000s attracted considerable commentary. Researchers noted the association between the two, but differed in the extent to which they were willing to directly

[9] Schoen, *et al.* (2013)

[10] Corscadden, *et al.* (2017)

attribute the fall in services to the fall in bulk billing.[11] For instance, in 2015 the Parliamentary Budget Office concluded that services were 'likely influenced' by the bulk billing rate.[12]

The reason it is difficult to attribute the trend in services to the trend in bulk billing is that other factors also influence use of health services. We listed some of them above. One important factor – which is also shown in Figure 2 – is the supply of GPs. This is likely to affect the bulk billing rate through price competition between GPs, and may also affect the use of services directly through increasing or decreasing access.

Another factor, which became more prominent in the mid-2000s, was the addition of new items to the Medicare schedule, some of which were tied to specific Government initiatives. For example, in 2005 the Government's 'Round the Clock Medicare' program dedicated $556 million over five years to expanding the availability of after-hours general practice.[13] Much of the growth in GP services per capita after 2005 can be attributed to the new after-hours items that were created as part of this program.[14]

Our take on this graph is that bulk billing has been a significant factor in ensuring access to primary medical care and that the decline in bulk billing in the second half of the 1990s had an adverse impact on access. This decline led then Health Minister Tony Abbott to introduce a range of measures to stimulate bulk billing. They worked.[15]

Less use of primary care can lead to greater health problems and higher costs in the longer term

Out-of-pockets reduce worthwhile care as well as unnecessary care.[16] Foregoing worthwhile care can mean that health problems get worse. For instance, someone's condition is likely to deteriorate if they do not take their prescribed medication.

Deteriorating health can then lead to higher health system costs in the future. Extending the previous example, someone who doesn't take their medication may end up in hospital. The cost of hospital stays are likely to end up considerably larger than the cost of the preventive primary care treatment.[17] High out-of-pocket costs influence patient decision making and may be to the long-term detriment of the health system.[18]

Cost barriers to accessing specialists in the community can also put more strain on hospital budgets. As noted above, about 8 per cent of people delay or do not see a specialist because of cost. Many of these people may end up seeing specialists through hospital outpatient services.

Longer-term costs also extend beyond the health system. If people get sicker, they are less likely to work, which cuts tax revenues and hurts government budgets. They may also need more support from carers and other kinds of government services.

[11] Birrell and Hawthorne (2004); Griggs and Atkins (2004); Jones, *et al.* (2004); Hopkins and Speed (2005); Khan, *et al.* (2004); and Parliamentary Budget Office (2015).
[12] Parliamentary Budget Office (2015), p.vii.
[13] Commonwealth of Australia (2005)
[14] Parliamentary Budget Office (2015)
[15] Pratt (2004)
[16] For a more detailed discussion, see Duckett and Breadon (2014), p.11.
[17] Ibid., p.11.
[18] Currow and Aranda (2016)

To put these impacts in perspective, the current government rebate for a standard general practice consultation (Level B) is $37.05.[19] The least complex standard emergency department visit in an efficient hospital is priced at $256, with the Commonwealth payment for each extra visit being 45 per cent of this, $115.[20] A hospital admission for asthma (DRG E69B), which could be avoided by better primary care, is priced at $1663.[21] And the Commonwealth contribution to an extra asthma admission in an efficient hospital is $749.

Out-of-pockets hit the vulnerable hardest

Changes to Australia's primary health care sector over the past decade have both helped and hindered the ease with which different segments of the community have been able to access health services.[22] Barriers to access created by out-of-pocket costs present a risk to equity across the community. This is because these barriers are highest for poorer, sicker people and people in remote areas.

Unsurprisingly, people on lower incomes are more likely to forego health services because of cost.[23] They also spend a higher proportion of their disposable income on health.[24]

People with poor or fair self-assessed health, and people with a long-term condition, are more likely to avoid going to the GP because of cost than are people with better health.[25]

People outside Australia's major cities are also more likely to delay or avoid accessing health services because of cost.[26] This is exacerbated by lower bulk billing rates outside the major cities.[27]

The high cost of seeing a specialist: governments need to use rebate setting and providing information to the public to drive prices down

About 80 per cent of general practice visits are bulk billed. However, the rate of bulk billing for visits to a specialist is much lower, and out-of-pocket costs, when a fee is charged, are much higher.[28] The out-of-pocket costs for procedures can also be very high. Consumers can also face out-of-pocket costs as a result of diagnostic services where they had no effective choice of provider.

High out-of-pocket costs for specialist care could be due to one of, or a combination of, four main reasons.

First, it may be that rebates for some procedures or for attendances are set too low. Rebates are set by government and

[19] Rebates applying from 1 July 2017.
[20] Non-admitted, category 5 patient in a larger hospital, URG 72.
[21] 2017-18 prices, E69B, Bronchitis and Asthma, Minor Complexity, inlier patient with no additional payment supplements.
[22] Fisher, *et al.* (2017)
[23] See Grattan analysis of survey data from the ABS and The Commonwealth Fund on page 7 in Duckett and Breadon (2014).
[24] Ibid.
[25] See Grattan analysis of survey data from the ABS and Searles et al. (2013) on page 8 of Duckett and Breadon (2014).
[26] ABS (2016b)
[27] See Grattan analysis of bulk billing data on page 9 of Duckett and Breadon (2014).
[28] Freed and Allen (2017)

may bear no relation to the efficient cost of providing a service. Unlike the situation in Canada, there is no obligation in Australia for government to consult with medical practitioners before setting fees.[29]

However, this explanation cannot account for the very high variation in fees. If high levels of extra-billing – billing above the schedule fee – were due to inadequacies in the schedule fee, then this would apply to all specialists equally. In fact, some specialists charge more than others. Nevertheless, tighter restrictions on fees would only be fair if the rebates are reasonable in the first place, and so rebates should be indexed in line with inflation and not frozen at the whim of government.

Second, a specialist's ability to charge a substantial out-of-pocket premium may simply be the result of the interaction of supply of services in a particular location and the demand for those services. If the market for specialist care was functioning perfectly, supply would adjust to meet demand.

The reality is specialist care is not a perfect market. Even with the increase in the number of medical graduates in Australia over recent years, there are still shortages of specialists in regional and remote Australia – and the current trickle-down policies are unlikely to fix this problem.

More needs to be done. Government should consider whether specialists' productivity can be improved, or whether other health professionals could perform roles in short supply. Our April 2014 report, *Unlocking skills in hospitals: better jobs, more care,* outlined some options.[30]

While Medicare provider numbers – which underwrite the fees of specialists – are freely available, specialists will tend to give priority to establishing their practices in more salubrious, city locations. There is no guarantee that the individual location decisions of newly accredited specialists will reflect community need.

Government should encourage new specialists to practice in rural and remote Australia. This should first involve carrots such as subsidies for the first few years in practice and other forms of support. But if carrots aren't working, sticks need to be considered, otherwise rural Australians will continue to suffer poor access. The sticks might include restricting access to Medicare billing in areas of existing over-supply in particular specialties. This would not preclude specialists establishing practices in over-supplied areas, but rather would limit public subsidies in those areas and thus provide an incentive on newly-minted specialists to establish in areas where the need is greatest. Medicare already provides differential rebates for general practice in different parts of the country (rural and regional compared to inner city). A targeted approach to specialist fees would build on that approach.

Third, high specialist charges and consequent high out-of-pocket costs may be the result of market power. It may simply be specialists maximising their income.[31] Even in areas of reasonable supply, specialists may be able to charge relatively

[29] Section 12 of the Canada Health Act provides that provinces must negotiate with the medical profession about 'reasonable compensation' if 'extra-billing' is to be prohibited.

[30] Duckett, *et al.* (2014)
[31] Johar, *et al.* (2017)

higher fees because they benefit from established referral patterns. Patients may not be aware of these higher fees until they are committed to be treated by that specialist.

A response to market power is to strengthen the market, to use competition between specialists to drive prices down. The first step to improving competition is to have more transparency about prices charged.

Government – and perhaps private health insurers too – should publish information on fees charged by specialists. This should include fees charged for attendance items and, in the case of procedural specialists, the fees charged for the five most common procedures they perform.[32]

Information should be published about how each specialist's fees compare to the average of specialists in a 10-kilometre radius (or some other measure of the local market area). In addition to median fees, the information should include data on the proportion of visits bulk-billed, and fees at the 10th and 90th percentiles.

Government should further discourage higher fees by eliminating a rebate when fees are significantly above the standard rebate. For example, rebates may only be paid if the specialist fee is less than twice the standard rebate. This would put more pressure on specialists to moderate their fees.

The fourth reason there may be high out-of-pocket charges is that some specialists are able to charge a premium for skill, or at least they might claim that is the basis for their high fees. Unfortunately, patients have no way of knowing whether this skill-based premium is warranted. Again, transparency can help here.

It is now possible for hospital-based specialties to report on quality measures such as complication rates or unplanned admissions to Intensive Care Units.[33] Governments and private health insurers should publish information which allows patients and their GPs to assess whether there is any evidence that a specialist's outcome-based premium is warranted.[34] The way in which government and insurers publish information could differ – with government publication being simply performance against agreed metrics, with insurers perhaps producing more drawing on that to produce more user-friendly information for their members such as star-ratings.

Quality of care is heavily influenced by the performance of the whole health care team, not simply the performance of one member of the team, and this may seem to invalidate individual practitioner reporting. However, the essence of private billing is that one individual is taking responsibility for treatment, so individual accountability is reasonable in that context.

There are, of course, challenges associated with publicly reporting indicators of providers' quality of care. Agreement would need to be reached on what are the key quality indicators for a range of

[32] It is recognised that some specialists are now charging 'booking fees' and other administrative fees which do not attract MBS rebates. This stratagem may be used by specialists to avoid public scrutiny. The best way around this might be a 'name and shame' approach, where patients are encouraged to report these fees on public web sites such as Whitecoat.

[33] Medibank, for example, has published quality measures for a range of surgical specialties.

[34] The information published should take account of the complexity of the patients.

procedures in each specialty. Specialty societies should identify a limited range of indicators seen as appropriate to measure quality of care. Published metrics could also include the specialist's propensity to provide low-value care (see later discussion).

Imperfect measures can be gamed, or discourage providers from treating high-risk patients. And not all differences in performance metrics reflect actual differences in performance. However, opportunities for gaming or over-interpreting performance metrics can be largely removed by reporting performance within broad bands – for example, the bottom 25 per cent, the central half, and the top 25 per cent of performers. In the first instance, reporting should simply state whether, based on the specialist's track record, future performance is likely to be of a high standard.[35]

Doctors patients don't chose

Most of these strategies are directed at helping consumers make a more informed choice, or helping to strengthen the operation of the market. But out-of-pockets also occur where there is no market, and consumers have no effective choice and may not even be aware of the names of the provider until a bill is received. Patients rarely chose who might assist in an operation, an inpatient has little effective choice in the radiology provider, nor may they be provided with any options about their anaesthetist.

A previous Grattan Report, *Blood money: paying for pathology services*, identified significant weaknesses in the pathology market and proposed remunerating pathology corporations as businesses rather than through the historic fee-for-service system.[36] A broader rethink of diagnostic service provision in hospitals is warranted.

Patients should not face unexpected bills from providers they did not chose. In the case of diagnostic services one option would be to fold their bills into the bill from the private hospital – after all, it is the private hospital which typically has a contract with the diagnostic services provider. This would place an incentive on the private hospital to negotiate about the levels of extra-billing which might occur. It would allow private insurers to manage out-of-pocket costs from diagnostic services as part of their contracts with private hospitals.

Similar arrangements might also apply for anaesthetists and assistants, but with their bill folded into the bill for the surgeon (or other proceduralist). Again, it is usually the surgeon who chooses the anaesthetist and the assistant.

An approach which offered patients greater protection might be to eliminate extra-billing where patients had no choice of doctor. This would extend current policies about financial consent so that where there was no such explicit consent, there could be no extra-billing. Such a policy could either be effected through MBS rules, or through consumer protection legislation.

[35] The low number of procedures completed by new specialists will make it more likely that their performance will appear to be above or below average. Accordingly, time practicing should be accounted for when assessing a specialist's performer. A Bayesian approach may be most appropriate for this.

[36] Duckett and Romanes (2016)

Public hospital outpatient services

People can access specialists without out-of-pocket costs at public hospital out-patient clinics. However, media reports suggest there are significant waiting times between a referral to a clinic and being seen. Most states do not publish information about outpatient waiting times, and reportedly long outpatient waits are used to reduce reported waiting times for inpatient care. All states should be required to publish outpatient waiting time data in a form which can help GPs make referral decisions. Outpatient waiting time data should be collated and published nationally.

What the government should and shouldn't do about out-of-pockets

There is no 'right' level of out-of-pocket costs in a health care system for the Government to pursue. One could take the view that any cost barrier to services in a universal health care system is unacceptable. Yet in reality, the cost to the Government (and the taxpayer) of removing all cost barriers is likely to be prohibitive.

Instead, the Government should bear three things in mind in regard to out-of-pocket costs.

First, seeking to increase out-of-pocket costs is not a good way to save money in the health care system. It could exacerbate current equity issues and, perhaps more to the point, it could be self-defeating by simply increasing costs in the longer term. As we have shown in many previous reports, there is still considerable scope for the Government to make other savings in the health care system.[37]

Secondly, the Government can help patients reduce their out-of-pocket costs by promoting transparency in fees and procedural outcomes. For example, knowing what specialists charge for common procedures – and whether there is any evidence that they achieve better outcomes – would allow patients and their GPs to make better-informed choices about referrals.

Thirdly, government should do more, using the rebate and controls on access to Medicare billing, to encourage medical specialists to locate in areas of greatest need.

[37] For example, see: Duckett, *et al.* (2014) 'Unlocking skills in hospitals: better jobs, more care'; Duckett, *et al.* (2014) 'Controlling costly care: a billion-dollar hospital opportunity'; and Duckett and Banerjee (2017) 'Cutting a better drug deal'.

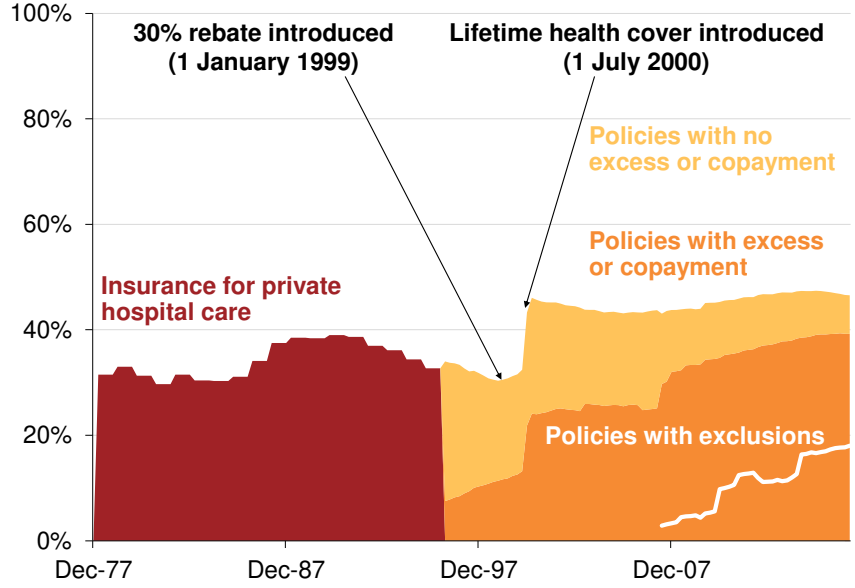
3 Private health insurance rebates are low-value public spending

Previous Grattan Institute reports have questioned the value of the health insurance rebate,[38] and the additional rebate for older people.[39]

Private health insurance rebates were introduced in 1999 with the objective of reducing the burden on the public health system. The number of Australians with private health insurance for private hospital care had fallen since the early 1990s (see Figure 3), and this was understood to be threatening the viability of private hospitals.[40]

The introduction of private health insurance rebates in 1999 had little impact on private health insurance coverage. There *was* a resurgence of coverage in Australia in the early 2000s. However, this increase was driven by intensive advertising and the approach of the 'lifetime coverage' deadline, rather than the private health insurance rebate.[41]

Figure 3: Introduction of the private health insurance rebate had almost no impact on coverage
Proportion of Australians with private hospital insurance



Sources: APRA (2017b); Duckett and Willcox (2015), figure 3.14.

[38] Daley, *et al.* (2013)
[39] Daley, *et al.* (2016)

[40] Insurance coverage for public hospital care – the measure typically shown in prevalence of health insurance – had also fallen precipitously since the introduction of Medicare in 1984, which had made such insurance otiose.
[41] Butler (2002); Ellis and Savage (2008).

There is a huge variety of private health insurance products, giving consumers choices about how big an up-front payment might be required in the event of hospitalisation (e.g. the contributor might be required to pay the first $500, an example of a *deductible*), and whether the policy will cover all exigencies (e.g. whether maternity care or mental health care will be covered, an example of *exclusions*). The higher the deductible and the greater the exclusions, the lower the premium.

Most of the increase in coverage following the introduction of lifetime cover was in products with deductibles or exclusions. Further, increases in premiums is leading many people to drop their level of cover, switching from 'full coverage' to products with deductibles and exclusions.

As shown in Figure 3, the vast majority (88 per cent) of health insurance policies now have some form of deductible. As Figure 3 also shows, there has also been a steady increase in the proportion of policies with exclusions and so now about 40 per cent of the insured population have products which do not cover hospital admissions for all types of conditions.

Economic research suggests rebates are a very expensive way to boost private health insurance coverage, because it takes a very large change in private health insurance premiums to alter an individual's decision on whether to take out private health insurance.[42] This finding appears to have held true in Australia: when the value of the rebate was changed for older and wealthier Australians in 2005 and 2014 respectively, private health insurance coverage did not appear to respond.[43]

Responding to the changed private health insurance profile

One consequence of the changed mix in the level of coverage is that many Australians face high out-of-pocket costs – or do not have coverage at all – when they use their insurance to be treated in a private hospital. The Government has established a Task Force to recommend policy changes. The Task Force has not yet reported. Policies that could be considered include:

- Standardising products to facilitate comparisons. One option would be to categorise policies into Gold, Silver and Bronze. Regulations could also be introduced to limit the range of exclusions which could be offered. For example, products offered to people over 65 might not be allowed to exclude orthopaedics, given the higher prevalence of orthopaedic with age. Similarly, the types of deductibles might be constrained to $500, $1000, and $5000 per year.

- Improving information about likely health service use to help people better evaluate exclusion options. The Government could make information available to enable people to judge the likelihood of people like them using particular health services. For example, the Government could provide a simple table showing, for a limited range of service types (e.g. orthopaedics, maternity care, mental health care), the chance that a person of a given gender and age-range would require hospital treatment in the next year.

- In the face of complexity, consumers default to easy choices such as simply renewing their existing policy. Where customers have chosen a policy with exclusions, government

[42] Cheng (2013)

[43] Kettlewell, *et al.* (2017)

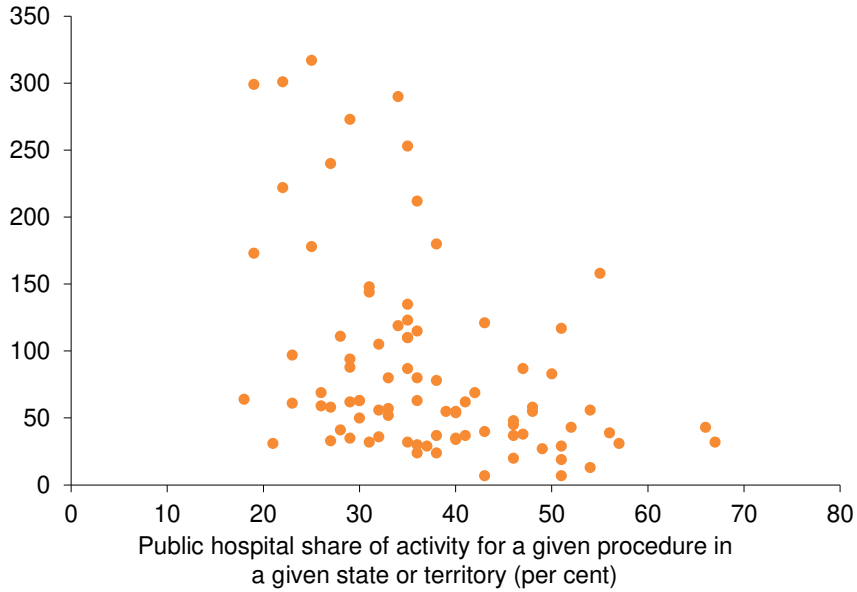
could require insurers to offer customers, at policy renewal time, polices where the insurer offers a tailored default based on the estimated use of particular services given the customer's age, gender and past use. Insurers could also be required to advise renewing customers of a more appropriate set of exclusions that minimises unexpected out-of-pocket costs.[44]

Increased private hospital care does not reduce public hospital waiting

One justification for the rebate was that increased support for public hospital care would take pressure off public hospitals. However, as has been shown previously,[45] shorter public hospital waiting times are associated with a greater proportion of *public* activity rather than a greater proportion of *private* activity. Specifically, the greater the proportion of activity in the public sector in larger specialties in larger states, the lower the median waiting times (see Figure 4).[46] Conversely, a larger private share is associated with longer public waiting.

Figure 4: Public hospital waiting times are shorter when the public hospital share of activity is greater

Median waiting time for a given procedure in a given state or territory, days



Notes: Procedures are cataract extraction; cholecystectomy; coronary artery bypass graft; cystoscopy; haemorrhoidectomy; hysterectomy; inguinal herniorrhaphy; myringotomy; prostatectomy; septoplasty; tonsillectomy; hip replacement; knee replacement; and varicose vein stripping and ligation.
Sources: Grattan analysis of Table 6.11 of Australian Institute of Health and Welfare (2015a); Table 6.3 of Australian Institute of Health and Welfare (2016a); Table 6.15 of Australian Institute of Health and Welfare (2017); Table 3.6 of Australian Institute of Health and Welfare (2014); Table 4.9 of Australian institute of Health and Welfare (2015b); and Table 4.9 of Australian Institute of Health and Welfare (2016b).

[44] Care would be needed in the design of the policy to avoid allowing insurers up-selling insurance unnecessarily.

[45] Duckett (2005)
[46] The methodological details are in the Appendix.

Longer waits and a greater private share might occur for a number of reasons: people might seek private care to avoid long waits; surgeon time is limited and if they spend that time in private care, they have less time to provide public hospital care; or surgeons might create longer waiting times to increase demand for private care which is more remunerative. Whatever the reason, policies directed at increasing public hospital provision and the public hospital share of the work are more likely to reduce public hospital waiting times than indirect policies aimed at supporting private hospital care. Expanding the private hospital share is therefore not a good way of improving public hospital waiting times and thus does not provide a justification for the private health insurance rebate.

Just as they have not driven a significant increase private health insurance coverage, rebates have not substantially decreased the demand on Australia's public hospitals. Rebates have, however, been expensive. In 2016-17, the Commonwealth Government spent $6 billion – or 9 per cent of all Commonwealth healthcare spending – on private health insurance rebates.[47]

The policy's benefits do not appear to justify its costs. Assuming that past patterns continue, it is estimated that every dollar cut from the rebate would improve the budget bottom line by between 60 cents[48] and $1.[49]

It is unclear whether private hospitals are more efficient than public hospitals

Despite the cost of the rebate, this expenditure could be justified if it were associated with an overall improvement in health system efficiency. That is, if private hospitals were demonstrably more efficient than public hospitals, then encouraging patients to be treated in private hospitals would be a system improvement.

Unfortunately, it is hard to compare the efficiency of public and private hospitals. The Independent Hospital Pricing Authority holds a good data set of the costs of treating patients in the larger public hospitals (the National Hospital Cost Data Collection). There are separate data collections held by the Commonwealth Department of Health, which report on fees charged to patients by private hospitals (the Private Hospital Data Bureau collection) and payments made by private insurers for private hospital care (Hospital Casemix Protocol data). The three data sources are held separately and have slightly different elements.

For public hospitals, the cost data includes information about all aspects of a patient's care. Private patients are billed separately by their treating doctors, and for diagnosing tests (including pathology and radiology). These fees attract Medicare rebates. Pharmaceuticals may also be billed separately. And for patients in private hospitals, prescriptions for relevant items are covered by the PBS. Studies of relative efficiency thus need to adjust for the different services captured in the different data sets. Cost

[47] Department of Health (2017b)
[48] Cheng (2013) found savings from reducing spending on the private health insurance rebate outweigh additional public hospital costs by 2.5: 1.
[49] The Parliamentary Budget Office assumed that public hospital expenses would not rise when people cancelled their private health insurance. Instead the increased demand for public hospitals services would be result in longer waiting lists in the short term. Parliamentary Budget Office (2016). Over the longer term, public concern about longer waiting lists might well lead governments to increase hospital spending.

comparisons need to take account of these different ways services are funded. As there are currently no publicly-available data sets which link MBS-billed and PBS-funded services to private hospital stays, it is not possible to make definitive relative efficiency judgements even at a DRG level.

In contrast to public hospitals, most private hospitals do not admit emergency patients. Almost 60 per cent of all elective admissions are admitted to private hospitals, but only 8 per cent of emergency admissions are admitted to private hospitals.

Holding beds available for emergency patients, and having staff on-call to attend when necessary, means that providing access for emergency patients adds to overall hospital costs. Patients admitted urgently often stay in hospital longer than elective patients with the same condition. Private hospitals tend to refer out more complex patients and receive referrals of less complex patients from public hospitals.[50]

The Productivity Commission reached different conclusions in its two studies of comparative costs. Its initial study found that public and private hospitals had similar average costs.[51] In contrast, a follow-up study found that for-profit hospitals were more efficient than public hospitals.[52] However, this study has severe methodological weaknesses; it uses aggregate data and inadequate standardisation for the impact of emergency care.

Table 1 shows information about length of stay for patients admitted to public and private hospitals for hip replacements. Length of stay is not a perfect measure of costs, and in the case of joint replacement prosthesis costs are significant, but it can show differences in the way care is provided, and could signal signals how costs might fall.

[50] Cheng*, et al.* (2015)
[51] Productivity Commission (2009)
[52] Productivity Commission (2010)

Table 1: Hip replacements in public and private hospitals, 2010-11

		Public			Private			Total
		Emergency	Elective	Total public	Emergency	Elective	Total private	
I03A: Hip replacement with catastrophic comorbidities or complications	**Number**	916	1,042	1,958	163	1,241	1,404	3,362
	Average length of stay	15.9	9.5	12.5	17.7	10.2	11.1	11.9
I03B: Hip replacement without catastrophic comorbidities or complications	**Number**	4,336	7,342	11,678	876	15,360	16,236	27,914
	Average length of stay	9.6	6.0	7.3	11.0	6.4	6.7	6.9

Source: Grattan analysis of National Hospital Morbidity Database.

At first glance, it might seem that private hospitals are more efficient than public hospitals in treating hip replacements, at least as measured by length of stay. But a closer look shows the reverse. The average length of stay for less complex hip replacements in private hospitals is 6.7 days, compared to 7.3 days in public hospitals.[53] But when one compares like with like, in terms of elective and emergency patients, this relativity is reversed.[54] For both elective and emergency patients, public hospitals have a shorter length of stay.

Policy should obviously not be made on the analysis one DRG. However, this analysis highlights the importance of standardising for within-DRG variation – particularly the elective-emergency mix – when comparing public and private hospitals. Previous studies have not done this.

It is thus not possible to say with confidence that private hospitals are more efficient than public hospitals, and so a policy to shift treatment from public to private cannot be justified on efficiency grounds.

Private patients in public hospitals

Public hospitals are required under the current Commonwealth-state agreement on hospitals to ask people on admission whether they wish to be treated as a public or private patient. States set revenue targets for public hospitals and, depending on the way

[53] DRG I03B, Hip replacement without catastrophic comorbidities or complications

[54] An example of what is known in statistics as the amalgamation or Simpson's paradox.

these targets are set, and what happens with over-target revenue, public hospitals may have an incentive to encourage patients to elect to be treated as private patients, especially where there is no financial consequence for the patient because any excess they may have had to pay under their insurance policies is borne by the public hospital. Doctors treating these patients also ensure there is no gap for the patient to pay.

These private-in-public policies have led to increased benefit pay-outs from private insurers. For example, total payments to public hospitals by insurers in the December 2016 quarter were 7.5 per cent higher than in the December 2015 quarter.[55] In contrast, payments to private hospitals were only 4.2 per cent higher. This pattern of significantly higher public growth is not replicated nationally in other recent quarters. However, some states (Queensland, South Australia, Western Australia) have shown a significant divergence between growth in private hospital payments and private-in-public growth in recent years, with much higher private-in-public growth.

The current Commonwealth-state funding agreement caps the growth payments from the Commonwealth to the states at 6.5 per cent. At the very least, this cap should also be applied to public hospital private patient growth; that is, any private patient growth in any state above 6.5 per cent would not attract Commonwealth growth funding. A stronger policy would be to cap Commonwealth growth payments for private patients at the same level as public patient growth in the state.

More worryingly, recent Australian Institute of Health and Welfare statistics show that in 2015-16 the waiting times for private patients in public hospitals was significantly less than for public patients. The average waiting time for public patients was 42 days, but for private patients who used their private health insurance to pay for their admission, the average waiting time was only 20 days.[56] Other measures of waiting time show a similar pattern.

If the 2015-16 data are confirmed in subsequent years, this may indicate that privately insured patients are getting priority access to public hospitals.[57] If so, this is a breach of the national funding agreements which require that patients be prioritised for admission on the basis of clinical need. Further analysis of the data is required to identify if this pattern is occurring in all states. For those states where there is a material difference in waiting times for privately-insured patients compared to public patients, the Commonwealth and the state should jointly audit hospitals which show this pattern.

A fundamental principle of Medicare is that patients are to be treated on the basis of need – public patients should not be relegated to the bottom of an admission hierarchy. Where there is evidence of prioritising privately-insured patients, the

[55] APRA (2017a)
[56] Australian Institute of Health and Welfare (2017)

[57] It may be that these data are an artefact – for example, the private patients may have greater clinical need. But the clinical specialty data published by AIHW does not seem to support that hypothesis.

Commonwealth should impose a severe penalty on the state, perhaps by excluding hospital activity in those hospitals where inappropriate prioritisation has occurred from counting toward recorded activity of the state for any quarter in which this has occurred.

Low-value care

A previous Grattan Institute report, *Questionable care: avoiding ineffective treatment,* proposed policies to address provision of treatments of low or no value,[58] but provision of questionable care still abounds. Stronger action needs to be taken.

There are also puzzling differences between patterns of care between public and private hospitals. For example, admissions to public hospitals for rehabilitation care have been essentially stable over the last three years (2013-14 to 2015-16), but admissions to private hospitals have increased by 30 per cent.[59] If this latter change has led to an improvement in outcomes for patients, say in terms of improved functioning, then the increased admissions, and associated costs, may be cost-effective. However, there is no published evidence to support this contention.

Rehabilitation care is an area where changing funding arrangements, for example to allow payments related to improved patient outcomes, is worth exploring. Private insurers' flexibility to deal with these issues is constrained by their existing regulatory environment.

As the Grattan report on questionable care noted, some hospitals have quite high rates of low or no value care. Private health insurers are constrained in how they can address this issue.

Phasing down the private health insurance rebate

The introduction of the rebate led to almost no increase in health insurance coverage and so was a poor strategy to achieve its stated objective. The significant increase in health insurance membership occurred with the introduction of lifetime-cover. Removing or phasing down the rebate – while keeping lifetime-cover and penalties on higher-income earners who do not have health insurance – may have a limited effect on membership. It may also have a limited impact on the level of coverage, given the change in the types of products purchased which has already occurred.

However, although a moderate decline in insurance coverage and consequential increased demand for public hospital admissions could be absorbed by the public sector, a dramatic shift would be disruptive and may impede access. Predicting the impact of phasing down the rebate is quite difficult. As was pointed out above, introduction of the rebate had a limited impact on membership. However, contributors may react quite differently to an effective price increase in the cost of insurance now, when

[58] Duckett, *et al.* (2015)

[59] Australian Institute of Health and Welfare (2015a); Australian Institute of Health and Welfare (2017).

wage increases are low or non-existent, compared to when the rebate was introduced.

It is quite possible that the price sensitivity ('price elasticity') of private insurance demand is quite different in today's economic climate compared to what was observed two decades ago. Reducing the rebate therefore might accelerate the downgrades of level of coverage which are currently besetting the market or lead to dropping coverage altogether.

These market conditions do not affect the issue of whether private health insurance should be subsidised, rather they highlight the need for caution is changing the existing subsidy arrangements. Any changes to the private health insurance rebate should therefore be gradual so that the impact on states and public hospitals can be properly assessed and addressed.

The private health insurance rebate varies by income and age of the contributor. Growth in total rebate spending by government is slowed by the indexation formula, which reduces the percentage of premiums subsidised if premiums increase faster than inflation. The current rebate structure is shown in Table 2.

Government spending on the private health insurance rebate could be slowed by further tightening up on inflation adjustments (e.g. using an index which has a slower growth rate), limiting the rebate to those with lower incomes (e.g. the Base group) or changing the rebate percentage for Tier 1 and 2 or just for Tier 2 contributors. Colleagues at Grattan Institute have previously recommended that the separate rates for older Australians be withdrawn because the principle of community rating provides sufficient protection for older Australians.[60]

Table 2: Rebate entitlement by income threshold 2017-18

Status	**Income thresholds**			
	Base	**Tier 1**	**Tier 2**	**Tier 3**
Single	$90,000 or less	$90,001 – $105,000	$105,001 – $140,000	$140,001 or more
Family	$180,000 or less	$180,001 – $210,000	$210,001 – $280,000	$280,001 or more
Age				
Under 65	25.934%	17.289%	8.644%	0%
65 to 69	30.256%	21.612%	12.966%	0%
70 plus	34.579%	25.934%	17.289%	0%

Source: ATO (2017)

Currently rebates are provided for both hospital and general (extras) insurance. But extras insurance has no relationship to public hospital use, so differential rebates could be applied to these products, or the rebate eliminated altogether, with minimal potential impact on public hospitals.

Almost half the Australian population has health insurance and any reduction in the value of the rebate will have an impact on family budgets. Policies for reducing the rebate, especially for the Base group (families with incomes below $180,000 a year),

[60] Daley, *et al.* (2016)

should therefore only be considered in the context of broader budget changes to ensure families, especially low-income families, are not disadvantaged.

Change in the level of the rebate should also be accompanied by deregulatory policies which allow insurers to address their costs – such as enhancing their ability to address low value care – at the same time as any revenue impact of a reduced rebate.

4 Appendix: Private activity share and public waiting

The data for this analysis was obtained from the Australian Institute of Health and Welfare's (AIHW) annual publications on Australian hospital statistics[61] and public elective surgery waiting times[62] for the years 2013 through to 2016. We examined data on 14 indicator procedures which included cataract extraction, cholecystectomy, hip replacements and coronary artery bypass grafts. These account for approximately 30 to 35 per cent of elective surgeries reported to the National Elective Surgery Waiting Time Data Collection database.

The AIHW publishes three measures of waiting time: days waited at the 50th percentile (median waiting time), 90th percentile, and the proportion of patients who waited more than 365 days. All data is disaggregated by state. We focused on the 50th and 90th percentile waiting time and compared this to data on public separations as a proportion of total separations for the indicator procedures.

For each procedure, we only included state level data if records were available across all three years. This excluded the ACT from the entire analysis. Tasmania and the Northern Territory were analysed for ten and six procedures respectively. These states make up a small proportion of the total admissions data and their exclusion is unlikely to bias our analysis.

Cross-sectional analyses for each reported year were similar and so here in Table 3 we present results from 2015-16 only.

Table 3: Descriptive statistics for waiting time and public patient proportion, 2015-16

	Min	Max	Mean	SD
Median waiting time (days)	7	317	87.09	73.84
Waiting time at 90th percentile (days)	26	659	246.4	128.9
Public share of procedures (%)	18	67	37.21	10.53

Source: Grattan analysis of Table 6.15 of Australian Institute of Health and Welfare (2017) and Table 4.9 of Australian Institute of Health and Welfare (2016b).

We found significant variation in waiting time data between procedures. Waiting times for coronary artery bypass grafts were consistently shortest. Longer median wait time were for septoplasty, hip and knee replacements. We did not analyse state variation in detail but it is clear that some states perform worse than others. For example, in NSW, the median wait time for a patient seeking a hip replacement is 212 days compared to 115 in Victoria.

[61] Australian Institute of Health and Welfare (2015a); Australian Institute of Health and Welfare (2016a); and Australian Institute of Health and Welfare (2017).

[62] Australian Institute of Health and Welfare (2014); Australian institute of Health and Welfare (2015b); and Australian Institute of Health and Welfare (2016b).

We plotted median and 90th percentile waiting time against the proportion of indicator procedures performed publicly. Using simple linear regression we generated r^2 values of 0.176 and 0.1961 respectively. Different functional forms had slightly higher r^2, around 0.2. Pearson correlation coefficient results are presented in Table 4.

Table 4: Association between public share of procedures and waiting times, 2015-16

	Median waiting time		Days waited at 90th percentile	
	r	2-tailed significance	r	2-tailed significance
Public share of procedures	-0.419	<0.01	-0.4429	0.00

Source: Grattan analysis.

For each of the three years of analysis, a statistically significant negative correlation was noted between public share and median and 90th percentile waiting time. This suggests that when more elective procedures are performed in the public system, waiting times are lower.

We also assessed whether changes in public share across years impacted on waiting times. We compared changes between 2015-16 and 2014-15 and between 2013-14 and 2014-15 and found no significant association, probably because there was so little shift in public share over these periods

Our analysis suggests that there is no evidence to support an assertion that increasing private share reduces the load on public waiting lists and in fact, increased public activity appears to be associated with reduced waiting times for patients.

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