GRATTAN Institute

Stopping the death spiral

Creating a future for private health

Stephen Duckett and Greg Moran

May 2021

Grattan Institute Support

Founding members

Australian Government

VICTORIA State Government

THE UNIVERSITY OF MELBOURNE

BHP

Endowment Supporters

The Myer Foundation

National Australia Bank

Susan McKinnon Foundation

Affiliate Partners

Susan McKinnon Foundation

Senior Affiliates

Cuffe Family Foundation

Maddocks

Medibank Private

The Myer Foundation

Scanlon Foundation

Trawalla Foundation

Wesfarmers

Westpac

Affiliates

Allens

Ashurst

The Caponero Grant

Corrs

McKinsey & Company

Silver Chain

Urbis

Woodside

Grattan Institute Report No. 2021-05, May 2021

This report was written by Stephen Duckett and Greg Moran. Jeremy Hunt provided extensive research assistance and made substantial contributions. Emma Campbell also made contributions to the report.

We would like to thank Shaun Gath and other colleagues for comments on the draft and discussions as part of the development of this report.

The opinions in this report are those of the authors and do not necessarily represent the views of Grattan Institute's founding members, affiliates, individual board members, or reviewers. The authors are responsible for any errors or omissions.

Grattan Institute is an independent think tank focused on Australian public policy. Our work is independent, practical, and rigorous. We aim to improve policy by engaging with decision makers and the broader community.

We acknowledge and celebrate the First Nations people on whose traditional lands we meet and work, whose ongoing cultures are among the oldest in human history.

For further information on Grattan's programs, or to join our mailing list, please go to: www.grattan.edu.au. You can make a donation to support future Grattan reports here: www.grattan.edu.au/donate.

This report may be cited as: Duckett, S. and Moran, G. (2021). *Stopping the death spiral: Creating a future for private health*. Grattan Institute.

ISBN: 978-0-6450879-3-2

Overview

Australia's private health insurance industry is in a death spiral. Government and the industry must come together to agree on a new industry plan to ensure the private health system is sustainable.

Grattan Institute and others have for years identified the problems with, and proposed solutions for, the health insurance market. But it's now clear that regulatory tinkering, government handouts, and blame shifting are not going to solve the industry's fundamental problems.

The causes of the death spiral are well known. An ageing population, increased use of healthcare services, and rising healthcare costs are driving up the amount of benefits that insurers have to pay out each year. As benefits paid increase, so do premiums. Rising premiums make health insurance less affordable and less attractive – particularly to younger and healthier people. As younger, healthier people drop their insurance, the insurance risk pool gets worse, premiums go up, more young people drop out, and the cycle continues.

But the private health system cannot be allowed to wither. Opinions vary on its value, but the reality is that private health plays a big role in Australia – most procedures are done in private hospitals, and more than 40 per cent of the population has private insurance.

This report shines a light on four specific problems.

Firstly, private hospital costs should be lower, and would be if private hospitals were as efficient as public hospitals.

Secondly, patients' out-of-pocket costs should be lower. Those costs are a major source of people's dissatisfaction with private health insurance, and egregious billing by a minority of doctors is a major cause.

Thirdly, private insurers pay too much for prostheses, because the way they are priced is opaque and not subject to competitive forces.

Fourthly, premium increases are too great and too frequent. Insurers that won't or can't offer their customers value for money should not be allowed to raise their premiums.

Change is inevitable. But at the moment each industry player is looking out for themselves, and policy settings inhibit many sensible reforms. All players need to come together to create an industry rescue plan: governments, insurers, private hospitals, device importers and manufacturers, and private specialists. Their joint interest in the sustainability of the sector must be brought to the fore. It's up to the major political parties to create a stable policy environment in which the federal government can build consensus among the competing interests.

As the industry struggles, huge amounts of public and private resources are being thrown at endless inquiries and PR battles. Agreement on a rescue plan won't be easy, but the payoff will be better a healthcare system for Australians.

Table of contents

1 The challenges facing private health

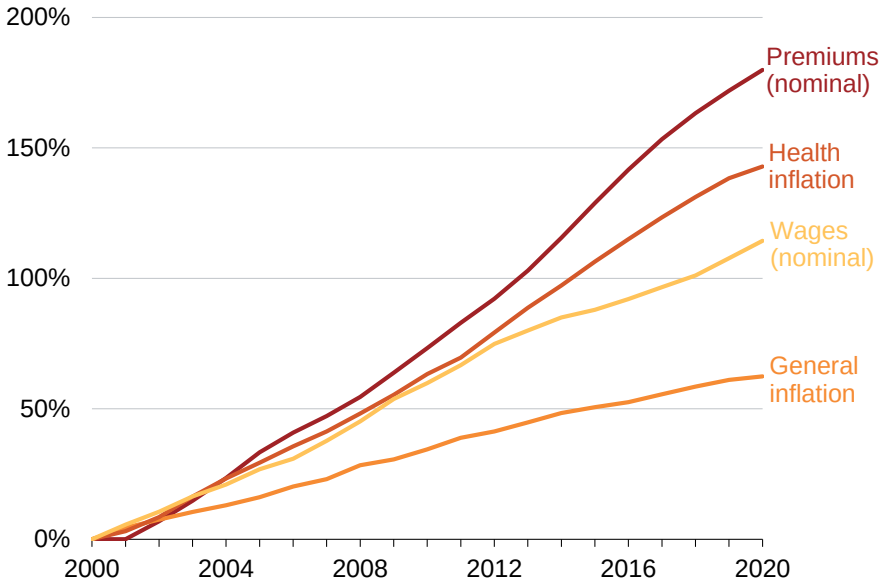
Over the past 20 years, private health insurance premiums have grown faster than inflation, faster than health-specific inflation, and faster than wages (Figure 1.1). The 2020 and 2021 increases were the lowest since 2001, but compared to household incomes the performance was still poor. If people want to keep their same level of insurance, they have to fork out more and more. Not surprisingly, many drop out or downgrade their cover – the rate of 'exclusions' and 'deductibles' is increasing (Figure 1.3 on page 7).

We identified the causes of the death spiral in our 2019 reports on private health.[1] The spiral continues: the population continues to age; people still face extortionate out-of-pocket medical costs from a handful of aberrant practitioners; the prosthesis rorts, where insurers are forced to pay prices more than twice those paid in the public sector, continue; and the government continues to tick-off premium increases.

There is still too much government red tape, mollycoddling, and created dependency, so the sector looks to government to fix its problems. But government feels paralysed because if it changes the rules there will be losers who will shout loudly.

The industry needs to face up to its own problems. Although some industry players are developing innovative responses, major industry segments are still looking to government to provide the fix, generally involving more subsidies or less consumer choice. All stakeholders need to agree on a new industry plan. This rescue plan should be bipartisan and cost-neutral to government. It should make the industry more efficient. The resulting lower premiums – or at least slower rate of increase in premiums – will ensure a larger market and more business for all.

Figure 1.1: Premiums have grown faster than inflation and wages
Cumulative increase in private health insurance premiums (industry average), average weekly ordinary time earnings, general inflation, and health-specific inflation



Source: Grattan analysis of Department of Health (2020a), ABS (2021a) and ABS (2021b).

1. Duckett and Nemet (2019a), Duckett and Nemet (2019b) and Duckett et al (2019).

1.1 The COVID crisis hasn't changed the industry's fundamental challenges

As for the entire economy, the COVID-19 pandemic created challenges for private health insurers in 2020.

From late March – as the first wave hit Australia – government shutdowns and restrictions on non-urgent healthcare meant people could not get many of the services they would normally under their private health insurance. The result, as Figure 1.2 shows, was that benefits paid by insurers fell significantly in the June quarter.

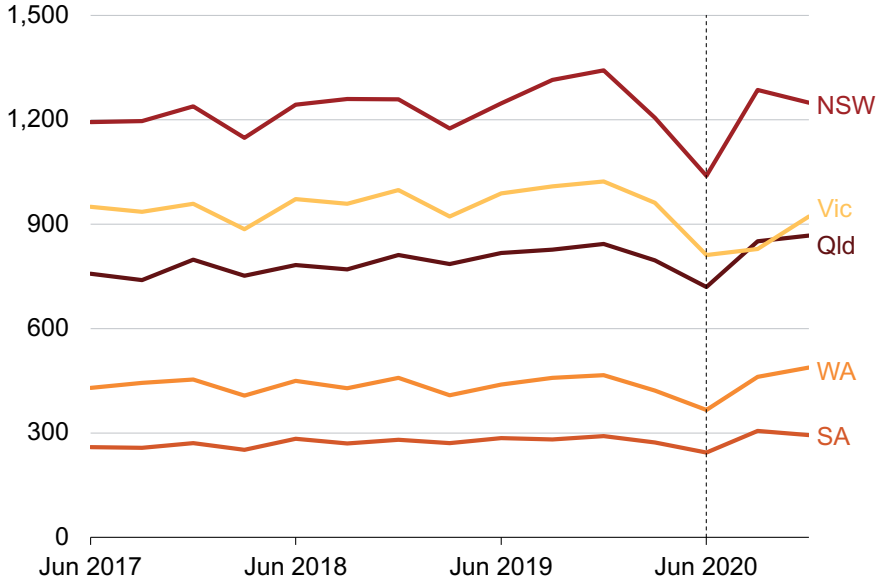
In the second half of the year, however, states other than Victoria were largely restriction-free, and benefits paid rebounded. Although the industry has collectively put aside $1.8 billion as a 'catch-up' provision – on the assumption that deferred procedures will be performed – the catch-up appears not to be happening.

Restrictions to hospital services, combined with the economic downturn, increased the risk that people would downgrade or drop their insurance during the year.[2] Insurers took steps to head-off membership losses, such as offering premium relief to people suffering financial hardship, and postponing for six months the increase in premiums planned for 1 April 2020.[3] Insurers also sought to add value to their product in a socially-distanced world, for example by providing cover for telehealth services.[4]

By the end of 2020, membership of private health insurers had actually grown to its highest level since March 2017.[5] The CEO of nib, Mark

Figure 1.2: Benefits paid by private health insurers fell sharply at the height of restrictions on hospital services

Total benefits paid by private health insurers for hospital treatment, hospital-substitute treatment, medical services, and prostheses, $ million



Source: APRA (2021).

2. Zhang et al (2020).
3. Private Healthcare Association (2020a) and Private Healthcare Association (2020b).
4. Private Healthcare Association (2020a).
5. It is too early to draw any conclusions from the slight increase in membership in the last half of 2020, but the trend of ageing membership continued in 2020; see Section 1.3 on page 8.

Fitzgibbon, said COVID-19 'appears to have lifted community interest in the need for protection'.[6] And although the margins were lower, the industry still turned a profit for the year.

The challenges met by the industry in 2020 were small beer in the grand scheme of things. As the next two sections explain, private health insurance continues to face an existential cycle of dissatisfaction with premiums and out-of-pocket costs, ageing membership, rising healthcare costs, and rising premiums.

1.2 Consumers are paying more but getting less

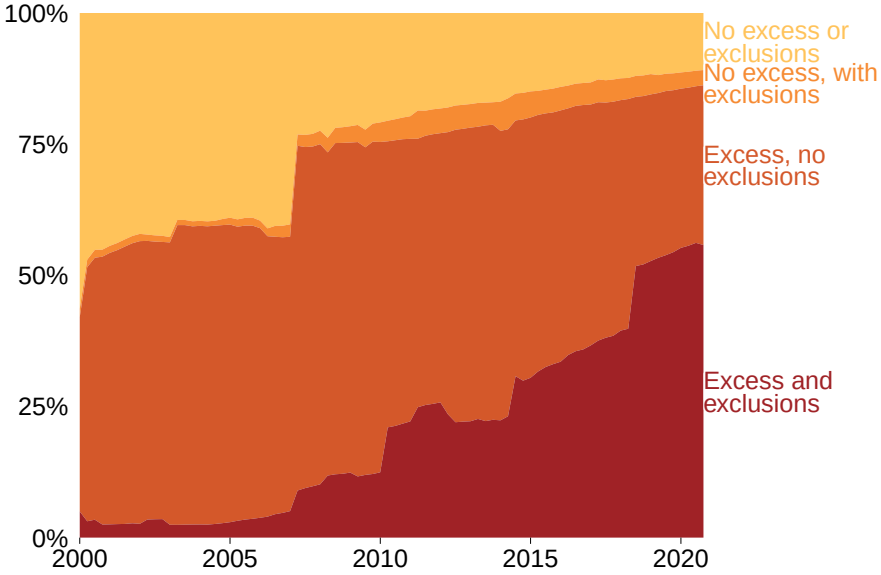
As Figure 1.1 on page 5 shows, premiums have risen faster than inflation and wages over the past 20 years.

One response to rising premiums has been for people to downgrade their cover, choosing policies with lower premiums that exclude certain services or require a minimum upfront payment (i.e. an 'excess') when claiming. Figure 1.3 shows that 20 years ago, fewer than half of policies had any exclusion or excess. Today, almost 90 per cent of policies have some form of exclusion or excess.

Insurers have sought to limit the number of people dropping their cover altogether by offering more options to downgrade. But this has made private health insurance more complex. And with complexity, some people may be taking on risks they do not fully understand when signing up to a particular policy, such as:

- liability for an excess or co-payment (which may not represent good value relative to the lower premium, depending on the person's probability of having hospital treatment);
- liability for medical bills from out-of-pocket costs; and

Figure 1.3: The share of people with 'top cover' continues to fall
Proportion of hospital treatment policies



Source: Grattan analysis of APRA (2021).

6. Baird (2021).

- forgoing medical coverage for some procedures (which may not represent good value, depending on the person's propensity for that condition).

With more exclusions and greater complexity comes the risk of unexpected out-of-pocket costs. And these higher out-of-pocket costs, on top of rising premiums, increase people's perception that private health insurance may not be good value for money – and the cycle goes on.

1.3 Ageing is the biggest cause of premium growth

As the benefits paid out by insurers increase, so do premiums. And benefits are increasing because of an ageing population, an ageing membership pool, an increase in health service use, and growth in healthcare costs above general inflation.

Figure 1.4 shows the contribution of each of these factors to the increase in real benefits per member in the five years to 2018-19. Ageing accounts for two-thirds of the increase.

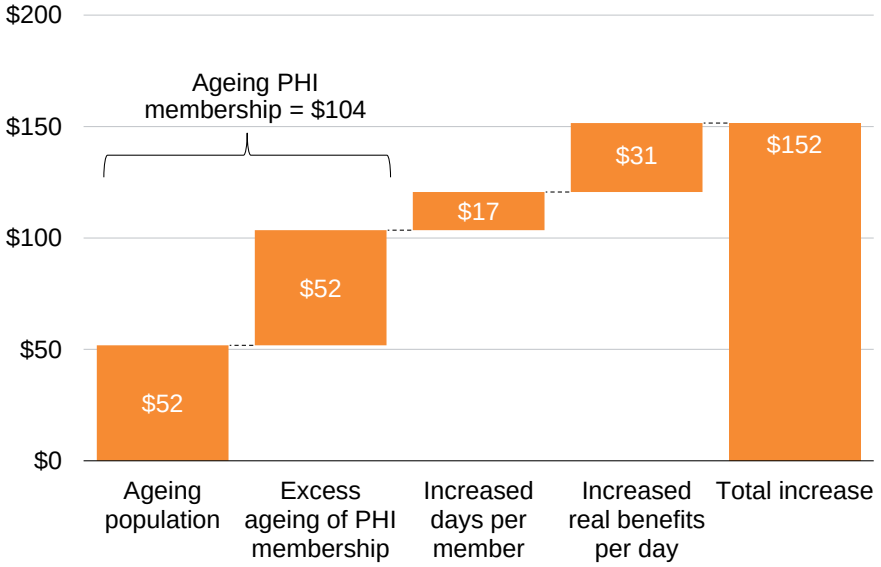
Older people claim more benefits than younger people on average. The average benefits for hospital treatment paid to people aged 65 or older in the December quarter of 2020 was $980, compared to just $196 for people younger than 65. And the share of people with private health insurance aged 65 or older has been increasing steadily. Even the surprising boost in membership among younger people in the second half of 2020 has not halted the trend.

The trend is a problem because – under the so-called community rating system – higher-claiming, typically older members are effectively cross-subsidised by lower-claiming, typically younger members. As the pool ages, the cross subsidy becomes less and less sustainable.

Adding to the problem is the fact that the healthcare services being claimed are *costing* more and more, as well as being *used* more and

Figure 1.4: Ageing, increased health service use, and inflation have all contributed to rising private health insurance (PHI) benefits

Change in inflation-adjusted benefits per member, 2013-14 to 2018-19



Notes: Benefits include hospital and hospital-substitute treatments. 'Increased real benefits per day' is the change in CPI-deflated benefits per day. This change reflects growth in healthcare costs above CPI as well as any change in treatments per day. Adapts decomposition method set out in Productivity Commission (2005).

Source: Grattan analysis of ABS (2021b), ABS (2021c) and APRA (2021).

more. Figure 1.1 on page 5 shows that while the overall price of goods and services is 62 per cent higher than it was 20 years ago, the price of healthcare is 143 per cent higher. And Australians are using the health system more as they get access to new technologies, treatments, and services:[7] the average number of private hospital episodes per PHI member has increased in the past decade, particularly for older people.[8]

1.4 The industry needs a rescue plan

Ageing might be the largest of the challenges facing private health insurance, but there is little the industry or government can do about the ageing of the population. Similarly, not a lot can be done to prevent people from seeking new and additional medical services as they become available.

Rather than attempt to push back against these 'macro' factors, governments and the industry should seize specific opportunities for greater efficiency or downward pressure on costs.

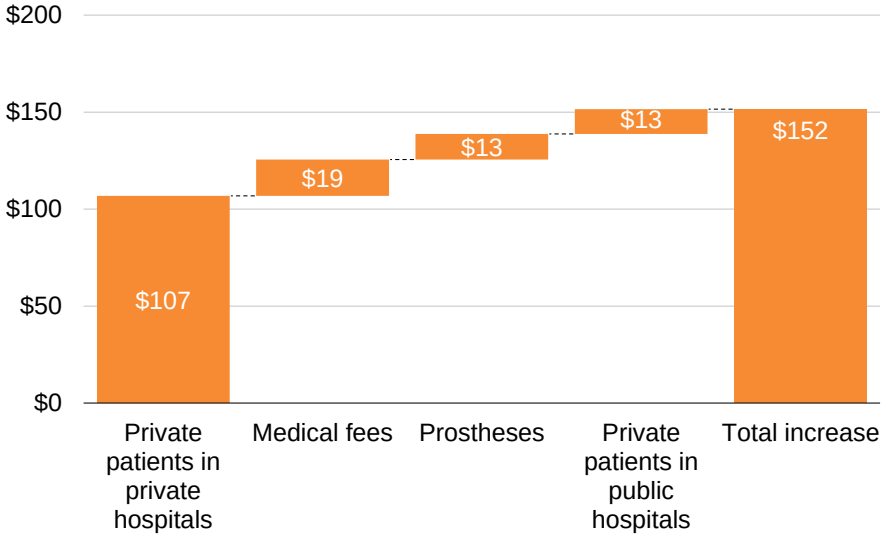
Figure 1.5 presents an alternative way of breaking down the increase in benefits paid over the five years to 2018-19.

It shows that the increase in benefits (and, by implication, premiums) has been driven by:

- *Private patients in private hospitals*, accounting for more than two-thirds of the growth in benefit payouts. We showed in a 2019 report that the length of stay in private hospitals is longer than in public hospitals, and that there was a higher rate of low- or no-value care in private hospitals.[9]

Figure 1.5: Medical fees and prostheses costs are responsible for one-fifth of the recent increases in PHI benefit outlays

Change in inflation-adjusted benefits per member, 2013-14 to 2018-19



Source: Grattan analysis of ABS (2021b) and APRA (2021).

7. Duckett et al (2019, p. 17).
8. Figure 2.4 in Duckett et al (ibid).
9. Duckett and Nemet (2019b).

- *Medical fees*, accounting for about 12 per cent of the growth in benefit payouts. We update our 2019 analysis in the next chapter.
- *Prostheses*, accounting for about 9 per cent. We consider this issue in Chapter 4.
- *Private patients in public hospitals*, accounting for about 9 per cent. In our 2019 report we drew attention to the perverse incentives included in the federal government's funding arrangements with the states, which encouraged admission of private patients.[10] That has now been addressed, but it is too early to assess the impact of this change on utilisation and hence on private insurers.

The following chapters shine a light on four specific problems with private health insurance: private hospital costs (Chapter 2), out-of-pocket medical bills (Chapter 3), prostheses costs (Chapter 4), and the level of premium increases compared to benefit payouts (Chapter 5). The final chapter recommends a new industry plan for private health.

10. Ibid.

2 Make private hospitals more efficient

Unnecessarily long stays and examples of low- or no-value care are more common in private hospitals than in public ones. This drives up the cost of private hospital care.

A new private health industry plan should create incentives for private hospitals to become more efficient. One way to do this would be for insurers to pay private hospitals in a similar way to how government funds public hospitals.

2.1 The inefficiencies in private hospitals

In our 2019 report on private health insurance, we showed that:[11]

- the length of stay of patients in private hospitals is longer than in public hospitals, once urgency of admission and other relevant factors are taken into account;
- there is more low- or no-value care in private hospitals than in public hospitals; and
- in-home rehabilitation is less common in the private sector than in public hospitals.

All these factors increase the cost of private health insurance – and the revenues of private hospitals.

We do not have new data on private hospital efficiency and low- or no-value care, but it is unlikely that the industry fundamentals have changed since our 2019 report.

11. Ibid.

2.2 An 'efficient price' for private hospital care

One way to encourage private hospitals to become more efficient would be for insurers to pay them for the patients they treat, not for how long patients stay in hospital or what other services are provided to them. Governments have funded public hospitals in this way for decades.

This change would require the Independent Hospital Pricing Authority to set an 'efficient price' for private hospital care, and private insurance being required to pay that. Private hospitals would no longer be paid more for keeping patients in hospitals longer. Savings could be achieved not only by reducing length of stay for private hospital overnight patients – where patients stay a day longer than similar public hospital patients – but also by increasing the proportion of same-day activity by converting overnight patients to same-day patients where it is clinically safe to do so.

Setting a bundled efficient price – where the rehabilitation component of a treatment episode is bundled up with the associated inpatient stay – could lead to additional efficiency improvements and reductions in private health insurance payments, with no loss of quality for patients.[12]

Adopting an efficient price would drive out waste and inefficiency in private hospital care and, over time, eliminate the excess length of stay in private hospitals. This should lead to reductions in private health insurance premiums of about 5 per cent.[13]

12. See Barnett et al (2019) and Agarwal et al (2020). However, there are technical difficulties with setting bundled prices – see Chapter 9 of IHPA (2019).
13. See Duckett and Nemet (2019b). Based on a reduction in average length of stay leading to a similar reduction in costs, with private hospital costs making up about half of total benefit payments. The reduction in private hospital premiums may be larger than 5 per cent. We assume here that private health insurers will pass on cost savings into premium reductions. As we showed in Duckett et al (2019),

2.3 A boon for patients – a single bill for their stay

In our 2019 report we also proposed a 'single bill' be issued to patients. It should be issued by either the medical specialist or the insurer, and would cover all aspects of the patient's care: days of stay, theatre costs, prostheses, medical costs, and everything else (see Box 1 for one patient's story, told to Stephen Duckett, which illustrates one problem with multiple bills after a private hospital stay).

Other than their agreed excess payments, there should be no out-of-pocket costs for patients for private hospital care, except where the hospital markets itself as providing higher levels of amenity.[14] These additional charges should be based either on a bed-day basis or a whole-of-stay basis, so patients have certainty about expected costs.[15]

Amenity, comfort, and friendliness of staff varies among private hospitals. These things are easier for patients to gauge than the quality of medical care. In an efficient market, whether the additional amenity is worth it should be a matter of patient choice.[16] Private health insurers could be expected to aim to negotiate agreements with private hospitals to eliminate out-of-pocket costs altogether.

Box 1: Jo's story

Jo was admitted to a major private hospital in 2021. She signed a consent form on admission, acknowledging there may be other fees, but she was not given any indication of the size of the potential fees. Jo had two visits to Medical Imaging during the stay, for services involving five item numbers. After discharge, Jo received two imaging invoices totalling $2,427. After deducting payments from Medicare and the insurer, Jo had to pay $950. On one invoice, the charge was 89 per cent above the scheduled fee, and on the other the charge was 51 per cent above the scheduled fee.

Jo's story highlights several problems:

- there was no real informed financial consent; and
- the insurer felt no ownership of the problem. It advised Jo that it did not have a 'no-gap' arrangement with the diagnostic provider. The insurer also could have included discussion about imaging and diagnostic fee charging in contract negotiations with the hospital.

Private health insurers could still provide additional 'pay for performance' payments under preferred-provider arrangements linked to clinical outcomes.[17] Private health insurers should be able to reduce the payment to hospitals below the efficient price if the hospital's care

premium growth over the past decade has principally been driven by growth in benefits; that is, gross margins (management expenses plus surpluses) have been constant.

14. Unfortunately, what is marketed as better amenity or care may simply be inefficiency. Private health insurers have an incentive to direct their members away from inefficient hospitals and should do so.
15. We would expect robust negotiations between the larger insurers and the larger hospital chains to constrain these additional charges.
16. Given the lack of comparative information available currently, patients cannot make an informed choice on other aspects of private hospital care.
17. Private health insurers should also develop their own coding audit processes to guard against gaming of coding: Steinbusch et al (2007).

falls short on agreed metrics.[18] Patients' agreed up-front payments (the 'excess') should reduce the insurer's 'efficient price' payments.

Our 2019 report also proposed ways to reduce or eliminate the provision of low- or no-value care – including by giving insurers more autonomy to not pay for that care.

Improving private hospital efficiency and reducing low- or no-value care could produce a 5 per cent reduction in premiums.[19] This would in turn benefit private hospitals, because demand for their services would increase.

18. Such as the hospital-acquired complications measure used for public hospital funding. In the first instance, insurers should adopt metrics already in place and agreed as part of public hospital quality incentives.
19. Duckett and Nemet (2019b).

3 Reduce out-of-pocket medical bills

People going into private hospitals often find that the benefits they receive from Medicare and their private insurance fund are not enough to cover what they are charged by the hospital and by the doctors who treat them. These nasty surprises are one of the main reasons people are dissatisfied with private health insurance.

Out-of-pocket costs on medical bills are often in the hundreds of dollars, and sometimes in the thousands. Some specialists charge at more than twice the Medicare schedule fee.

The secret schedule of fees issued by the Australian Medical Association to its members legitimises high fees. It apparently indexes fees with inflation so doctors accrue all the benefits of changes in technology – the fee relativities of the 1970s are baked into the price schedule of the 2020s.

Government initiatives to publish data about the costs patients are likely to face when they have a particular procedure, or even when they use a particular specialist, will help inform patients. But these initiatives have limitations, and have only been partially implemented. In any case, they alone won't be enough to rein in excessive costs. More dramatic reform is needed.

3.1 Medical out-of-pocket costs are often higher than hospital out-of-pocket costs

A patient incurs a 'medical' out-of-pocket cost when there is a gap between the fees charged by their treating doctors and the benefits the patient receives from Medicare and their private health insurer. A patient can also incur an out-of-pocket cost on the fees charged by the hospital itself, although this amount typically reflects the excess that the patient has agreed on with their insurer.

Out-of-pocket costs are often substantial. In 2019-20, the average medical out-of-pocket cost was $544.[20] This average has ranged from $483 to $652 over the past decade, but – as Figure 3.1 on the following page shows – over the past six years the share of hospital stays that involve no medical out-of-pocket cost has decreased from about 70 per cent to less than 60 per cent. The share of stays that incur an out-of-pocket cost between $100 and $1,000 has increased from 16 per cent to 25 per cent.

The average hospital out-of-pocket cost in 2019-20 was $411, which was lower than the average medical out-of-pocket cost. However, the average hospital out-of-pocket cost is about $50 higher than it was six years ago, and the share of hospital stays that incur such a cost between $500 and $1,000 almost doubled in that time (Figure 3.1 on the next page).

3.2 A small share of highly-billed services account for most of the total medical out-of-pocket costs incurred

In our 2019 report on specialist bills, we used a billing threshold at twice the Medicare fee as a measure of excess or 'egregious' billing. We labelled the handful of doctors who charge at that rate as 'greedy'.[21]

This approach was criticised because, it was argued, the Medicare fee is an illegitimate benchmark. That is a fair comment – only about one quarter of services are billed at or below the Medicare fee. However, it is also true that only 6 per cent of services are billed at more than twice the Medicare fee. So although the Medicare fee may be unfair,

20. These averages are calculated across just those hospital stays where an out-of-pocket cost was incurred.
21. Ibid.

94 per cent of services were billed below twice the Medicare fee, which suggests that twice the fee is a legitimate cut-off to determine excess fees. Most services are billed within sight of the schedule, not more than double or triple it.

We can find no good reason to moderate our language about these excessive fees.[22] We also note that US research has shown that the higher the medical fees, the poorer the quality.[23]

There were $726 million of out-of-pocket costs incurred on medical services in Australia in 2019-20. Figure 3.2 on the following page shows that just 6 per cent of services accounted for almost 90 per cent of this amount. The fee charged on each of these services was more than twice the Medicare schedule fee, and the average amount charged was more than three times the Medicare fee.

This pattern in doctors' billing has not changed during the COVID-19 pandemic – on average, 6 per cent of services continued to be billed at more than twice the Medicare fee during 2020.

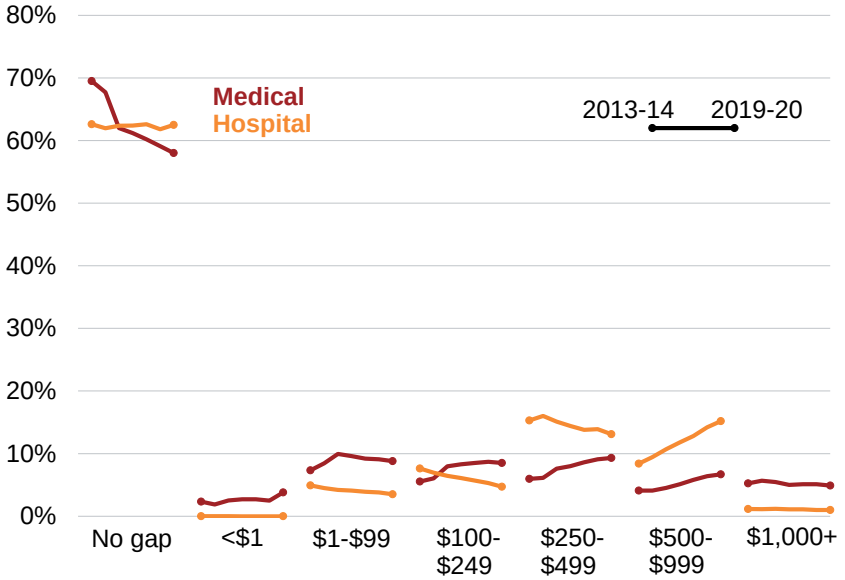
In fact, the share of services each year being charged at more than twice the Medicare schedule fee has not changed much over the past 15 or so years. However, the average amount charged by excessive billers – the handful of greedy doctors – has crept up over this period, from 2.7 times the Medicare fee to more than three times the fee.

3.3 Better information for patients is only a small step toward putting downward pressure on doctors' bills

Patients have a right to clear information, before they consent to a particular treatment, about the costs they might face. If they have such information early, they can avoid nasty surprises later on.

Figure 3.1: Medical out-of-pocket costs have become more common, as have large hospital out-of-pocket costs

Share of private hospital stays with a Medicare Benefits Schedule component (Medical), and share of all private hospital stays (Hospital), by size of out-of-pocket cost (gap)



Source: Grattan analysis of Department of Health (2021).

22. Interestingly, one private hospital advised us that our report was one stimulus for their program (described here https://eastsydneyrapidpathtotreatment.com.au/) for better transparency and control of medical out-of-pocket costs.
23. Whaley (2018).

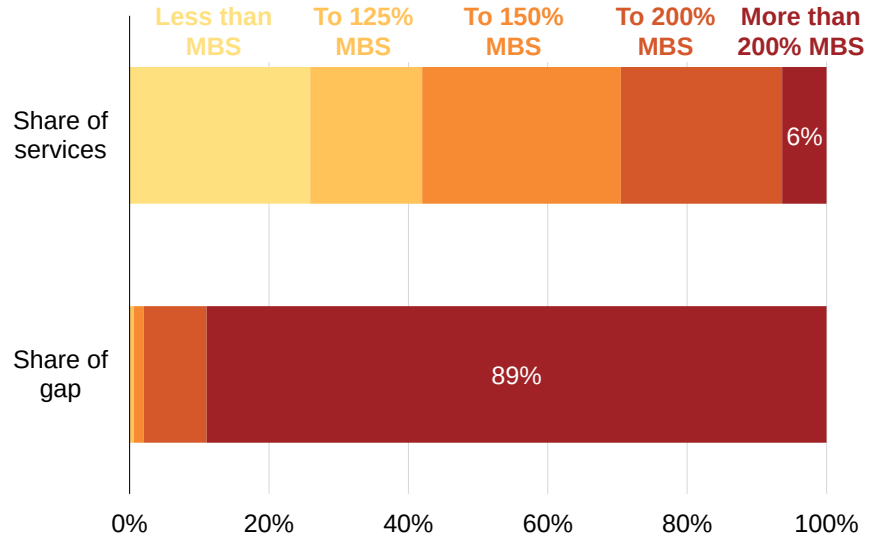
The Federal Government is slowly providing patients with more information on costs. In December 2019 it launched the Medical Costs Finder, an online tool that enables people to look up examples of 'low', 'typical', and 'high' doctors' fees and out-of-pocket costs for a particular procedure or appointment, by Primary Health Network area.[24] At the time of the launch, the Government announced it would expand the information provided to include the 'fees for particular medical specialists'.[25]

The Medical Costs Finder is useful for letting patients know about the potential for out-of-pocket costs, and sometimes the ballpark size of those costs. But the range of costs presented for some procedures and appointments is quite wide, meaning a patient will be left with an unclear picture of what to expect.

A patient's out-of-pocket cost will ultimately depend on the fees charged by the particular doctors that treat them, as well as the level of benefit paid by their insurer for the particular service. A patient can find out the latter from their insurer, but there remains no comprehensive, public source of information on the former. The Secretary of the Health Department has said that the Government's plans to provide information on the fees charged by individual specialists have been delayed because of the COVID crisis.[26] The Government holds information in its Medicare data set on the billing practices of doctors. With appropriate notice to doctors that it intends to use the information as part of public accountability, it could make that information available on a cost-finder website.

Figure 3.2: Six per cent of inpatient medical services account for 89 per cent of all medical gaps

Share of total gap and total services in each fee bracket relative to the Medicare Benefits Schedule (MBS) fee, 2019-20



Source: Grattan analysis of APRA (2021).

24. 'Low' is the 10th percentile from 2018-19, 'typical' is the median, and 'high' is the 90th percentile.
25. Hunt (2019).
26. Clun (2020).

3.4 There are many changes that could reduce out-of-pocket payments

Comprehensive, public information on fees and costs would help, but even that is unlikely to significantly reduce the size and prevalence of out-of-pocket costs, because patients face an inherent power imbalance when dealing with doctors.[27] The more serious the patient's health problem, the greater will be their sense of vulnerability.

A new private health industry plan should include the structural reform required to reduce surprise out-of-pocket payments. This may come about through downward pressure on medical bills, or with more deals between doctors and insurers to bridge the gap. In a 2019 report, we suggested this could involve reforms to billing processes so that it was the private hospital, rather than the patient, that agreed on a fee with the specialist.[28] Another possibility the industry should consider is whether the insurer should issue the bill.

Private health insurers need to step up too. Rebates for procedures vary dramatically across funds,[29] and different rules among funds may mean that small differences in fees lead to large differences in out-of-pocket payments, as the billing staff of specialists find it impossible to keep track of the vagaries and intricacies of each fund's rules. An industry plan could include an initiative to standardise fund rebates, eliminating that excuse for variation in out-of-pocket payments.

An industry plan might also address the apparent reluctance of funds and doctors to enter into contracts to limit patient out-of-pocket payments. Funds' ability to contract is regulated by the *Private Health Insurance Act* 2007, which provides only that contracts not impinge on 'professional freedom',[30] but this limitation might add to the profession's scepticism about contracts which involve risk and gain-sharing with funds. An industry plan might also change who can claim Medicare benefits on behalf of patients – making it easier for private hospitals or even insurers to manage billing.

27. Medical Board of Australia (2018).
28. Duckett and Nemet (2019b, pp. 30–31).
29. AMA (2020).
30. Sections 172-175 of the *Private Health Insurance Act* 2007.

4 Fix the prosthesis market

Private hospital insurance pays out more than $2 billion each year in benefit payments for prostheses, accounting for more than 12 per cent of all benefit payments. Private insurers are required by law to pay benefits for products on the 'Prostheses List'. But the way in which products are added to this list and priced is opaque and shielded from competitive forces.[31]

A new private health industry plan should reform pricing arrangements for prostheses. Competitive forces need to be brought to bear on the market so that there are stronger incentives to reduce costs and increase quality.

4.1 The current prosthesis pricing shambles

Prosthesis prices are not set by the market, but by a committee. The Prosthesis List Advisory Committee makes recommendations to government on the prices for more than 10,000 individual items – including staples and glue. In contrast to state-based systems – where a central purchaser uses tenders to ensure value for money – there is no formal tender process, nor any serious assessment of quality.

Private health insurers, responsible for paying for prostheses, are effectively price-takers, with no power to ensure the supply chain is efficient.

No market player has an incentive for efficiency, and at least one player – device importers and manufacturers – has an incentive to maximise spending. There is no market to ensure the best price. The private health insurer, responsible for paying for the prosthesis and wearing the long-term costs in the event of poor quality, has no control over the choice of the prosthesis, no control over whether the surgeon chooses one with the lowest revision rate, and no control over price.

The approved price schedule is an example of the failure of the existing arrangements: private hospital prosthesis prices are more than double the public hospital prices (130 per cent higher).[32] There is no evidence that private hospital outcomes are any better than public hospitals', despite this price premium.

The whole structure of centralised pricing inhibits efficiency and quality in the use of prostheses. It should be dismantled. Price regulation should be a last resort, used only when there is demonstrable evidence of market failure. Bizarrely, an attempt by one entrepreneurial supplier to introduce an element of market competition failed (see Box 2 on the next page).

4.2 Previous policy changes haven't delivered the reform that is needed

The prosthesis payment policy is reviewed regularly, with each successive iteration alienating a different stakeholder who then lobbies for change in their interest. There is no apparent coherence in policy settings.

The most recent change to price setting was in 2017, when government reduced prices for some categories of prostheses by between 7.5 per cent and 10 per cent. But the industry can seek to recoup revenue in response to targeted reductions by 'unbundling' – that is, by redefining

31. We have discussed the problems of prosthesis pricing before: Duckett (2019), Duckett and Nemet (2019b) and Duckett (2021).

32. Independent Hospital Pricing Authority (2019). This report is not public; it has been withheld while the Government consults with the device industry association which would be presumably embarrassed by the evidence of industry success in driving up prices.

Box 2: Preventing competition has been ruled OK

In 2016, the case *Applied Medical Australia Pty Ltd v Minister for Health* [2016] FCA 35 (5 February 2016) was brought before the Federal Court after the government refused a request from Applied Medical, a prosthesis manufacturer and supplier, to lower the minimum benefit price for a group of prostheses on the Prosthesis List from $412 to $99. Applied Medical had argued that $412 was too high, and that the prostheses in question could be provided at a significantly lower price. The inflated figure, the company claimed, was the result of a poorly designed mechanism for selecting the minimum benefit.

The mechanism in question (the 25 per cent utilisation policy) designated a group's minimum benefit based on the lowest price of one of its products with at least 25 per cent market share. Applied Medical argued that this policy was restricting competitive corporate behaviour: it protected incumbents, and did not allow smaller, more innovative firms to gain market share in the usual way via lower pricing.

Ultimately, the Court held that the Health Minister's representative had acted acceptably. However, the judge made several noteworthy comments about policy change. Firstly, he said that even if Applied Medical had presented a compelling case, changing the policy for identifying the minimum benefit was a big undertaking. In his view, despite the evident shortcomings of the present system, the fact that it would be administratively difficult to introduce a different mechanism meant the government was entitled to do nothing.

The judge then discussed additional challenges of changing the 25 per cent utilisation policy, saying it was 'not a prohibited consideration' to take the views of other product sponsors into account when deciding whether to introduce a new minimum benefit mechanism. He said there was 'no evidence that the proposed change advocated by the applicant would be supported by the vast majority of other product sponsors', and that this was sufficient justification for the government not changing the minimum benefit.

Of course, other manufacturers are unlikely to support changes to a system that currently protects them, so the Court's decision prevented an opportunity for competition which might have reduced health insurance premiums.

what a prosthesis set is, taking some items out of the set and charging for them separately. Evidence of unbundling can be seen in the causes of the increase in prosthesis costs over the five years to 2018-19 – the increase in 'general miscellaneous' items, which includes the easily-unbundlable screws, nails, staples, and glues, accounts for more than half the real growth in benefit payments for surgically implanted prostheses.[33]

4.3 A standard prosthesis price would help

The Government should introduce incentives for efficiency and quality in the prosthesis market.

The federal Department of Health recently consulted on new prosthesis pricing arrangements, setting out two options:[34]

> OPTION 1: Consolidate the Prostheses List using the Diagnosis Related Groups (DRGs) model and set benefits with reference to the prostheses price components of relevant DRGs, with administration moved to the Independent Hospital Pricing Authority (IHPA).
>
> OPTION 2: Consolidate and redesign the Prostheses List with extensive changes to pre- and post-listing assessment and benefit-setting processes, with administration of benefit-setting supported by the Department.

Option 2 should be rejected, because it would keep a centralised, insider-driven approach. Option 1 should be implemented, because it would ensure that at least one stakeholder had an incentive for efficiency.

Under Option 1, there would be a standard prosthesis payment for each relevant DRG.[35] The DRG-specific payment should not necessarily be at the average price, which reflects the excess payments incorporated in the current payment model. Instead, it may be appropriate for the new price to:

- reflect the price of the median prosthesis set in a DRG;
- reflect the price of the bottom quartile prosthesis set in a DRG;
- reflect public hospital prices; or
- be based on a national tender for prostheses, accessible by both public and private hospitals.

A DRG pricing approach would have several benefits. Firstly, the DRG classification was designed to be clinically meaningful and to be used for payments, so it would be appropriate to use it for payments for prostheses. The new prosthesis payment would be based on what peers do, or, preferably, what the most efficient peers do for like patients.

Secondly, there would now be an incentive for efficiency. Surgeons could still choose more expensive prostheses, but there would be no obligation on insurers to pay for more expensive products, so hospitals would be required to absorb those excess costs. This would put pressure on importers and manufacturers to reduce their prices.

Thirdly, there would be a single bundled price for all constituent elements, reducing the potential for gaming and addressing the recent increase in costs associated with unbundling.

33. 'Type A' prostheses. Grattan analysis of APRA (2021).
34. Department of Health (2020b).
35. More accurately, for each relevant Adjacent DRG. The existing DRG classification was developed so that the DRGs are coherent bundles, in terms of resource use, across all aspects of care such as days of stay, theatre time use, and prostheses. Establishing a separate price for prostheses may require some revision to the overall DRG classification system to ensure homogeneity of prosthesis costs. An alternative would be to create a specific, Adjacent-DRG prosthesis price list. The Independent Hospital Pricing Authority could do this quite quickly using existing data.

What we are proposing is not novel, experimental, or risky. Public hospitals already have an incentive for efficiency in their prosthesis choice. There is no separate payment for prostheses, but rather the prosthesis cost is bundled into the total hospital payment, set using DRGs. And in the US, bundled payment initiatives are showing promising results.[36]

The prosthesis market is an international one, with innovations occurring in many countries. Innovation in this market is unlikely to be affected by changes in prosthesis pricing in Australia.

4.4 Benefits should be passed on to consumers

The new policy we propose would significantly reduce payments for prostheses. It would shift revenue away from device importers/manufacturers and private hospitals. Private health insurers would gain from such a shift, and their outlays would be reduced. As part of their future proposals for premium increases, each insurer should be required to estimate the savings the new policy is likely to yield, and demonstrate that they have passed these savings on to consumers.[37]

Policies should also ensure that any excess costs of prostheses are not passed on to consumers through increased co-payments.

A new prosthesis payment policy should improve efficiency in the sector, help to improve the average quality of prostheses used, moderate health insurance premium increases – and thus help make private health insurance more sustainable.

36. McLawhorn and Buller (2017).
37. If implementation of a DRG-based prosthesis approach drags out, a quick interim step would be to negotiate private hospital access to public hospital prosthesis contracts and re-base the current prosthesis list on those, lower prices. This is a second-best approach because it does not address the unbundling issue.

5 Force insurers to better justify premium increases

Premiums are private heath insurers' largest source of revenue, and benefits paid are their largest expense. The proportion of premium revenue returned to members in the form of benefits is known as the 'claims ratio'. Although there are other factors, a high claims ratio generally means that private health insurance is more valuable to members.

Individual health insurers with claims ratios lower than their peers should face additional scrutiny before being permitted to increase their premiums.

5.1 Claims ratios vary between insurers

Figure 5.1 shows that, until recently, the average claims ratio was about 86 per cent, and that this figure increased during 2020, possibly because of COVID effects.

Figure 5.1 also shows that there is considerable variation in insurers' claims ratios. Some of this variation may be justified. Insurers vary in the services they provide; for example, some provide dental and other services. Insurers also vary in their overheads, such as their administrative costs associated with recruiting contributors and managing claims.

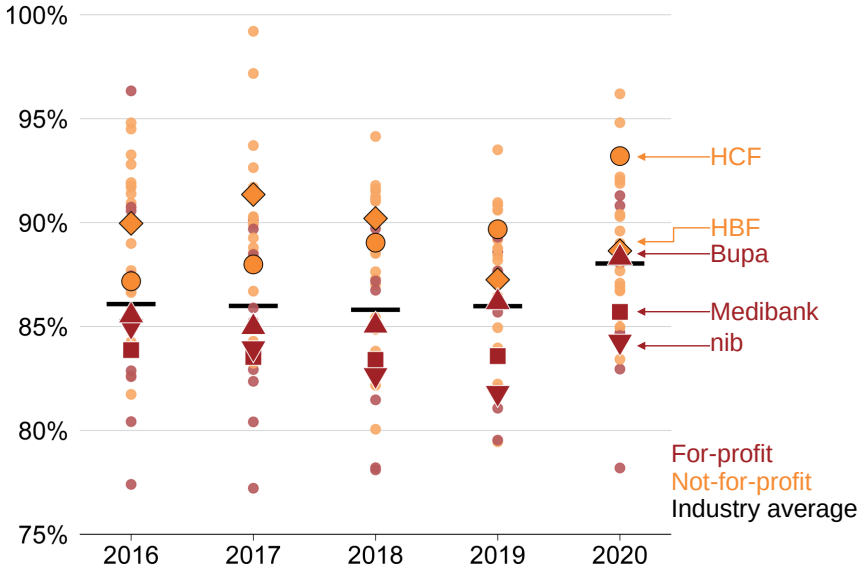
5.2 Insurers with low claims ratios should have to better justify their premium increases

A new private health industry plan should reinforce the incentives for insurers to improve their claims ratios.

In the US, the claims ratio is regulated and funds are required to return at least 80 per cent or 85 per cent of premiums as benefits, averaged over three years, depending on the nature of the market in which

Figure 5.1: Many funds, both big and small, return less than 85 per cent of premiums to their contributors

Benefits paid as a proportion of premium revenue, by financial year



Notes: Fund benefits include benefits paid for hospital and general insurance (including state ambulance levies). Premium revenue includes all revenue from the health insurance business (excluding health-related business revenue and investment income). The datapoints for four small insurers are not shown because of missing and outlying data.

Source: Grattan analysis of APRA (2020).

they operate. But there are problems with this approach, at least as implemented in the US.[38]

To some extent the claims ratio is a crude instrument – it may be that higher management expenses may lead to better contracting, for example. But in the long term, that better contracting should flow through into reduced premiums.

In Australia, premium increases need to be approved by the Minister for Health. The proportion of premiums returned to members should be one of the factors the Minister takes into account in deciding whether to approve premium increases.[39]

The Minister could require funds to provide additional justification for a proposed increase if the proportion of their premiums returned to members is less than 80 or 85 per cent. If the Minister was still not persuaded of the case for the increase, he or she could reject it.[40]

In 2019-20, nine funds in Australia had a claims ratio of less than 85 per cent, including one with a ratio of less than 80 per cent. If these funds reduced premiums to achieve the 85 per cent ratio, premiums in those funds would fall by an average of 2 per cent.[41]

38. Cicala et al (2017), Yang and Lin (2017) and Cole and Karl (2019).
39. In NSW, premium increases for Compulsory Third Party insurance against motor vehicle accidents may be rejected or 'adjusted' if the insurer could make an excessive profit as a result of the proposed increase. See section 2.25 of the NSW *Motor Accident Injuries Act* 2017.
40. To be clear, the intention would not be to mandate a minimum level for claims ratios. Rather, the intention would be to place additional scrutiny on proposed premium increases.
41. Grattan analysis of APRA (2020).

6 Create a new industry plan for private health

The private health industry – private health insurers, private hospitals, device importers and manufacturers, and private specialists – has weathered the COVID storm. But the industry's underlying problems have not gone away. The 'death spiral slowly rolls on.

Government has so far responded with tinkering, for example by allowing discounted premiums for under-30s, and allowing stay-at-home under-30s to remain with family insurance plans in the hope that they will pick up their own insurance when they turn 30. But none of this changes the underlying dynamics of the industry.

To date, most industry players have been too willing to foist the industry's problem onto government, and government has been too willing to accept this burden. Too often, one sector of the industry blames another for their woes, and enlists government help to try to shift costs. This is not sustainable.

The industry is over-regulated and cosseted. It needs to embrace efficiency-driven reform to create a better product which people want to buy. Patients should not get unpleasant bill shocks after paying insurance premiums all their lives. Prosthesis prices in private hospitals should be closer to the prices paid by public hospitals. Patients admitted to private hospitals should not unnecessarily stay longer than similar patients admitted to public hospitals.

A do-nothing strategy – either by government or industry segments – is not viable into the long term. This leads to two scenarios for the future of the industry – one of disruptive change and one of managed change.

Scenario 1: Disruptive change

The disruptive change scenario would probably be led by larger private health insurers. Each major insurer would probably pursue a slightly different strategy, but all would try to address the industry's current weaknesses, especially higher-than-inflation cost growth, and unexpected out-of-pocket payments. We have already seen some examples of these strategies with new insurer-hospital-doctor partnerships; new doctor contracting arrangements; proposed new partnerships with international insurers;[42] and new comparative information to inform consumers' choices. Under this scenario, small insurers may find it hard to compete, and fold. Private hospitals party to these new arrangements would thrive, others would not. Similarly for doctors.

The extent of disruption would be constrained by existing red-tape which protects existing industry segments – the Prosthesis List being the best example. The maze of distorting rules which currently characterise the industry means that the disruptive change scenario cannot address the industry fundamentals – and so the death spiral would continue.

Scenario 2: Managed change

Disruptive change by its nature involves some industry players inventing and implementing new approaches, creating a competitive advantage for themselves. The managed change scenario embraces that reality but also involves systematic, industry-wide change which would re-position the whole industry. Under the managed change scenario, all industry segments would accept some belt-tightening and

42. ACCC (2020).

the need to drive industry costs down, and all would accept short-term pain for improved long-term industry viability.

This report shows that managed change, achieved through an efficiency-driven industry plan, would help the private health industry to overcome its contemporary weaknesses. Improved efficiency would lead to reduced premiums, which would lead to market growth, which would benefit all players.

An efficient managed-change strategy has two preconditions – a recognition by all parties of their joint interest in creating a viable future, and a stable policy environment.

6.1 The joint interest

Too often, the private health industry dynamic has pitted payees (device importers and manufacturers, medical specialists, and private hospitals) against payers (the insurers). Yet if private health insurance membership continues to decline, demand for private hospitals, private specialists, and devices will go down too.

To stop the death spiral, all parts of the industry need to work together. They need to recognise that there are savings to be made in the industry, but that this will require all parties to make compromises. And efficiency savings must be passed on to consumers, to ensure increased demand for private health insurance and private healthcare.

6.2 A stable political environment

Private health has been politically contested for decades. At various times, the Liberal Party has attempted to dismantle Medicare, and Labor has attempted to undermine private health insurance.[43] But the political reality now is that private health insurance plays a big role in Australia's healthcare system – most procedures are done in private hospitals, and more than 40 per cent of the population has private insurance.

It is more difficult for industry participants to plan when political change may lead to fundamental policy change. Ideally, a new private health industry plan would be bipartisan, with Labor committing to maintain industry fundamentals such as the private health insurance rebate. Policy stability would encourage industry players to accept compromises and efficiency savings.

6.3 Developing an industry plan

Reforming the private health industry will not be simple. Although the goals are clear – a bigger private market and a viable industry – there will be conflict about how to achieve them. In these circumstances, the only effective strategy is 'political implementation', driven from the top, but with stakeholders engaged so as to build consensus.[44]

The current government has negotiated a series of long-term agreements with elements of the private sector – but these have been negotiated as separate, bilateral (government-industry segment) agreements. A successful managed-change plan requires a collective agreement involving government, private health insurers, private hospitals, private device manufacturers and importers, and private medical specialists. That agreement should be focused on making the industry more efficient.

Such government-driven industry plans are not uncommon in Australia. In recent years the Government has sought to give effect to its long-term vision for industries such as defence and manufacturing through industry plans.[45]

43. Duckett and Nemet (2019a).

44. Matland (1995) and Coleman et al (2021).
45. Department of Defence (2018) and Department of Industry, Science, Energy and Resources (2020).

A private health industry plan would have major benefits for consumers. It should lead to reduced premiums and fewer surprise medical bills for patients. It should lead to fewer demands on the public purse via industry subsidies. Ultimately, it could put private health on the path to a viable future.

Bibliography

ABS (2021a). *Average Weekly Earnings, Australia*. Australian Bureau of Statistics.

_____ (2021b). *Consumer Price Index, Australia*. Australian Bureau of Statistics.

_____ (2021c). *National, state and territory population*. Australian Bureau of Statistics.

ACCC (2020). *Honeysuckle Health and nib: Authorisation application*. Australian Competition and Consumer Commission. https://www.accc.gov.au/public-registers/authorisations-and-notifications-registers/authorisations-register/honeysuckle-health-and-nib.

Agarwal et al (2020). Agarwal, R., Liao, J. M., Gupta, A. and Navathe, A. S. "The Impact Of Bundled Payment On Health Care Spending, Utilization, And Quality: A Systematic Review". *Health Affairs* 39.1, pp. 50–57.

AMA (2020). *Private Health Insurance Report Card 2020*. Australian Medical Association. https://ama.com.au/sites/default/files/documents/AMA_Private_Health_Insurance_Report_Card_2020.pdf.

APRA (2020). *Operations of Private Health Insurers Annual Report*. Australian Prudential Regulation Authority. https://www.apra.gov.au/operations-of-private-health-insurers-annual-report.

_____ (2021). *Quarterly private health insurance statistics*. Australian Prudential Regulation Authority. https://www.apra.gov.au/quarterly-private-health-insurance-statistics.

Baird, L. (2021). "Nib chief confident final dividend can lift to pre-pandemic levels". *Australian Financial Review*. 22 February. https://www.afr.com/companies/financial-services/nib-maintains-dividend-as-profit-takes-double-digit-hike-20210222-p574li.

Barnett et al (2019). Barnett, M. L., Wilcock, A., McWilliams, J. M., Epstein, A. M., Joynt Maddox, K. E., Orav, E. J., Grabowski, D. C. and Mehrotra, A. "Two-year Evaluation of Mandatory Bundled Payments for Joint Replacement". *The New England Journal of Medicine* 380.3, pp. 252–262.

Cicala et al (2017). Cicala, S., Lieber, E. M. and Marone, V. *Cost of service regulation in US health care: Minimum medical loss ratios*. National Bureau of Economic Research.

Clun, R. (2020). "Specialist fee transparency website 'put on ice' due to pandemic". *Sydney Morning Herald*. 27 October. https://www.smh.com.au/politics/federal/specialist-fee-transparency-website-put-on-ice-due-to-pandemic-20201026-p568uc.html.

Cole, C. R. and Karl, J. B. (2019). "The Differential Effects of Medical Loss Ratio Regulation on the Individual Health Insurance Market". *Journal of Insurance Regulation* 38.1, pp. 1–19.

Coleman et al (2021). Coleman, A., Billings, J., Allen, P., Mikelyte, R., Croke, S., MacInnes, J. and Checkland, K. "Ambiguity and conflict in policy implementation: the case of the new care models (Vanguard) programme in England". *Journal of Social Policy* 50.2, pp. 285–304.

Department of Defence (2018). *Defence Industrial Capability Plan*. https://www1.defence.gov.au/business-industry/capability-plans/defence-industrial-capability-plan.

Department of Health (2020a). *Average annual increases in private health insurance premiums*. https://www.health.gov.au/resources/publications/average-annual-increases-in-private-health-insurance-premiums.

_____ (2020b). *Consultation Paper: Options for reforms and improvements to the Prostheses List*. https://consultations.health.gov.au/technology-assessment-access-division/prostheses-list-reform-options/.

_____ (2021). *Hospital Casemix Protocol Annual Reports*. https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-HCPAnnualReports.

Department of Industry, Science, Energy and Resources (2020). *Make It Happen: The Australian Government's Modern Manufacturing Strategy*. https://www.industry.gov.au/data-and-publications/make-it-happen-the-australian-governments-modern-manufacturing-strategy.

Duckett, S. (2019). *Prosthesis pricing needs fundamental reform: Speech to ARCS (Association of Regulatory and Clinical Scientists)*.

Duckett, S. (2021). *How to reform the prosthesis market: Grattan Institute's submission to the Department of Health's consultation on options for reforms and improvements to the Prostheses List*. Grattan Institute. https://grattan.edu.au/submissions/how-to-reform-the-prosthesis-market/.

Duckett et al (2019). Duckett, S., Cowgill, M. and Nemet, K. *Saving private health 2: Making private health insurance viable*. Report No. 2019-13. Grattan Institute. https://grattan.edu.au/report/saving-private-health-2/.

Duckett, S. and Nemet, K. (2019a). *The history and purposes of private health insurance*. Report No. 2019-05. Grattan Institute. https://grattan.edu.au/report/the-history-of-private-health-insurance/.

_____ (2019b). *Saving private health 1: reining in hospital costs and specialist bills*. Report No. 2019-12. Grattan Institute. https://grattan.edu.au/report/saving-private-health-1/.

Hunt, G. (2019). *New website to improve consumer understanding of medical costs*. Minister for Health, Media Release, 30 December. https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/new-website-to-improve-consumer-understanding-of-medical-costs.

IHPA (2019). *Pricing Framework for Australian Public Hospital Services 2020-21: Consultation Report*. Independent Hospital Pricing Authority. https://www.ihpa.gov.au/sites/default/files/minisite/static/8601/pricing-framework-2020-21/consultation-report/introduction.html.

Independent Hospital Pricing Authority (2019). *Prostheses costs in the private and public sector*.

Matland, R. E. (1995). "Synthesizing the implementation literature: The ambiguity-conflict model of policy implementation". *Journal of Public Administration Research and Theory* 5.2, pp. 145–174.

McLawhorn, A. S. and Buller, L. T. (2017). "Bundled payments in total joint replacement: keeping our care affordable and high in quality". *Current reviews in musculoskeletal medicine* 10.3, pp. 370–377.

Medical Board of Australia (2018). *Guidelines: Sexual boundaries in the doctor-patient relationship*. https://www.medicalboard.gov.au/codes-guidelines-policies/sexual-boundaries-guidelines.aspx.

Private Healthcare Association (2020a). *Health funds committed to providing financial relief for members impacted by COVID 19*. Media Release, 26 March. https://www.privatehealthcareaustralia.org.au/health-funds-committed-to-providing-financial-relief-for-members-impacted-by-covid-19/.

_____ (2020b). *Health funds Postpone 1 April Premium Increase*. Media Release, 29 March. https://www.privatehealthcareaustralia.org.au/health-funds-postpone-1-april-premium-increase/.

Productivity Commission (2005). *Economic implications of an ageing society: Technical paper 6 - Health cost decompositions*. https://www.pc.gov.au/inquiries/completed/ageing/technicalpapers.

Steinbusch et al (2007). Steinbusch, P. J., Oostenbrink, J. B., Zuurbier, J. J. and Schaepkens, F. J. "The risk of upcoding in casemix systems: a comparative study". *Health policy* 81.2-3, pp. 289–299.

Whaley, C. (2018). "The association between provider price and complication rates for outpatient surgical services". *Journal of General Internal Medicine* 33.8, pp. 1352–1358.

Yang, C. C. and Lin, H.-J. (2017). "The (Mis)alignnment of Health Insurers' Efficiency Measures from Different Perspectives and Their (Un)Linkage with Financial Ratios and Asset Allocation". *Journal of Insurance Regulation* 36.8, pp. 1–21.

Zhang et al (2020). Zhang, Y., Liu, J. and Scott, A. "Who is ditching private health insurance during the pandemic?" Melbourne Institute of Applied Economic and Social Research. https://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0005/3529589/ri2020n30.pdf.