Medibank Private

Submission to the Competition Policy Review

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Introduction

Medibank is pleased to provide this submission to the Australian Government's Competition Policy Review. Ensuring Australia has a sound competitive environment is critical to helping the nation build productive and innovative businesses that deliver value for money goods and services to consumers.

Human capacity to engage in productive work and so produce economic value, often termed "human capital", is amongst the most important elements in the creation of a prosperous society. A great many factors input into this capacity, but there can be no doubting that amongst the most important of these, at both an individual and macro level, is health. As such, the relationship between healthcare and economic wellbeing is of fundamental importance to Australia.

With this in mind, Medibank welcomes the Competition Policy Review's decision to include the health sector in its analysis. Over 25 years after much of the Australian economy was opened to greater levels of competition and the benefits this produced, competition in the health sector remains muted, protected by high levels of regulation and difficulties in developing functional markets. The sector cries out for micro-economic reform.

Medibank is of the view that reform in health needs to tackle three broad issues: the asymmetry of information between providers and consumers; inefficient market design; and a need to move to a less prescriptive regulatory model in insurance.

Summary of key recommendations

- State and federal governments should move their focus from one emphasising healthcare supply and regulation to facilitating the design and operation of efficient markets.
- The Australian Government should develop and publish an expanded range of standardised healthcare information including price and quality measures for hospitals and health services providers.
- The Australian Government should sponsor further investigation and development of a competitive social health insurance model of healthcare delivery.
- The Australian Government deregulate the private health insurance premium setting process and move to an independent price monitoring regime.
- Access to second tier default benefits be limited to small and regional independent hospitals.
- Prosthesis pricing and purchasing arrangements be revised.
- Commissions payable to internet aggregators and other intermediaries should be fully disclosed during the sale process.
- Private health insurance rules be modified to permit no claims bonuses on general treatment products.
- Regulations governing how private health insurers can work with and fund primary care should be reviewed with a view to encouraging greater involvement of insurers.

About Medibank

At Medibank, we stand For Better Health.

These three simple words sit at the heart of everything we do. They define why we exist and what we stand for. For Better Health means seeing every interaction with our customers as an opportunity to build a relationship. It means we promise three things:

- Better Choices – we help people make positive health decisions and feel in control of their health
- Better Confidence – we ensure people feel confident about their health and offer genuine peace-of-mind
- Better Outcomes – we advocate for an improved health system that produces quality health outcomes but also contain health costs.

Medibank is Australia's largest provider of private health insurance and health solutions. Each year, we pay billions of dollars' worth of hospital and allied health claims and directly deliver almost 600,000 clinical services, helping millions of Australians live healthier, fuller lives. With a large and diverse customer base, Medibank is one of the best recognised brands in Australia. We are proud of the position of trust we have established and of our integral role in Australia's health system.

Protecting health and wellbeing

With Medibank and ahm amongst Australia's most trusted private health insurance brands, we are the private health insurer of choice for over 3.8 million people Australia wide, including over 200,000 overseas visitors and students. Our size allows us to offer value for money products for customers at all life stages across all states and territories and to secure sustainable pricing when purchasing health services on their behalf. They also rely on Medibank health insurance products for access to our nationwide network of partner hospitals and ancillary service providers.

Further bringing our Vision to life, Medibank has deliberately chosen to go beyond the standard health insurance with a strong value proposition that ensures peace of mind and the best in healthcare, including:

- Immediate access and treatment.
- Doctor of choice or preferred treatment pathway.
- Access to a quality accredited national network of hospitals and ancillary provider.
- Nurse & health advice 24/7 every day.
- Care coordination and integrated care for complex patients.

We also draw on the strength of our brand to offer complementary insurance products, including Medibank Travel Insurance, Medibank Life Insurance and Medibank Pet Insurance. These products are strongly aligned to our core insurance business, extending peace of mind to all members of the family, including those who are overseas and much-loved family pets.

Virtual and face to face healthcare

Delivering on our commitment to support health and wellbeing, Medibank Health Solutions has become Australia's largest provider of telephone health coaching, nurse advice and triage, telephone chronic disease management and web-based health and wellness advice. As the service provider for publicly funded and available services including *healthdirect Australia*, *after hours GP helpline* and NURSE-ON-CALL, our expertise is experienced everyday by thousands of Australians.

We are also responsible for providing access to on- and off-base healthcare services for the Australian Defence Force. Applying from point of injury or illness through to recovery, our services connect Australian Defence Force personnel with on- and off-base health professionals, radiology, pathology and optometry services across Australia. We also provide the Australian Defence Force with a world class telehealth service delivering triage, health advice and referral services 24 hours a day, seven days a week.

The Australian Healthcare sector

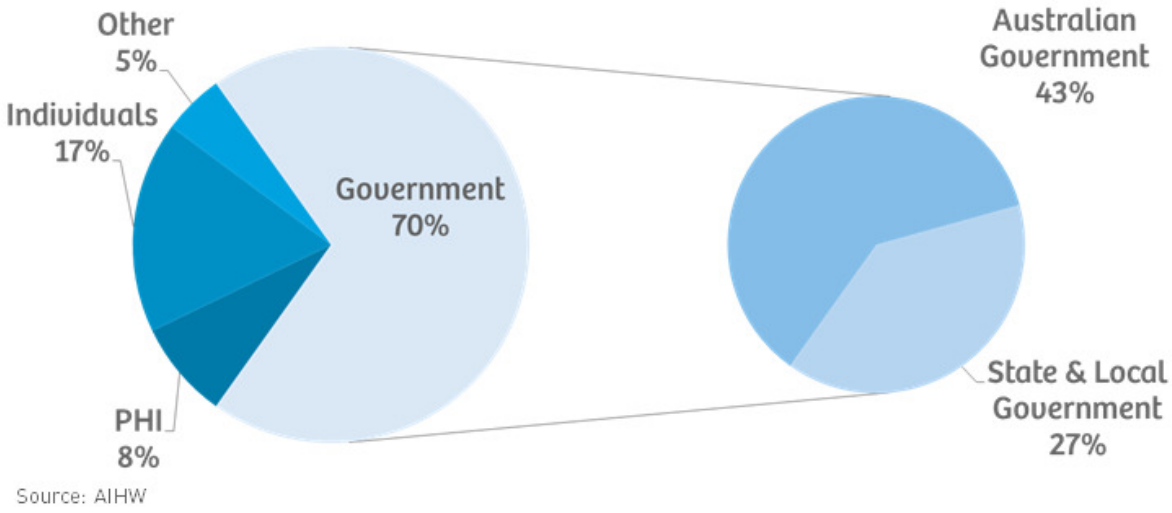
Australians are fortunate to enjoy access to one of world's most advanced healthcare systems, one which sees the nation consistently ranking highly on global healthcare indices.

Generous levels of government funding mean that all healthcare consumers can access publically funded healthcare services including public hospitals, subsidised general practitioner, medical specialist and diagnostic services and subsidised pharmaceuticals. Frequently these services present as "free" to the user at the time of use[1], often leading to demand exceeding supply resulting in rationing in the form of queuing.

Consumers also have the option to access "private" healthcare services delivered outside of the public system. While all health services available in the public system tend to also be available privately (and some exclusively so[2]), the services most commonly associated with the private sector are private hospitals, privately billing doctors and privately billing allied health services.

Consumers who choose to use the private system will generally avoid the rationing in the public system, but will incur a financial expense in doing so. Some consumers opt to help manage private healthcare expenses by taking out private health insurance[3], however with not all private sector health services insurable and with caps on some benefits, individuals also directly fund a substantial proportion of healthcare services. Today over 50 per cent of Australians have some form of private health insurance.

The mixed funding nature of the Australian healthcare system is illustrated by the chart below:



In practice funding is often blended together from multiples sources. For example the costs of medical services delivered in a private hospital are shared amongst Medicare, private health insurers and individuals, while some general practitioner and most specialist outpatient consultations are funded by both Medicare and individuals.

This mixed nature of the Australian health system produces both positives and negatives for consumers. On the positive side, the private system grants consumers greater levels of choice and control over their healthcare than the public system, including no or low delays to access care.

[1] Public subsidies are funded via a special 1.5 per cent income tax levy (Medicare levy) and through general taxation.

[2] For example, many allied health consultations and products, non-PBS pharmaceutical items and many health devices and appliances.

[3] Private health insurance policy holders themselves are eligible for a publicly funded rebate on the cost of premiums of up to approximately 40 per cent, depending on age and income levels.

This benefits not only private patients, but also public patients who find the queue for healthcare shorter than it otherwise would be.

The private system also provides consumers with an expanded range of treatment options, products and pathways that either have not been deemed worthy of scarce public funding, or have yet to be assessed for such by the various regulatory bodies that govern the public system.

Negative outcomes associated with mixed funding system include unclear and ambiguous levels of responsibility for healthcare management, planning, funding and delivery. At times this manifests itself in attempts by funders to cost shift to each other, leading to less than optimal clinical and cost outcomes than if the system was more integrated and responsibilities clearer.

The mixed system also leads to a lack of integration between the public and private health care sectors, a muddling of the lines between regulator and funder and a lack of competition among healthcare providers and therefore minimal incentives for innovation or efficiency.

As a result of these issues, consumers often find navigating the healthcare system and its arbitrary lines of demarcation confusing.

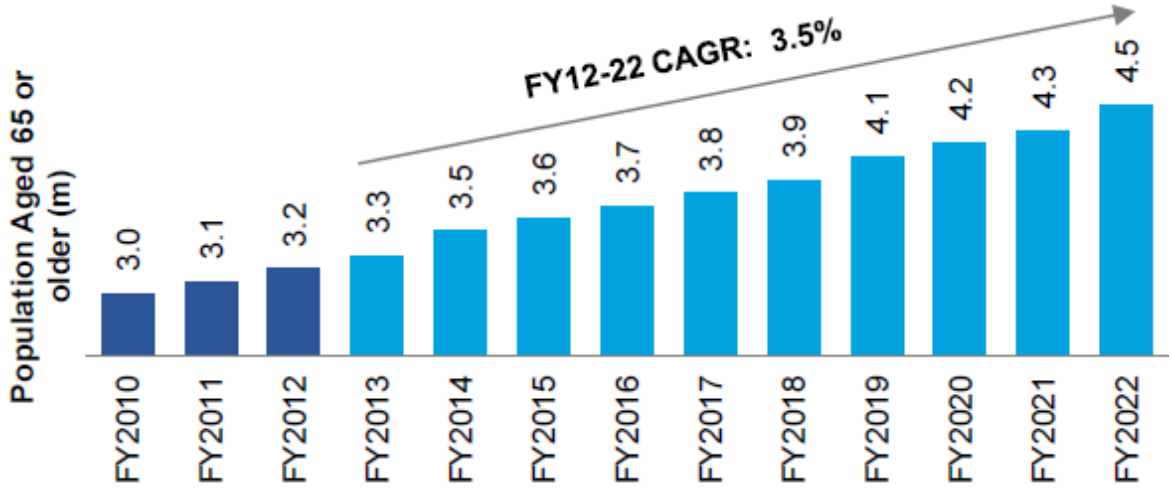
Cost pressures

Health expenditure in Australia during 2011–12 was $140.2 billion, equal to 9.5 per cent of GDP. Over the decade until 2012, total spending more than doubled, growing from $69b in 2003 to $140b in 2012, a compound annual growth rate of 8.18 per cent. In comparison, over the same period real GDP growth has averaged approximately 3 per cent.

Barring a sudden decrease in the annual growth rate, health expenditure would appear to be on track to continue to increase as a proportion of gross domestic product into the foreseeable future.

A key driver behind expenditure growth in the last decade has been the creeping growth in healthcare utilisation by people of all ages. In short there is an ever increasing propensity for Australians to consume healthcare, including seeing doctors more often, having more tests and operations, and taking more prescription drugs than they have in the past[4].

In the coming decades demographic change looks likely to further increase the proportion of GDP spent on healthcare. As has been well established elsewhere[5], the number of people aged 65 and over (and who tend to consume more healthcare than younger people), is set to grow both in absolute numbers and as a proportion of the total population.



[4] Daley, John, *Budget Pressures on Australian Governments,* Grattan Institute, 2013
[5] For example, in the Treasury's Intergenerational Report series.

Clearly, one implication of ageing is an increase in demand for healthcare overall. However it will also lead to a skewing the current demographic balance, with the Australian population containing proportionally less younger, productive people who pay for and deliver healthcare and proportionally more older, less productive people who consume it.

All funders of healthcare are considering how to manage this risk. Medibank's principal concern is the potential for this trend to drive benefit outlays sharply higher and so lead to private health insurance becoming unaffordable, or at least perceived as unaffordable.

If this were to occur, it is likely to lead to a reemergence of the downward spiral of adverse selection experienced by the industry in the eighties and nineties, which saw the healthy low claimers required in a community rated system exit, leaving an ever smaller rump of less healthy, higher claiming policy holders. Such an outcome would risk forcing millions of policy holders back into the public health sector, with negative implications for the sustainability of the overall system.

Competition can drive positive reform in healthcare

The long term sustainability of the health sector, including the private health insurance industry, can be enhanced by introducing greater competition to the sector.

Healthcare is highly regulated. In part the rationale for regulation is that it protects consumers by setting and policing standards of care, licensing healthcare providers, setting and controlling costs and providing universal equity of access to all health consumers. Aspects of these regulations, most notably the setting quality and licensing standards, remain crucial and the organisations that develop and maintain them are critical to the operation of the Australian health system.

However in other respects relying on regulation alone as the means to deliver a healthcare system that meets the needs of consumers appears to have been less than fully effective. Queues for healthcare remain and are lengthening, patients receive treatment inconsistent with best practice guidelines, high rates of preventable error and infection persist and costs including individual out of pocket expenses continue to grow.

Regulation has also failed to ensure the supply of critical health workers such as specialists meets the demands of the system. For example, control of medical specialist training numbers by craft groups and Colleges constrains supply and forces up costs. In the meantime, the regulatory burden on existing healthcare professionals is substantial and hinders the achievement of the primary purpose of providing healthcare services[6].

The degree of regulation also means that the interests of system experts are protected above those of consumers. Healthcare is heavily institutionalised and overly focused on meeting the needs of the system itself; as a result it frequently fails to provide services and products that are tailored to consumer wants and needs.

In other markets, competition has helped to improve these sorts of consumer welfare issues. Generally speaking, markets exposed to competition tend to see gains in efficiency and increased quality and innovation. Theoretically then, increasing the level of competition in the healthcare sector would seem an appropriate way to enable deregulation and drive consumer value higher.

Without doubt there are aspects of the healthcare system that would benefit from this approach, particularly in the private health insurance sector (discussed in more detail later). The goal of substituting competition for regulation in health should not be to simply cut costs, rather it should

[6] Novak, J., Berg, C., Wilson, T,. *The Impact and Cost of Health Sector Regulation*, Australian Centre For Health Research Limited. 2007

be to improve the outcome for every dollar spent on health but at the same time acknowledging that there are risks of market failure that must be addressed.

As the principle regulator, Government has a key role to play in this. A deregulation, competition enhancing process needs to be led by Government which will need to adjust its role to be more involved in facilitating the design and operation of efficient markets.

Recommendation: State and federal governments should move their focus from one emphasising healthcare supply and regulation to facilitating the design and operation of efficient markets.

Market failure a barrier to greater competition in healthcare

The healthcare sector demonstrates several characteristics consistent with market failure. In order for competition to achieve the benefits associated with it in theory, the causes of this market failure needs to be addressed.

The technical nature of healthcare means the market for it suffers extensively from information asymmetry. Compared with their provider or supplier, healthcare consumers are usually less informed about their health status, treatment options and outcomes and likely costs. While the internet has improved the situation, authoritative sources of information for consumers to help make an informed choice are few, particularly in relation to treatment alternatives, cost and quality.

Often the only signal available to consumers is the price associated with a service. With little other information available, consumers generally do not know whether the price represents good value or not and this can lead consumers to associate expensive care with quality, when in fact no such relationship need exist.

Obtaining any information, even price information, on healthcare services can be difficult and often involves transaction costs of their own. Unlike many markets, it is generally not possible for consumers to accurately research healthcare services in advance without paying for the information[7]. These transaction costs act as barriers to consumers seeking alternative treatment options or quotes (i.e. via a second opinion) as they are likely to be incurred again.

Even after incurring a transaction cost, the information obtained may still be imperfect. For example, additional expenses in a private hospital admission such as diagnostic costs and post-treatment outpatient costs may not be known until after the service has been provided.

The technical nature of healthcare also gives rise to a challenging principal-agent relationship between providers and consumers. Typically consumers do not have the technical knowledge to critically compare the price and quality of alternative treatments on offer and are often not familiar with the way the healthcare system functions. As a result consumers may relinquish responsibility for making decisions about their treatment to their provider.

This places considerable market power in the hands of providers and suppliers. In some cases this problem can lead to negative market outcomes such as supplier-induced demand[8]. The

[7] For example, a consumer is unlikely to find out about the treatment options and prices of a surgical procedure until they attend a paid consultation with their specialist or surgeon, at which point they may have already sunk other financial and time costs they may be reluctant to pay again.

[8] Supplier-induced demand refers to the concept that because providers are in the position of both advising patients on their need for medical care and supplying health services, providers can influence patient demand for medical services to create additional demand. This may not occur out of self-interest, but can arise as part of the provider's attempt to promote the well-being of their patient. See Bickerdyke, I., Dolamore, R., Monday, I. and Preston, R. 2002, *Supplier-Induced Demand for Medical Services*, Productivity Commission Staff Working Paper, Canberra, November.

Productivity Commission suggests the extent of delegation by consumers to their provider is probably more marked than for the healthcare market than other markets[9].

Improved information on quality and price would improve consumer outcomes

As noted earlier in this submission, the Australian healthcare system often presents as free to the user at the time of use. While welcomed by consumers, from an economically pure point of view there is an argument for greater use of price signals as a way to unlock competitive markets in healthcare and so improve the consumer experience and value.

However, for the benefit to be realised, markets need to be supported by strong mechanisms to allow consumers to make informed, value-based choices. Currently, restrictions on how data is used and published (particularly Medicare data) mean consumers and their agents[10] do not have access to the informational tools needed. Were it to be made available such information would enable the development and operation of efficient markets and the concomitant withdrawal of competition inhibiting regulation.

At a base level there needs to be greater consumer level transparency on price and quality of care metrics and improvements in the uptake of evidence based clinical guidelines amongst providers. Government has a key role to play here, principally in redesigning health sector rules and procedures.

Recommendation: The Australian Government should develop and publish an expanded range of standardised healthcare information including price and quality measures for hospitals and health services providers.

Other actors within the health system can also take part:

- Medibank sees itself as having a lead role to play in the delivery of improved standards of consumer information and it is developing new tools to help policy holders balance the information disparity and better understand quality and cost in healthcare delivery.
- Organisations responsible for clinical standards, such as craft group based colleges and associations should, take the lead in narrowing the gap between the best practice clinical guidelines disseminated to the medical community and actual practise.
- Providers themselves have an important role to play, both in adopting enhanced clinical standards, but also in improving its standards of communication with consumers. This includes improving the use of plain language to describe what is being purchased, better information on the treatment options and improved disclosure of pricing.

Overseas there is evidence that when these sorts mechanisms are in place price signals can help drive consumer engagement and competition. The introduction in the United States of Consumer Driven Health Plans is based on the notion that increasing an individual's personal financial exposure to health care costs causes them to be more engaged in their own health (including the cost of their own health) and display similar levels of consumer self-maximising behaviour seen in other markets.

The absence of clear comparative data means that this type of reform could not be trialled in Australia at the present.

[9] Ibid, p. 13.

[10] An agent in this sense could conceivably be a private health funds, a government body or a patient's coordinating GP – whomever the consumer trusts to help them make an informed decision.

Concentrated market power and influence distorts the health sector

It is worth noting that the health sector contains many powerful interest groups that have been successful at withstanding competition orientated reforms. Together with the challenges in creating functional markets noted above, this factor has played a leading role in preventing meaningful market orientated reforms in the sector.

There are numerous examples of markets in the health sector that have been able avoid being exposed to competition:

- Preservation of workplace demarcations through the restriction of skills and employment broadening in healthcare. A recent example is attempts to restrict the employment of nurse practitioners and pharmacists to perform tasks traditionally associated with GPs.
- Medical specialist labour force, via industry emplaced limits on university and post-graduate training opportunities and restrictions on the ability of overseas based specialists to access the Australian market.
- Pharmaceutical distribution, resulting in the supply of prescription pharmaceutical items in the community being limited to a traditional and protected model of pharmaceutical distribution.

Issues of consumer safety and quality control are often cited as the reasons for these restrictions, but they also have the effect of distorting the market by restricting supply of services to meet demand.

A competition enhanced healthcare system for Australia

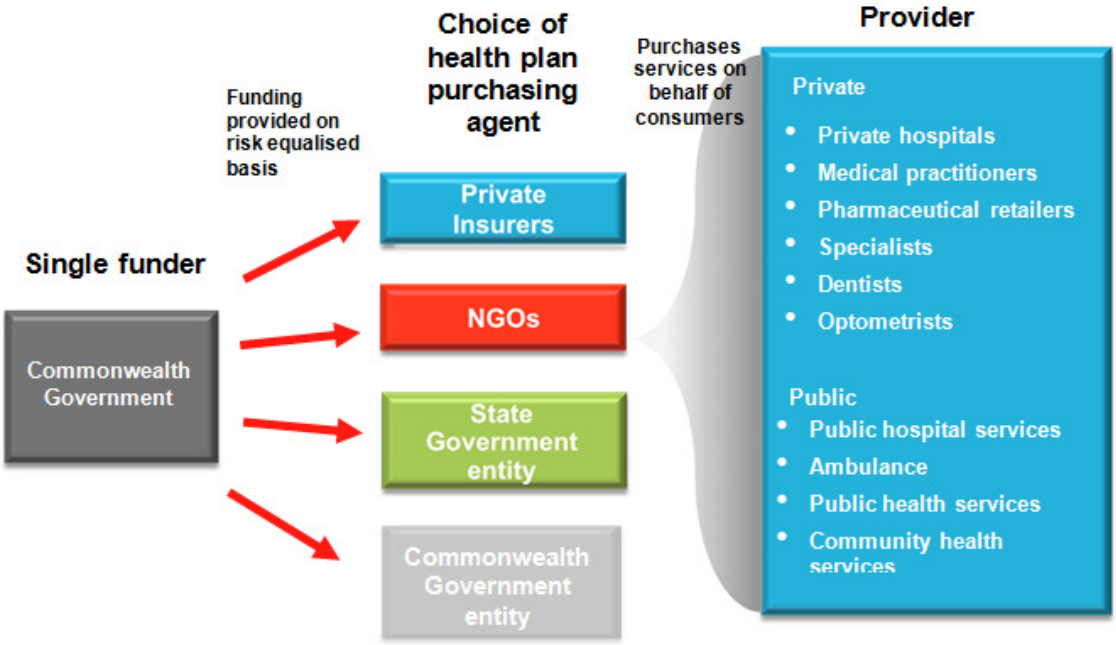
While it may exceed the scope of the *Competition Policy Review*, it is worth noting that a model of reformed, competition enhanced health system has previously been presented.

In its final report, the National Health and Hospitals Reform Commission set out a proposal for a reorganisation of the Australian health system to competitive social insurance model it called Medicare Select. One of the key goals of the proposed model is to improve consumer welfare via greater choice and competition.

Conceptually, Medicare Select has similarities with systems in Austria, Belgium, France, Ireland, Netherlands and Switzerland. Key features are:

- A single public funder of healthcare (the Australian Government), which funds a prescribed set of health services set out in a universal service obligation (USO). This would address current shortcomings in terms of unclear responsibilities and system fragmentation.
- Eligible person would be able to choose whether they access a government (state or federal) or privately operated health and hospital plan agent to deliver the USO.
- USO plans would be funded on a risk-adjusted basis per person, according to a range of factors that might include age, gender, socio-economic status and place of residence.
- At a minimum, health and hospital plans under Medicare Select would include the current Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and access to public hospitals.
- This USO could be further supplemented by additional services including extended allied health coverage, advanced dental care, enhanced hospital amenity and access.
- Plan providers would then strategically purchase the health services necessary to meet this obligation and the needs of their members by entering into competitive contracts with health care providers.

The diagram below sets this out more clearly:



The Medicare Select model invites the benefits of competition at two points:

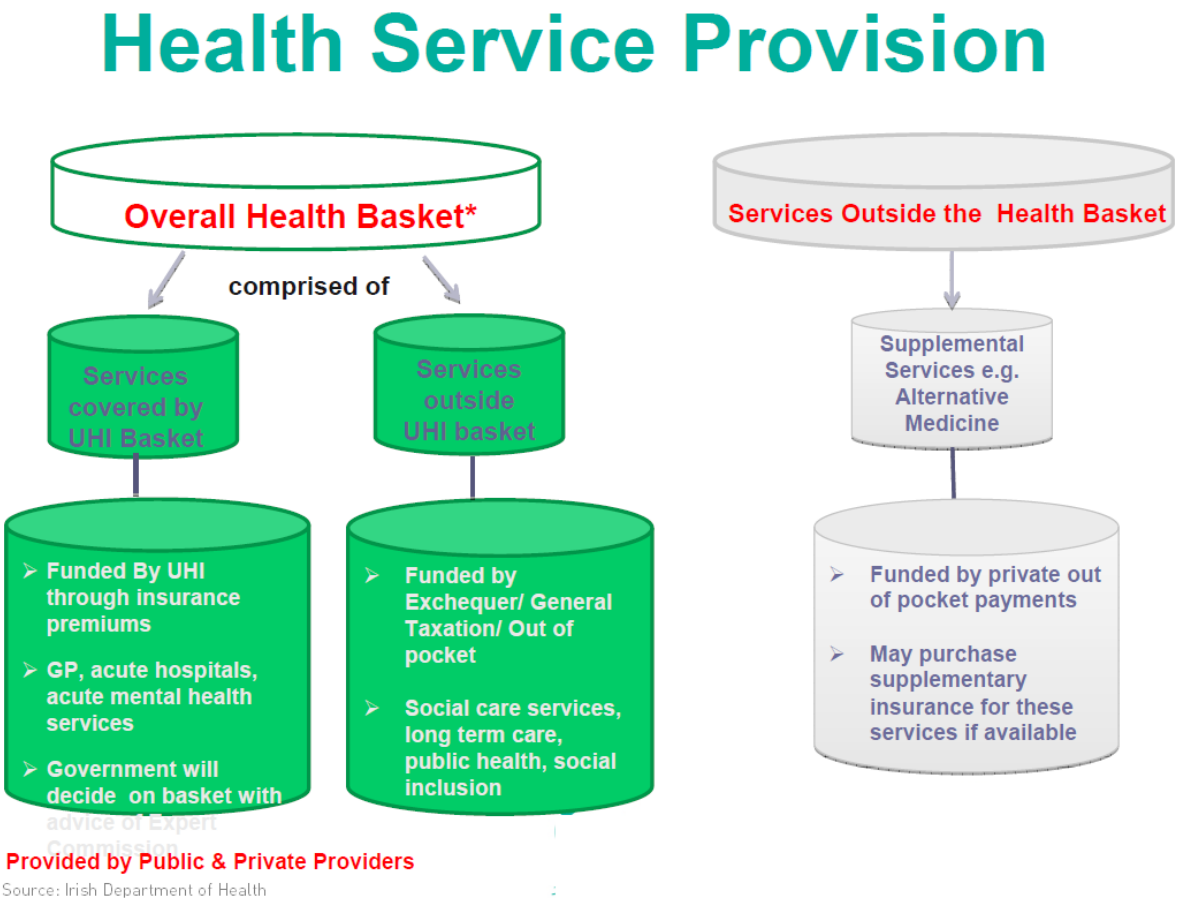
- Competition in the health plan purchasing agent market. This would drive administrative efficiency, better risk management and consumer choice.
- Competition in at the provider level, as consumers and their agents seek the most efficient and value creating service providers.

For more information see the final report of the National Health and Hospitals Reform Commission, *A Healthier Future For All Australians*.

Recommendation: The Australian Government should sponsor further investigation and development of a competitive social health insurance model of healthcare delivery.

International comparisons

Medicare Select has frequently been compared to the health structural reforms implemented in the Netherlands in 2006. Recently Ireland has also elected to adopt this approach, developing what it calls Universal Health Insurance (UHI). The implementation process will be is interesting to observe as the Irish Government is determined to learn from problems exposed during the Dutch implementation, including a loss of control over costs in the first few years of operation. The image below is taken from a recent **Irish Department of Health** presentation describing the proposed system.



The Government of Ireland hopes to have the new system in place for 2019, indicating the long lead times associated with such fundamental system change. This underlines the need for investigation of applicability of such a system to Australian to begin as soon as possible.

Competition enhancing reforms in private health insurance

Private health insurance is amongst the most heavily regulated industries in Australia. The regulatory framework impacts on the scope of services covered, product design, pricing, discounts and capital requirements. Private health insurance is also required to be offered on a community rated basis, which is underpinned by a complex risk equalisation scheme.

In isolation many of these regulations are well intentioned and appear worthwhile; in practice the overall burden of regulation has the effect of inhibiting innovation and restricting insurers capability to address costs and grow consumer value.

Actual and potential health insurance policy holders aren't immune from this complexity. To encourage participation in private health insurance there are negative consequences for people who do not participate by a certain time (the Lifetime Health Cover loading) or for higher income earners who do not participate at all (the Medicare Levy Surcharge, which is reconciled via the taxation system).

On the other hand, when consumers do choose to privately insure they are assisted to meet the expense with the Australian Government Rebate. Recently this Rebate has been means tested and indexed to CPI, adding additional layers of complexity for consumers to wade through.

This incentive framework has been successful in increasing participation from around 30 per cent of the population in the late 1990's to almost 50 per cent now, but the time for a review and overhaul in order to encourage a new wave of participation is approaching.

Rather than regulating in detail how private health insurers operate, Medibank believes the aim of policy makers should be to ensure a competitive industry that enhances consumer welfare and value. This would see an industry that is incentivised to:

- Better manage its risk profile, so as to limit outlays.
- Drive efficiency in the procurement of health services, with improved health outcomes for every dollar spent.
- Drive down management expenses.

Premium process reform

The process by which private health insurers are approved to increase premiums is onerous. It involves multiple submissions and assessments by numerous government agencies and, ultimately, approval by the Minister for Health. It is a long, resource intensive process that commences in approximately September for application in April the following year.

The current premium setting process is falling short of best practice regulation:

- The process limits competition. The nature of premium vetting and approval is one of 'blind tender', in which funds must submit proposed price changes without knowledge of the actions of their competitors. Removing this competitive signal could encourage funds to adopt a strategy of maximising the potential increase and revising later if necessary.
- The constraint imposed by the annual application process means that funds must price in a risk contingency to allow for unexpected changes in cash flow over the course of the following 18 months, which flows through to prices.
- The Minister rather than an independent regulator sets regulated prices, creating a perception of political interference.
- There is a lack of transparency with reasons for premium setting decisions not made public.

- There is a lack of evidence of market power to warrant Government and regulator intervention.

While clearly not the intent, the Australian Government's role in setting premiums is limiting innovation in the private health insurance industry and its ability to help build a more effective and efficient health system. This is because price regulation removes the link between better performance and higher profits, reducing the incentive to innovate and improve efficiency and slowing productivity gains in the sector.

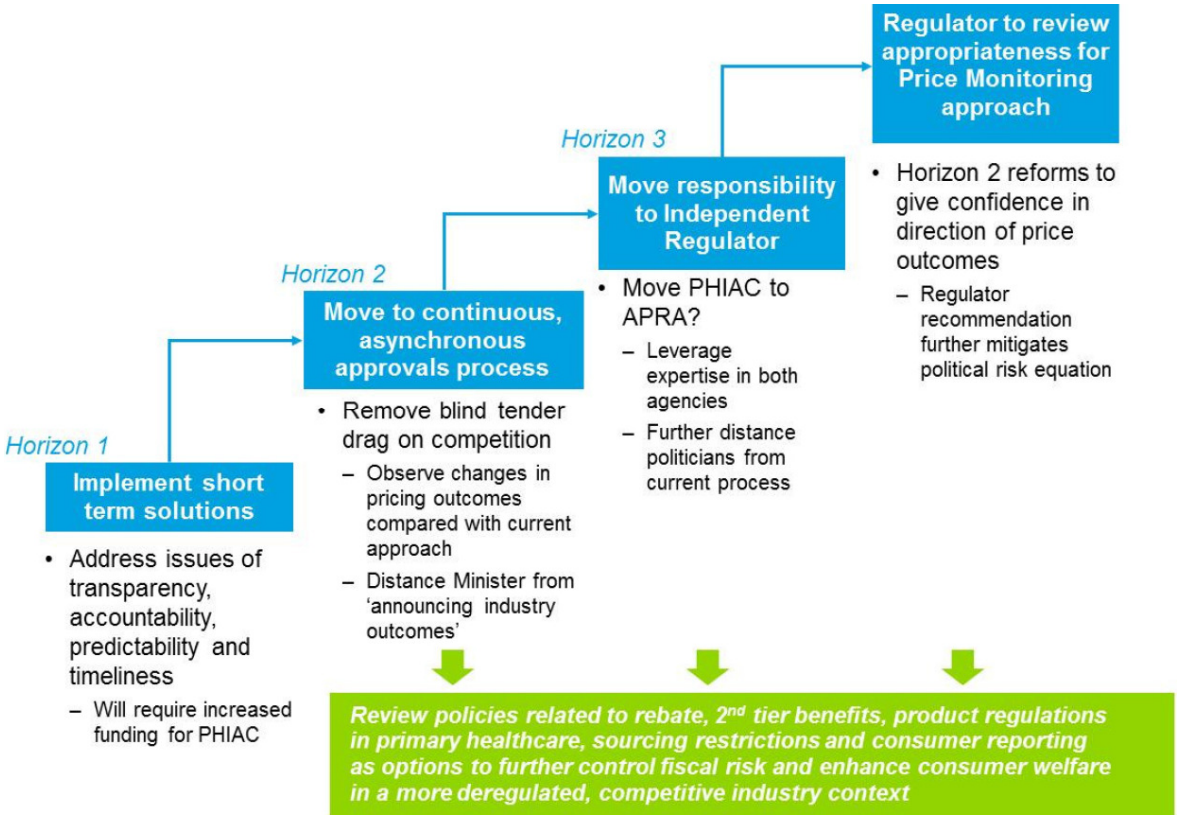
In a market that looks to competition over regulation, better performing funds would be rewarded with greater profits and returns to shareholders. This would provide strong incentives for firms to innovate and drive efficiency improvements. Medibank strongly recommends reforming the premium setting process to achieve this goal.

Consumer welfare is still protected under this model because price competition enforces discipline and moderation. With consumers able to switch funds at any time, including transferring waiting periods served, any fund that tried to increase margins by pushing prices too high would be punished by the market.

Noting that moving from a regulated to a competitive framed market is a substantial change, Medibank does not advocate full deregulation. Its preferred model is to move to a more light-handed approach called price monitoring, which would allow funds to set prices as they wish, with premium growth being monitored by an independent regulator.

The rationale behind price monitoring is to grant funds the flexibility to decide when premium changes should occur and by how much, thereby promoting competition between funds, which will aim to attract consumers through lower prices relative to another fund.

In 2012 Medibank commissioned Deloitte Access Economics to review private health insurance premium reform, including price monitoring and the steps that should be followed to achieve. Deloitte recommended the process below:



Aspects of these are underway, including shorter term improvements to the current process and the recently announced decision of Government to abolish PHIAC and transfer its functions to other entities. Medibank considers that any move to a continuous, asynchronous approvals process would likely come in parallel with the introduction of price monitoring, rather than before it.

Deloitte suggested there could be a certain degree of flexibility in the system of price monitoring if implemented, but that the design could encompass:

- Monitoring prices
- comparing prices to costs
- monitoring rates of return
- monitoring quality of service
- publishing information collated
- intervening if changes are not deemed appropriate.

Medibank notes the recent National Commission of Audit endorsed moving to a price setting model. We are also encouraged by the reference in the 2014 Health Portfolio Budget Statement to the Government developing options for improvements in premium setting to drive competition and deliver strong consumer protections. We consider a move to a price setting regime is the best way of achieving these goals.

Recommendation: The Australian Government deregulate the private health insurance premium setting process and move to a independent price monitoring regime.

Product and rules reform

Observing the seemingly irreversible upward trend of benefit outlays and the adverse growth implications of recent legislative changes[11], the time is right to allow greater competitive forces into the private health insurance industry. With this in mind Medibank has identified a set of competition enhancing reforms which can be applied to the industry with relative ease.

Reform of Second Tier Default rules

The PHIAC paper *Competition in the Australian private health insurance marke*t, released in June 2013, noted that heavy regulation impedes the ability of insurers to control costs along the supply chain. One aspect of this that is amenable to change are Second Tier Safety Net rules.

The second tier default safety net requires that private health insurers pay eligible hospitals a minimum of 85 per cent of the average paid to similar hospitals in the State, where they do not have a contract with that hospital. Hospitals may charge patients an out of pocket expense, leading to unforeseen costs for patients or forcing them to switch health funds or treatment to the public system.

In effect, the second tier safety net regulates a floor price that private health insurers must pay eligible private hospitals which are out of contract with a given fund. This inflates the prices paid by funds both for out of contract and in contract hospitals, as it dramatically shifts the balance of power in negotiations.

Reforms to the second tier safety net would allow greater competitive pressure between private health insurers and large private hospital networks, reducing benefit outlays and placing downward pressure on premiums.

[11] Including the means testing and indexation of the Australian Government Rebate.

Medibank recommends limiting access to second-tier default benefits be limited to small and regional independent hospitals. This would encourage more robust negotiations between insurers and larger hospital networks, ensuring better health outcomes for every dollar spent.

Other alternatives that have been suggested to attenuate the anti-competitive nature of second tier default rules are adjusting the current safety net downwards to 75 per cent, or abolish the safety net and replace with a direct subsidy for small hospitals.

Recommendation: Access to second tier default benefits be limited to small and regional independent hospitals.

Prostheses pricing reform

Under current regulations, private health insurers have no ability to negotiate either individually or collectively the price paid for prostheses, leading to significantly higher prices in Australia than in comparable countries. Moreover, funds are obliged to purchase prostheses through private hospitals. These arrangements undermine competition and are a key source of higher prices in the Australian market.

Medibank notes the prices paid for prostheses are much lower in the public system, because state health systems run central tenders for manufacturers to supply public hospitals. Medibank estimates that if the private health system could move to a similar tender system it result in a 7 per cent reduction in the total cost of prostheses, saving over $100 million per year.

The key issue impeding reform has been the desire to maintain clinical choice for medical practitioners. This is changing, with major private hospital groups now mandating which devices can be used in their hospitals.

There are three key steps required to address this issue:

1. Separating the prostheses listing process from the prostheses pricing process.
2. Establish a prostheses purchasing committee serving as a group buyer for prostheses on behalf of all private funds and hospitals.
3. Establish a centralised tendering system for private procurement of prostheses based on the current public systems. Regular retendering would ensure that savings from exchange rate improvements flow through to the Australian health system.

Recommendation: Prosthesis pricing and purchasing arrangements be revised.

Commission transparency in the internet aggregator market

Internet aggregators allow consumers to compare participating private health insurance policies across pre-determined criteria, such as price and excess levels. This gives consumers easy access to certain information on competing products, and has reduced barriers to entry by reducing the power of existing brands.

Aggregators now account for almost 20 per cent of all sales, and over 60 per cent of consumers consult aggregators prior to making a purchasing decision[12]. On the one hand this drives greater competition, but on the other hand this largely unregulated segment of the industry presents issues for consumers.

When they convert searches into a sale, aggregators receive commissions of between 30-50 per cent of the annual premium. Because commissions received by aggregators vary across insurers, there is an incentive to promote policies that will generate higher revenue rather than meet the needs of consumers.

[12] Medibank internal research.

Based on the advice they receive from aggregator sites, consumers may be purchasing insurance products that do not meet their needs, potentially exposing them to significant and unexpected medical costs in the future.

ASIC identified the behaviour of internet aggregators as a concern in December 2012, and signalled it would ensure that they complied with relevant consumer protection legislation[13].

While aggregators are providing advice and selling one of the most important financial products that a family will buy in any given year, they are not regulated in the same way as other financial advisers.

The pervasive nature of commissions is recognised by the Future of Financial Advice (FoFA) reforms. The reforms ban financial advisers from receiving payments that could influence financial product recommendations to retail clients, such as commissions. While Medibank does not advocate a FoFA style ban on commissions we do recommend greater disclosure consistent with the intent of the FoFA reforms as a means to provide consumers the information they require to make informed choices.

Recommendation: Commissions payable to internet aggregators and other intermediaries should be fully disclosed during the sale process.

Modified community rating for ancillary health cover

Community Rating requires that all insurance policies are offered at the same price to any person irrespective of risk factors including age, prior utilisation of health services or income. Medibank supports the key tenets of Community Rating.

Because community rating does not price insurance premiums according to risk or prior utilisation, it unavoidably produces a greater propensity for moral hazard, where policy holders consume more services because they have insurance and do not face the true cost (or any cost) of accessing those services. Premiums are inefficiently driven up by the extent to which this behaviour causes excessive consumption of health services.

Empowering insurers to address legitimate moral hazard failures, especially in relation to ancillary cover could lead to significant reductions in premiums.

For example, private health insurance funds cannot reward policy holders that have previously claimed optical expenses for not claiming in a particular year, even if that reward were as low as a $10 reduction in premiums. The inability of funds to address a clear moral hazard by encouraging those with optical coverage to not claim every year drives up premiums for all private health insurance policy holders.

Medibank internal research indicates that 40 per cent of optical claimants claim for new frames every year. There is unlikely to be a medical need for such frequent claiming.

Allowing the introduction of no claims bonuses for frequent claimants in ancillary cover would represent a practical step to put downward pressure on premiums without penalising individuals for using their insurance.

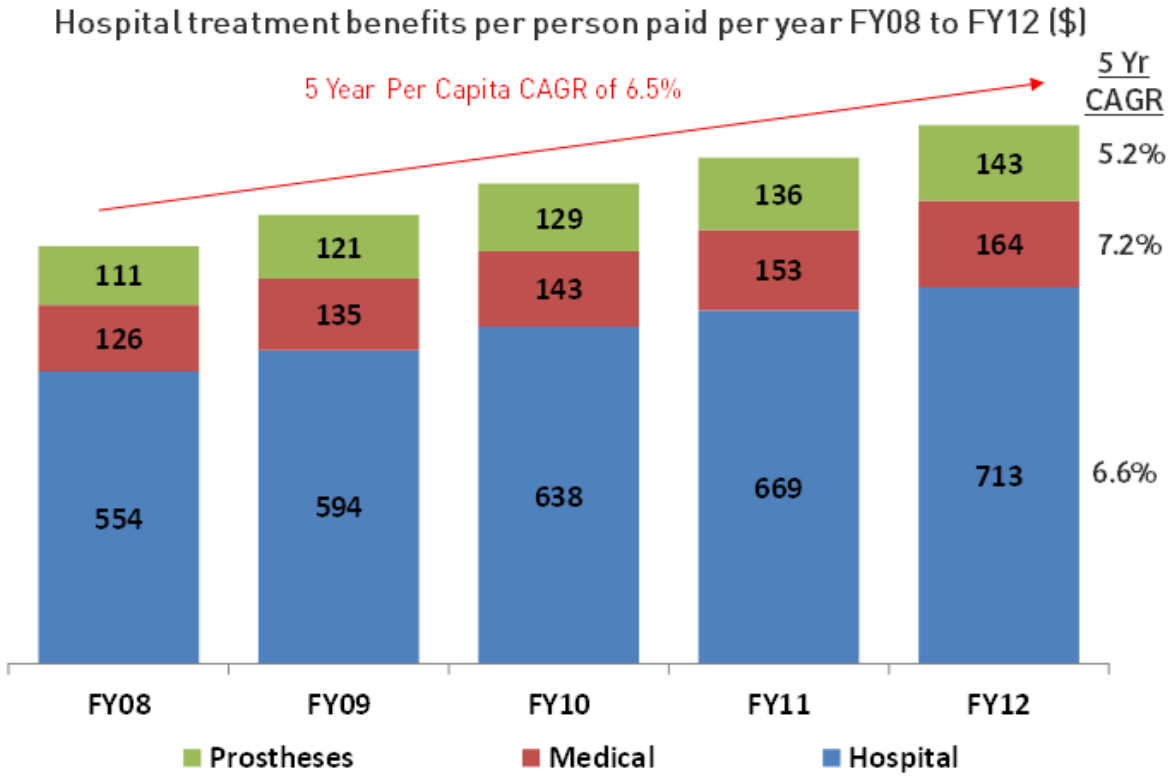
Recommendation: Private health insurance rules be modified to permit no claims bonuses on general treatment products.

[13] See http://www.cornucopiafp.com.au/articles/news/asic-targets-insurance-comparison-sites,-researchers.aspx, accessed 17/06/14

Private health insurer involvement in primary care

Any analysis of private health insurance affordability must take account of where policy holder premiums are spent. For every dollar of premium revenue earned, Medibank pays out approximately 86-87 cents in policy holder benefits. The largest share of this is for hospital claims. In financial year 2012-13, almost three quarters of benefits paid by Medibank were the costs of hospital services, including accommodation, medical services and prosthesis devices.

On its own this no bad thing – coverage against these expenses is, after all, a principal reason why policy holders purchase private health insurance. However the rate of growth in year on year hospital benefits is of concern. Over the last five years hospital treatment benefits per person have risen at a compound annual growth rate of 6.5%, as detailed in the chart below:



As noted earlier in this paper, maintaining the affordability of private health insurance is important to the health system as a whole, yet growth in hospital benefits is the key underlying driver of premium growth and left unaddressed could lead to premiums becoming unaffordable. This circumstance is not exclusive to Medibank - all health funds also experience this same circumstance.

In recent years Medibank has attempted to reduce pressure on hospital benefit outlays through smarter purchasing of hospital services and by better managing high risk patients. While these initiatives have been successful and remain important, in order to truly make a difference to hospital benefit growth rates Medibank considers it necessary to work more closely with the primary care sector.

Normally the first point of contact for people requiring medical assistance, primary care is typically taken to refer to services provided by medical professionals such as general practitioners, nurses and pharmacists. Generally it is delivered in a community setting rather than hospitals.

The crucial role of primary care in Australia's healthcare system cannot be understated. Because primary care receives, diagnoses, treats and (where necessary) refers patients on to more specialised secondary or acute care, it acts as both driver and container of overall healthcare costs. With chronic disease growing as a share of total burden of disease in Australia, this importance can only grow. Managing chronic disease in the community produces better health outcomes and is far more cost effective than relying on expensive acute care hospital admissions to treat its effects.

For these reasons Medibank has developed a strategy that will see it playing a greater role in primary care than it has in the past. Presently it is running a pilot scheme in Queensland testing a differentiated primary care experience for members. This program is allowing Medibank to build familiarity with primary care and understand how closer collaboration with GPs, particularly in the area of preventative health, can assist policy holders stay healthy and out of hospital.

Medibank is also developing an innovative integrated care program aimed at high needs and complex patients[14]. Analysis of claims data demonstrates that a small minority of just 2.3 per cent of Medibank policy holders recurrently account for approximately 1/3 of annual hospital related benefit outlays. If Medibank can assist this cohort to have lower numbers of hospital admissions the rewards, for both the policy holder and the fund, could be substantial.

This situation is not unique to Medibank. All funders of hospital services will have a similar profile of high utilising and complex patients and similar costs associated with them. One of the benefits of the Medibank model is that it can be applied equally to public patients as well as its own policy holders. In fact becomes the model becomes even more efficient in such cases because of the cost-sharing benefits.

As evidenced by these programs, private health insurer involvement in primary healthcare does not necessarily require changes to the existing healthcare regulation. However rules restricting insurer involvement are unhelpful and add complexity and Medibank is keen to work with the Australian Government to examine opportunities for beneficial reform in this regard. Medibank is opposed to any attempt to extend current restrictions on private health insurance funding of primary care.

Recommendation: Regulations governing how private health insurers can work with and fund primary care should be reviewed with a view to encouraging greater involvement of insurers.

[14] Medibank's integrated care model can be effectively overlaid on to the existing health and social services system without the requirement for systemic reform. The model is specifically built to eliminate systemic breakdowns that lead to hospitalisation for high utilising and complex patients.

Conclusion

There a key aspects of the health sector, including the private health insurance industry, that could benefit from being exposed to competition. A competition exposed health sector would improve the quality of health outcomes for each dollar spent and promote consumer welfare.

However, due to characteristics that resemble market failure and the actions of powerful groups with vested interests in the current system, achieving such reforms are difficult. Nonetheless, addressing these issues is necessary and should be done now. Delaying changing the system will mean costs only grow and problems will be all the more difficult to fix address in the future.

Private health insurers are ready to play a role in improving the health system but need to be supported by being allowed to be more commercial and innovative. This includes addressing anti-competitive forces in the health supply chain and tackling moral hazard failures.

In the long term the benefits of competition are best achieved via fundamental structural reform of the health system, such as by moving to a managed competition social health insurance system similar to that seen in the Netherlands and under development in Ireland.