AMA

The AMA Repeat Prescription for Private Health Insurance

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INTRODUCTION

In October 2020 the AMA published our Prescription for Private Health Insurance.[1] At that time private health insurance (PHI) was in trouble and, after extensive analysis, we developed a list of policy prescriptions to improve the health of the system. Each proposal had one of two ultimate goals – to either make private health insurance more affordable for those who currently cannot afford it, or to improve its value proposition for consumers, and the wider health system.

After 5 years of declining PHI membership, there have now been 10 quarters or growing membership[2] so that there are 513,618[3] more people with private hospital insurance than when the AMA released our report in October 2020. However, the trend is still for older people to take out insurance at a higher rate than younger people, with 40% of the insured population over 60 and only 6% aged 20-39 and 24% aged 40-59 (between Sept 2020 and Dec 2022).

Despite this upturn, our private health system is still not well. While private health insurers have seen significant increases in their profit margins, private hospitals are entering their fourth year of reduced capacity (whether this has resulted from COVID 19 or now workforce shortages) and therefore reduced profitability.

These recent swings in profitability demonstrate that management of Australia's private health system is failing. Failing healthcare providers, failing governments and failing our patients.

Reform to our whole system must continue – Australia's private health system is no longer fit for purpose, it does not suit the times or take into account the needs of today, let alone the pressures and changes of tomorrow. Yet now is when we need our private health system more than we have ever done before. Our public hospitals are overflowing, and patients are waiting years on the hidden waiting list to see be seen in outpatient clinics before they can even be put on a surgery waiting list.[4]

Our private health system continues to provide access to specialists, access to treatment, access to surgery. This is the reason so many Australians have chosen to invest in PHI even when cost of living pressures are higher than they have been for many years.

Australians spend a lot of money on PHI, but many do not see the value. There are immediate changes we can make to ensure that it delivers value for consumers in terms of meeting a person's health needs, and to meet the needs of an ageing population with increasing chronic disease and multimorbidity. The planning and innovation to create such a system must take place now – it must be evidence based, wholistic and purposefully designed.

We are not doing this work and we do not have the appropriate mechanisms to support this work to be done. Australia needs an overarching body to bring the sector together to allow all stakeholders to work better together support enduring reforms.

Now is the time for Government to invest in this capacity through the establishment of a Private Health Insurance Authority. Such an authority needs to be patient centred and independent – so it can provide evidence-based advice and recommendations to government about future directions for the sector. Now is the time for the Government to step up and design an Australian health system which integrates our public and private sectors and provides all Australians with access to high quality health services now and into the future.

As part of the AMA Repeat Prescription, we are again outlining a call for action with renewed proposals. Like our first Prescription each proposal has one of two ultimate goals – to either make private health insurance more affordable for those who currently cannot afford it, to improve its value proposition for consumers, and the wider health system, or to position our private health system into the future.

AMA'S RENEWED CALL FOR ACTION

Premium Rebate Restored

Restore the PHI rebate for targeted groups to make private health hospital insurance affordable for younger Australians and those in the workplace on lower incomes.

Minimum payout

Australians need to know they are getting value from their PHI premiums. A minimum amount of 90% needs to be returned to the health consumer for every premium dollar paid. This needs to be a standardised return that is higher than the current PHI industry average right now.

Medicare Levy Surcharge

The Government should change the Medicare Levy Surcharge levels and thresholds, to settings the deliver on the policy intent. The AMA has costed a change to the surcharge from 1.25% (for people earning over $105,001) to 2%. But as our private health system is complex, changes to the surcharge need to be coordinated with any other reforms.

Lifetime Health Cover loading

The AMA believes that our Lifetime health cover settings are working to keep people out of PHI. The Government needs to change the Lifetime Health Cover loading and penalties – especially the starting age to make it an easy choice for Australians to stay in PHI for life. This should include reviewing the way in which penalties ramp up for late entrants who join later in life and pay premiums just before they are most likely to claim.

Default Benefit Arrangements

Default benefits are an essential protection for patients in our private health sector. The Government needs to ensure second tier default benefits support a reinvigorated and resilient private health system by providing a safety net for private hospitals and supporting innovation by underpinning community-based and home-based hospital programs.

Risk Equalisation

The AMA believes that we need to ensure that our risk equalisation arrangements continue to support the community rating principle. Any changes to risk equalisation must minimise incentives for PHI to discriminate against consumers and continue to actively support community rating.

Extending PHI beyond hospital

The Government needs to develop appropriate funding and accreditation systems that enable private health service providers to roll out more innovative and flexible health programs either as a day visit, community outreach or hospital in the home models. These models need to be developed in close collaboration with existing health services to best meet community need.

Regulation of the private health sector

To support reforms to the private health sector the Government needs to establish a Private Health System Authority - an independent, well resourced, statutory body to oversee the private health system, and to safeguard patient choice which is central to its value proposition alongside speed to entry.

BACKGROUND

Australia's private health system is complex – it is the sum of many policy levers and a multiplicity of different funding approaches. It is also the product of a range of external factors, including the state of the public and primary health systems, the demographics of our population, the impact of the economy and the health choices each of us make, all of which are contributing to an ageing, chronically unwell population.

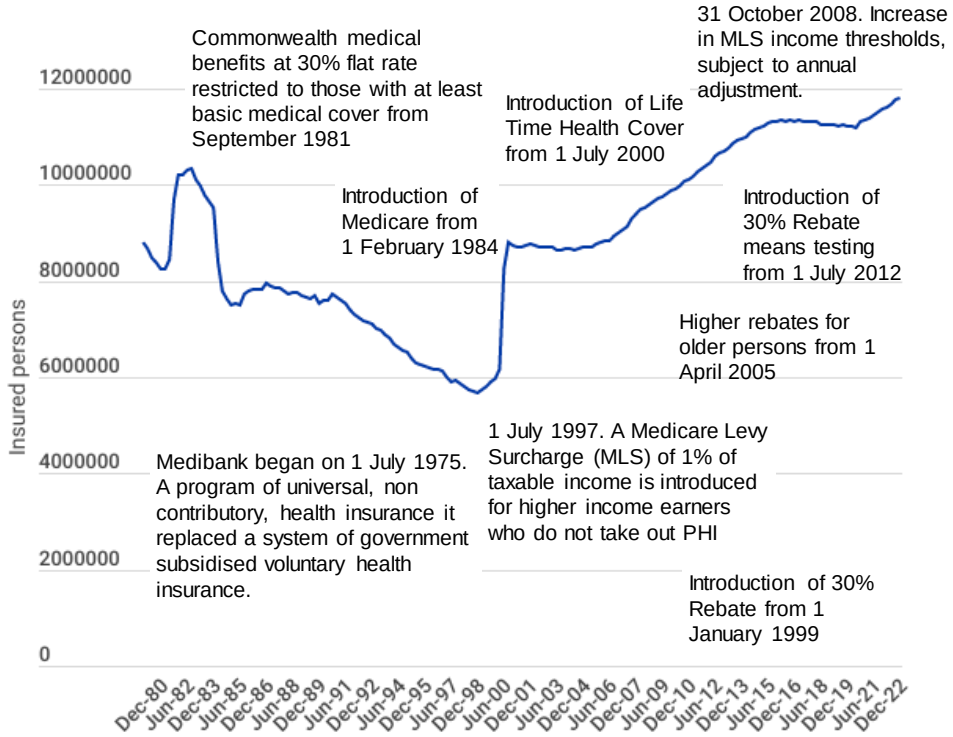
The impact of any one of these factors can be small or large and this can change as the other dynamics and the demographics of our Australian population also change. The Australian Prudential Regulatory Authority graph shows clearly that pulling on individual policy levers at some times has had negligible effects (e.g., the introduction of the MLS in 1997) and yet changing other levers at other times, caused a major shift (such as the introduction of Lifetime Health Cover in 2000).

But none of these mechanisms stay static and each needs to be made and kept relevant. We need to ensure every part of the jigsaw puzzle that makes up our private health system is performing optimally and is fully integrated with all other aspects. To fail to do this means we create a system that does not optimise the resources that go into it, that does not provide best practice service, and does not deliver the best health outcomes for the millions of Australians who use it every day.

The AMA has advocated for changes to the private health system in Australia including to PHI. These changes must have at their very core the ability to improve the value proposition for patients.

For Australians to take out private hospital insurance and maintain that coverage through their lives, they have to see the value in the product they are purchasing. PHI products not only have to deliver value for the amount people pay but they must also be transparent to consumers. Purchasing PHI is incredibly complex. The move to the Gold, Silver, Bronze and Basic categories improved the situation, but there are still a multitude of products out there offering a bewildering array of choices. The AMA believes more work needs to be done to make PHI products more transparent and easier to navigate for consumers and providers.

Figure 1: Private hospital treatment coverage (insured persons as a percentage of the population)[5]



This value cannot be determined solely by the cost to Australians of their PHI premiums. People take out insurance for the following reasons:

- To gain better, quicker access to health care;
- To have a choice of doctor and choice of hospital;
- To increase peace of mind regarding costs associated with medical treatment; and
- To access a better range of treatment options.

The problem with obstetric care arrangements

The AMA has called on the Government to get PHI reforms right since the inception of the gold, silver, bronze and basic categories. We have called for pregnancy cover to be included in all levels of policies and, understanding this was a costly move for insurers, for obstetrics to be added to the risk equalisation pool. Pregnancy is a natural part of life and a strong value proposition for younger members. Failing including pregnancy coverage in all levels of PHI, the AMA believes that Government should put in place the same waiver that applies to psychiatric care. Members are able to upgrade their hospital cover for psychiatric care once in their lifetime without waiting a further period beyond the 2-month waiting period for limited psychiatric benefits.

The AMA does not believe that we are currently heading in the right direction to deliver on these values.

As with our original Prescription for Private Health Insurance, the AMA believes that the policy recommendations outlined here are viable and need urgent consideration for this year's Commonwealth Government budget.

As a sector we need to address many underlying issues to make private health sustainable into the future. The changes to policy outlined in this paper are just a next chapter. Further reform and engagement with all players is still crucial to deliver an adaptable, future-ready private health system, and the AMA stands ready to continue leading the medical profession in that effort, as demonstrated at our Private Health Summit in June 2022.[6]

PREMIUM REBATE

Restore the PHI rebate for targeted groups to make private health hospital insurance affordable for younger Australians and those in the workplace on lower incomes.

The Commonwealth Government introduced the Private Health Insurance Rebate on 1 January 1999, to support people in taking out PHI, providing a non-income tested financial support for individuals and families via a 30 per cent reimbursement of premiums paid, or a 30 per cent premium reduction.

The Government has since introduced means testing of the rebate and it has lowered the maximum rebate available to policy holders. Through a complex, inadequate indexation process, the Government lowered the maximum rebate a policy holder under 65 can receive from 30 per cent to 24.608 per cent, as of April 2022.[7]

The AMA Prescription for Private Health Insurance considered the question 'Does the Government still get value from the rebate? Does supporting Australians to take out PHI generate a better outcome for the whole health system?'

Our work showed that private households contribute out of pocket expenses and excess payments of $1.29 billion per annum in addition to the $12.9 billion in hospital premiums paid. This $14.2 billion in private contributions to their own health equates to $3.78 of additional care for every $1 that the Government directs to the rebate for hospital treatment.[8]

Lifting the rebate from the current base rates up to 30 per cent for those aged under 65 and for those aged 65-69 will have a significant impact on Government rebate expenditure but additional members to the insurance pool will assist in putting downwards pressure on the premiums themselves, and start to generate benefits for insurers, the Government and consumers.

The AMA has costed out the impact of an increase to the PHI rebate at $5.31 billion between 2022–23 and 2025–26 (to restore to previous levels) for people under 65 (see below) but failing this the AMA is calling on government to at least restore the rebate for targeted groups to make private health hospital insurance affordable for younger Australians and those in the workplace on lower incomes.

Explanatory note regarding costings to restore PHI rebate

In the costings, the 'premium' refers to the 'average base premium' that insurers set. The 'price' refers to the retail price that consumers pay for that premium after any applicable rebate. Some policies will affect the base premium, which is then assumed to also be passed onto consumers through the price. Policies involving the rebate will have a direct effect on the price but may also have an indirect effect on the premium through change in the underlying PHI membership.

In the costings it is assumed that the 'additional PHI policies' claims experience, which arise in response to incentives to either retain or join PHI, will be at a reduced average rate to existing members (60 per cent of the average rate).[9] This is based on most of the incentives targeting people aged 65 and under, who have a much lower average claim profile.

There are also additional benefits to individuals and government which are not costed directly. The claims which are made against the additional PHI policies, even if at a reduced rate, still offer direct benefit to the individual claiming. Those benefits paid also offer care which otherwise would have to be carried out in the public hospital system. The benefits are most likely to accrue to reduced wait times for public hospital patients given the capped public hospital funding model.

The costings for restoring the PHI rebate to its previous levels are only for people aged under 65 (30 per cent for those earning $90,000 or less, 20 per cent for those earning between $90,001 and $105,000, and 10 per cent for those earning between $105,001 and $140,000). For family policies the rebate levels used are the same as for singles, however the equivalent household income thresholds for couples are double those of singles. The income thresholds for singles and couples match the existing MLS thresholds.

The price elasticity of demand for the impact of the change in the rebate was estimated at -0.5 ceteris paribus (with no other simultaneous changes a 1 per cent decline in price increases policies by 0.5 per cent), specifically among those under the age of 65.7,8 The total cost to government between 2022–23 and 2025–26 is calculated as $5.31 billion. The number of additional PHI policies are measured as the difference between the baseline and the policy scenario at each year.

Table 1: Impact of an increase to the PHI rebate (to restore to previous levels) for people under 65.

	2022-23	2023-24	2024-25	2025-26	Total
Additional private health insurance policies (above baseline)	340,709	348,224	360,322	371,606	371,606
Rebate for additional private health insurance policies ($m)	343	360	383	407	1,494
Additional rebate for existing private health insurance policies ($m)	982	1,050	1,136	1,222	4,390
Change in Medicare Levy Surcharge revenue ($m)	-7	-8	-8	-9	-32
Reduction in average premiums because of new members (%)	1.82	1.92	2.04	2.16	2.16
Clawback rebate from lower premiums ($m)	138	146	155	164	603
Reduction in the price of private health insurance policies for members with $90,000 or lower income (including rebate and lower premiums) (%)	9.07	9.42	9.78	10.15	10.15
Net cost to government ($m)	**1,194**	**1,272**	**1,373**	**1,474**	**5,312**

MINIMUM PRIVATE HEALTH INSURANCE RETURNS

Australians need to know they are getting value from their PHI premiums. A minimum amount of 90% needs to be returned to the health consumer for every premium dollar paid. This needs to be a standardised return that is higher than the current PHI industry average right now.

Private health insurer expenses

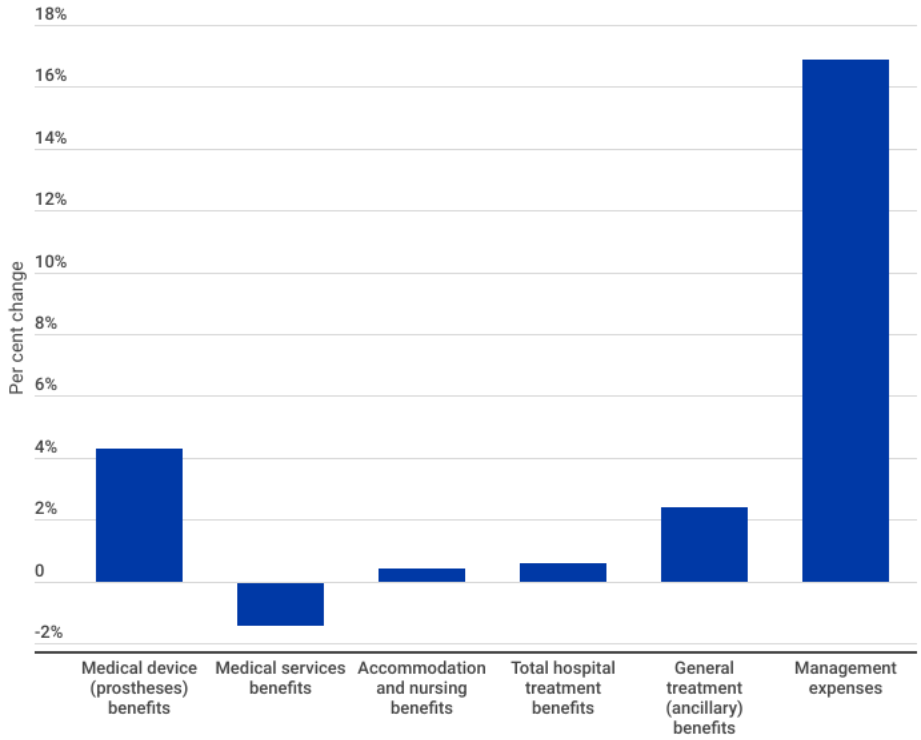
Private health insurers will generally aim to set premium levels to cover the expected costs of benefits (that is, payments made on behalf of insured members for admitted hospital costs including doctors' fees), plus the fund's management costs.

Regardless of whether a private health insurer is for profit or not-for-profit they have a number of expenses in common to deliver benefits. For any episode of healthcare funded by an insurer they cover the following main expenses:

- Hospital expenses — the amount paid to the hospital
- Medical expenses — the amount paid to doctors
- Prostheses — the amount paid to buy item such as hip and knee joints or cardiac stents.

All insurers also incur management expenses- the costs of them doing business such as wages, rent, marketing costs, salaries, claims handling expenses and profit margins in the case of for-profit insurers. The amount paid by insurers for management expenses can vary considerably, with an industry average of 10 per cent of contribution income, but some spending over 15 per cent.[10] If management expenses as a proportion of payments are higher, a smaller proportion of premiums is being spent on members' claims for admitted hospital treatments. Naturally, such calculations are complex, but it is likely that a greater proportion of premiums being paid towards benefits is one indicator of value and return on investment. As Figure 2 shows, increased management expenses have been a significant contributor to increases in PHI premiums over the past 3 years.

Figure 2: Cost components to increases in PHI premiums over the last three years to June 2022

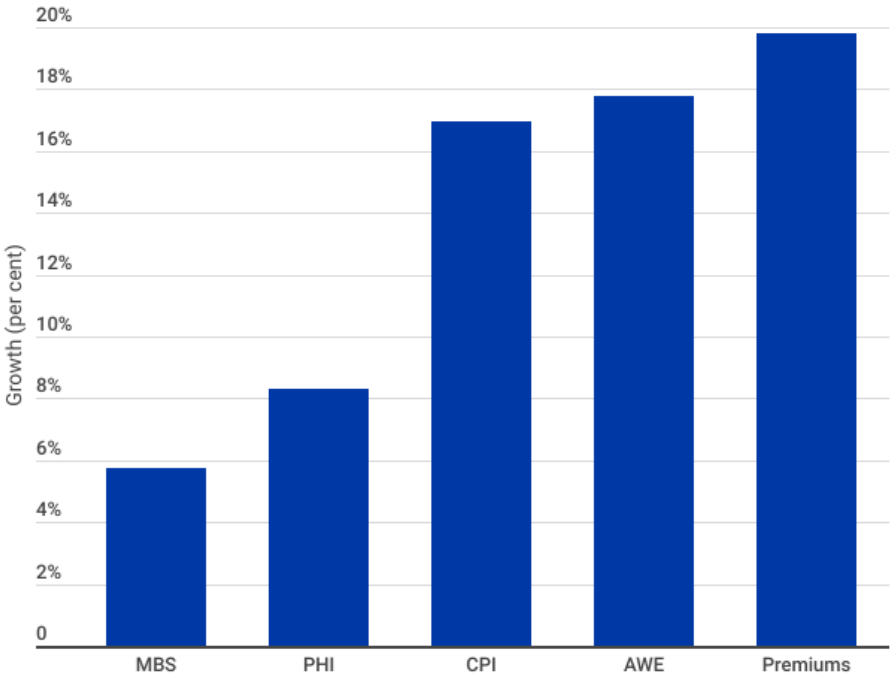


MBS benefits and PHI rebates have not kept pace with inflation. Doctors' costs (which include rent, electricity, staff wages, supplies and insurance) have continued to increase and this disparity also gives rise to increasing out of pocket costs for individuals.

Years of inadequate indexation has meant that the patient rebate provided by Medicare no longer bears any relationship to the actual cost of providing high-quality services to patients, and the rebate paid by private health insurers is not sufficient to make up the difference. The medical practice therefore must either absorb these costs and risk becoming unviable or pass more of the cost onto patients through higher out of pocket costs.

Figure 3 shows that private health insurers' returns to doctors is strongly linked to the MBS indexation rates and not increases to their premium levels. This inadequate indexation has effectively resulted in a cost shift from the government and private health insurers to healthcare providers and patients.

Figure 3: Increase of MBS, PHI Returns, CPI, AWE and Premiums 2018 to 2022



PHI rebates are calculated from the rebate levels provided by Nib, Medibank and Bupa in the AMA's Private Health Insurance Report Cards for the period 2018 to 2022

The MBS, CPI, Awe and Premium increases are also derived from the AMA Private Health Insurance Report Cards for the period 2018 to 2022

Impact of COVID-19

We have now had 10 quarters (or over two years) of increasing hospital treatment insurance membership (rising from 43.6 per cent in June 2020 to 45.1 per cent in December 2022)[11] and along with this insurer profitability (on the back of reduced demand) has never been higher. At the start of the pandemic insurers promised not to make profits on the back of COVID 19.

The AMA acknowledges that many insurers have returned funds back to their members, but their expenditure on management expenses and profit margins still remain generously high. We call for the money that patients pay in PHI premiums to come back to them in the form of healthcare delivery, not increased profits for insurers — there should be a mandated minimum amount that every insurer is required to return to patient care.

The AMA has suggested increasing the minimum rate of return to a figure higher than the current industry average.[12] For the AMA Prescription for Private Health Insurance, we proposed 90 per cent (at the time of publication, October 2020, the industry average was over 88%) and mandating it across the industry, would build confidence in the eyes of consumers, return a greater share of funds to patients, and provide justification to the taxpayer for additional Government funding being invested into PHI. Since 2022 the pay-out ratio has fallen further so that it is now 86.4% per cent,[13] in spite of the increased profitability of insurers and their pledge not to profit from the COVID 19 pandemic.

Cost of increasing the minimum payout

The direct cost to government of an increase in the minimum payout ratio is zero. There would however be indirect costs – the main one being that additional PHI policies would cost the government additional PHI rebate. A behaviour shift towards more PHI policies would mainly be seen among those currently not subject to tax penalties or incentives – those earning $90,000 or less.

With more people taking out PHI policies, there would be 'second round effects' of lower premiums further boosting the number of people taking out policies, including those earning over $90,000. These second-round effects are not estimated or included in the costs.

The policy itself would not encourage as many people over the age of 65 and those subject to MLS to take out PHI as these people already receive a larger benefit on average (through greater use) or a much larger price incentive through existing policies. The impact of a 90 per cent minimum pay-out ratio is costed at $560 million over the forward estimates.

Table 2: Impact of implementing a 90% minimum pay-out ratio

	2022-23	2023-24	2024-25	2025-26	Total
Direct change in premium	-3.8%	-3.8%	-3.8%	-3.8%	-3.8%
Additional PHI policies	173,171	170,641	170,498	170,117	170,117
Rebate for additional PHI policies ($m)	138	138	141	143	560
Net cost to government ($m)	**138**	**138**	**141**	**143**	**560**

MEDICARE LEVY SURCHARGE

Originally introduced in July 1997 for income earners over $50,000, the 1 per cent Medicare Levy Surcharge (MLS) aimed to encourage those that could afford it, to take up PHI membership. At the time, an income of $50,000 was the threshold for the highest income bracket of taxation, a marginal rate of 47 per cent. The comparable threshold is now $180,000 where marginal tax is paid at 47 per cent. The MLS rate is now levied at the rates of 1%, 1.25% or 1.5% depending on taxable income.

The key policy principle behind the MLS was that higher income earners who did not have PHI were penalised with a higher surcharge. This position has been eroded by Government who have both frozen and applied low indexation to the threshold over many years. But also, we have seen a growth in premiums outstripping low wage growth, which has compounded the impact.

For some cohorts we see the perverse outcome of the MLS being applied to people at a lower income than originally intended, but the amount levied is less than the rate likely to be paid for a reasonable PHI product, due to increased premiums.

Increase of MLS

Costing is provided below for increasing the MLS to 2 per cent for those earning $105,001 or greater. If applied without matching incentives to Lifetime Health Cover, the effect will be to raise more revenue but reduce the number of additional PHI policies. The total cost to government across the forward estimates is an estimated $1.01 billion. This policy cost estimate does not include the simultaneous increase in the PHI rebate.

Table 3: Impact of increasing MLS to 2% for people earning $105,001 or greater (without LHC change)

	2022-23	2023-24	2024-25	2025-26	Total
Additional PHI policies	138,270	169,373	183,397	189,313	189,313
Rebate for additional PHI policies ($m)	38	52	59	58	206
Change in MLS revenue ($m)	-163	-201	-216	-227	-808
Reduction in average premium	0.7%	0.9%	1.0%	1.1%	1.1%
Net cost to government ($m)	**200**	**253**	**275**	**285**	**1,014**

Increase of MLS alongside changes to Lifetime Health Cover

As LHC is currently under review with many different options being considered to encourage PHI membership, it is not possible to provide a detailed costing for as yet unknown changes. Instead, we have provided costing for the higher MLS rate of 2 per cent for people earning $105,001 or greater, if introduced alongside a change in LHC.

If implemented alongside improvements to LHC, the change in the MLS rate would drive more people who are over the $90,001 income threshold but under the $105,001 income threshold to take up a PHI policy.

The changes to LHC itself are not included in cost estimate below because this won't cost the government directly (same as for changes to youth discounts). Rather, improvements to LHC will cause indirect costs to government from:

- an increase in the cost of the PHI rebate due to more people taking out PHI policies
- a decrease in MLS revenue due to more people taking out PHI policies

These indirect costs are included in the estimate below. When the MLS policy change (increase to 2 per cent for people earning $105,001 or greater) is introduced alongside improvements to LHC, the cost to government rises to $1.42 billion over the forward estimates.

Table 4: Impact of increasing MLS to 2% for people earning $105,001 or greater (with LHC change).

	2022-23	2023-24	2024-25	2025-26	Total
Additional PHI policies	197,910	229,014	247,495	262,169	262,169
Rebate for additional PHI policies ($m)	70	85	96	101	352
Change in MLS revenue ($m)	-223	-261	-281	-301	-1,066
Reduction in average premium	1.1%	1.3%	1.4%	1.5%	1.5%
Net cost to government ($m)	**293**	**346**	**377**	**402**	**1,418**

LIFETIME HEALTH COVER LOADING

The AMA believes that our Lifetime health cover settings are working to keep people out of PHI. The Government needs to change the Lifetime Health Cover loading and penalties – especially the starting age to make it an easy choice for Australians to stay in PHI for life. This should include reviewing the way in which penalties ramp up for late entrants who join later in life and pay premiums just before they are most likely to claim.

Lifetime Health Cover (LHC) is an initiative that started on 1 July 2000. It was designed to encourage people to take out hospital insurance earlier in life and to maintain it. People who do not take out hospital cover before the 1st of July following their 31st birthday, but then decide to take out hospital cover later in life, will pay a 2 per cent loading on top of their premium for every year they are aged over 30. LHC loadings only apply to hospital cover, and the maximum loading that can be applied is 70 per cent, and once you have paid the loading for 10 years of continuous cover, it is removed.

In our 2020 Prescription for Private Health Insurance the AMA identified that while LHC was once a signal to buy into insurance when you turn 30 it may now be acting as a barrier. If you aren't in a position to buy insurance until the age of 35 (due to starting a career later and low wages growth), you'll face some significant penalties under LHC at a time when many young people are also saving to buy a house, repaying their HECS-HELP student contribution debt and raising children.

The AMA does not have access to the data required to do the analysis in this area. We commend the Government for undertaking this actuarial analysis and look forward to providing comments on any proposed policy direction.

The AMA believes that any changes to LHC need to deliver on the following key principles:

1. Attract new, younger people into the PHI pool,
2. Deter (or compensate adequately) for late entrants,
3. Deter 'hit and runs' that is people who take out PHI only to use it for costly health issues and then surrender their coverage following their treatment,
4. Not to discourage use of health insurance by the old/sick, especially for those that have been in PHI for considerable periods of time,
5. To support, not be an impediment to, appropriate innovation in health care.

DEFAULT BENEFIT ARRANGEMENTS

Default benefits are an essential protection for patients in our private health sector. The Government needs to ensure second tier default benefits support a reinvigorated and resilient private health system by providing a safety net for private hospitals and supporting innovation by underpinning community-based and home-based hospital programs.

Default benefits are an essential protection for patients in our private health sector. Second tier default benefits ensure consumers continue to have choice of service provider and are protected from large out-of-pocket costs, which are both important to the value proposition of PHI.

The primary objective for the second-tier default benefit arrangements must be as an essential safety net for consumers attending non-contracted hospitals. The existence of default benefit arrangements supports a diversity in the private hospital sector and assists in managing the balance between hospitals and insurers (or insurer groups) with very large market shares.

Recent history has shown how quickly a sector can come under financial pressure. In the lead up to the COVID-19 pandemic, insurers were increasingly under fiscal threat as participation rates had dropped for 20 successive quarters (5 years) and their outlays were continuously increasing. Through the pandemic participation rates have now climbed for 8 successive quarters (2 years) and outlays have decreased due to the impact of lockdowns and workforce shortages. Private hospitals have now faced 3 years of decreased activity which has significantly impacted on their ability to generate income.

Second-tier default benefits play a moderating influence through these industry swings, ensuring that adequate funding is maintained to health providers to deliver a quality level of service. Second-tier default benefits also provide a safety net for hospitals facing financial hard times – they have a reasonable safety net price that prevents insurers from taking undue advantage and trying to achieve greater levels of cost control at the expense of patient outcomes.

The AMA is calling for second tier default benefit arrangements that support a reinvigorate and resilient private health system by providing a safety net for private hospitals and supporting innovation by underpinning community based and home-based hospital programs.

Second-tier default benefit arrangements should not stifle innovation

Australia needs a reinvigorated and resilient private health system, that provides the right programs which are cost effective, clinically advantageous, medical practitioner led and insurer funded. One that focuses on continual improvement, supports new and improved clinician led models of care and the adoption of new technology. The AMA does not see the current second-tier default benefit settings achieving this.

Unlike admitted overnight hospital care, there is no provision for minimum default benefits for day programs or home-based services. Consequently, consumers can only access these programs if their insurer has contracted with the hospital to cover them, or if the insurer has a financial interest in the service. Providing default benefits for day programs, outreach and home-based care programs for appropriate clinical care would widen consumers' care options and increase access to more efficient and clinically appropriate health services.

Providing default benefits for community based and home-based programs would support the establishment of these programs on a sustainable basis. Moreover, it would provide certainty for hospitals and other medical providers looking to invest in these new programs, which would lower the cost to support and promote further innovation in the private health sector. However, clinical quality must not be compromised through any reforms. Depending on how they are designed and implemented, models that shift treatment from hospitals to home and community settings have the potential to reduce the quality, safety, intensity, frequency and outcomes of that care. Robust standards need to be enshrined in clinical governance arrangements to ensure that, in efforts to reduce the costs of care, this does not result in lower quality or inappropriate standards of care.

RISK EQUALISATION

The AMA believes that we need to ensure that our risk equalisation arrangements continue to support the community rating principle. Any changes to risk equalisation must minimise incentives for PHI to discriminate against consumers and continue to actively support community rating.

The purpose of risk equalisation is to support the community rating principle. Insurers are not allowed to risk rate premiums and risk equalisation partially compensates insurers with a riskier demographic profile by re-distributing money from those insurers paying less than average benefits to those paying higher than average benefits.

The Government has been undertaking work that looks at changing the very core principle of how risk equalisation is managed in Australia.[14] Currently Australia uses a model of risk sharing (or retrospective risk equalisation) that compensates insurers for differences in actual spending.

The Government has been investigating moving to a system with a strong component of prospective risk equalisation. Prospective risk equalisation risks incentivising insurers to increase pressure on hospitals, on doctors and on patients to make cheaper but not necessarily the most clinically advantageous choices.

The AMA has serious concerns about moving to a system largely dominated by prospective risk equalisation. Such a move does not have patients and the broader value they derive from the private health system at its core. The proposed shift to prospective risk equalisation has a focus which seems much more about 'preserving incentives for insurers to control costs' or 'incentivising insurers to operate efficiently' to improve affordability.

A focus on efficiency without balance could see:

- Increased pressure on contracts with hospitals reducing diversity and choice (especially in outer metropolitan and rural areas);
- The development of lower cost options for patient care that do not deliver better clinical outcomes;
- Increased pressure on medical practitioners to enter into contracts with PHIs that include targets set to meet the insurers fiscal objectives which can limit clinical autonomy and undermine patient outcomes; and
- PHI run care programs that are not linked to the patients' medical practitioner.

The AMA does not support a move to prospective risk equalisation without adequate safeguards for clinical independence or a fit for purpose regulator ensuring that the patient is central to the management of the private health system.

We need this regulator so that when insurers put undue pressure on their customers, when they try and substitute for inferior care, or when they put quotas on hospitals and medical practitioners as part of the opaque commercial in confidence contracts they negotiate, we have a body that provides balance, ensures quality standards are enforced, and listens to the voice of the patient when they come up against their insurer.

The real value proposition and the reason people choose PHI is lost in prioritising for efficiency and cost reduction. Any shift to prospective risk equalisation will likely help insurers minimise costs, but it will achieve this by creating a system which will reduce patient choice and the clinical autonomy of doctors.

EXTENDING PHI BEYOND HOSPITAL

The Government needs to develop appropriate funding and accreditation systems that enable private health service providers to roll out more innovative and flexible health programs either as a day visit, community outreach or hospital in the home models. These models need to be developed in close collaboration with existing health services to best meet community need.

The AMA has been calling for reform of the private health sector to design a better system – a system that supports the right programs that are cost effective, clinically best practice, medical practitioner led, and insurer funded.

The AMA welcomed the Government's announcement in the 2020-21 budget that it would be working on expanding home and community based mental health and rehabilitation care as a good start to creating a more modern, innovative private health system. That work has not proceeded, and this is a lost opportunity for the Australian health system and for our patients. We are calling on Government to not abandon this area of health reform because it might look difficult but to embrace the opportunities and do the work to make these essential reforms happen.

Hospital Substitution Programs

Health care is changing and becoming more mobile through improvements in medical technology and IT. Innovation in our health systems is what will drive future improvements in patient outcomes and contribute to making our system more sustainable in the long term. The AMA strongly supports the development of hospital in the home and similar programs delivering more home-based and community care.

Across Australia, programs that support palliative care, chemotherapy, mental health and rehabilitation as day visits or even in patient's homes are being delivered by private hospitals and private health insurers. Quality programs that shift treatment to home and community setting, that integrate care into patients' lives and usual care teams have the potential to reduce costs and improve health care outcomes. As a sector we need to come together and work out how to support the quality programs and ensure they are provided accessibly to patients that will benefit from them.

Primary Care

Currently, private health insurers have very little involvement in primary care and general practice, funding a few limited programs usually under trial arrangements.

Whilst the AMA does not support insurers being able to directly fund GP services generally, we do think there is scope for them to fund primary care services in targeted areas like GP directed hospital avoidance programs. Considering the increasing level of chronic disease in our population the idea that insurers could help to improve health and wellness through clinician led preventative health services has merit and should be explored.

The AMA believes that any move to expand the role of private health insurers should be carefully planned and negotiated with the profession to ensure that the outcome is in the best interest of patients and does not compromise the clinical independence of the profession or interfere with the doctor/patient relationship. This expansion needs to be supported by evidence and underpinned by appropriate safeguards and regulation. The system as it is currently configured does not provide the ability of the sector to come together and work to improve patient centred innovation.

Clinical safeguards

Clinical quality and safety must not be compromised through the development of innovative models of out of hospital care. Depending on how they are designed and implemented, models that shift treatment to home and community settings have the potential to reduce the quality, safety and outcomes of that care. Clinicians need to know that the programs they are referring their patients to are evidence based and delivering a high standard of care.

Accreditation of such programs cannot be left to the provider or to insurers – they are not always impartial. To support continuing innovation and reform the AMA has called for the establishment of an independent and appropriately resourced authority – a Private Health System Authority – to bring together all the players in the sector to build a better system.

The authority should have the capacity, objectivity, and expertise to ensure that robust mechanisms are in place to balance the interests of all sector stakeholders in the delivery of innovative, patient-centric, clinician led care.

The Government has shown us that private health is complex and hard and sometimes beyond their expertise to drive forward. To tackle these hard problems, and to make the breakthroughs our private health system and our patients need, the AMA believes we need this independent, expert authority to drive the difficult reforms. An authority that can bring together the expertise, data, analysis and impartiality to stay the distance in supporting improved patient centred care.

REGULATION OF THE PRIVATE HEALTH SECTOR

To support reforms to the private health sector the Government needs to establish a Private Health System Authority - an independent, well resourced, statutory body to oversee the private health system, and to safeguard patient choice which is central to its value proposition alongside speed to entry.

Current regulatory arrangements were designed at a time when PHI was in a relatively healthy position with strong membership, when most insurers operated on a not-for-profit basis, and when private hospitals had a greater profit margin. The current arrangements are effective at protecting the interests of consumers by maintaining insurer solvency, managing consumer complaints, and ensuring the safe delivery of healthcare. However, mechanisms to ensure the private health system is changing in a lasting way and as government policy intends are limited and ad hoc. There are also limited whole-of-system mechanisms to ensure the needs of patients, day hospitals, private hospitals, private health insurers, medical device manufacturers and doctors are considered and balanced.

For example, the current constraints on private health insurers owning majority shares of healthcare services and providing vertically integrated care are largely practical and commercial considerations made by the sector, as opposed to a legislative mandate from government. There are also no mechanisms overseeing the impact of broader health system reforms on the private sector, or mechanisms to ensure that the policy settings underpinning the private sector remain fit-for-purpose. These gaps in regulation ultimately impact the patient through unexpected out-of-pocket costs and make it challenging for patients to navigate an already complex system.

The AMA is calling for the establishment of an independent authority to oversee the private healthcare system to fill gaps in the current regulatory framework, oversee the sector helping maintain a level playing field, collect and analyse data growing the evidence base for policy decisions and highlight system issues to government.

The cost of a Private Health System Authority

The direct cost of an independent authority which currently doesn't exist is difficult to estimate. At present, the Australian Prudential Regulation Authority (APRA) provides prudential regulation of private health insurers. APRA reports that its total operating expenditure for the 12 months to 30 June 2020 was $196.2 million.[15] Using the number of private health insurers it prudentially regulates (37 during 2019-20) and comparing that to the total number of entities it regulates (2,273), we could apportion the cost to a sensible approximation of $3.2 million per year.

As the role currently performed by APRA is only one of an expanded set of roles envisioned for the proposed authority, additional funds would be required to fulfil these extra functions. The total annual cost of the proposed authority is estimated in the table below, which includes the $3.2 million cost reallocated from assuming responsibilities from APRA.

The government could choose to recover the ongoing cost of the authority through charges to insurers. This would represent approximately 0.1 per cent of revenue taken by private health insurers ($25m per year in 2019-20). This would likely see the cost passed on to consumers through higher premiums in the order of 0.1 per cent.

An additional $10 million is estimated to be required to establish the new authority and consult with stakeholders regarding its ongoing roles and responsibilities. If cost recovery was undertaken, this $10 million would be the only net cost to government across the forward estimates.

Table 5: Cost of a Private Health System Authority

	2023-24	2024-25	2025-26	Total
Establishment cost ($m)	10	-	-	10
Ongoing Cost ($m)	29	30	32	
Cost recovery through charges to insurers ($m)	29	30	32	
Net cost to government ($m)	**10**			**10**

CONCLUSION

Our current health system is the result of decisions taken years, if not decades ago. Now is not the time for timid, incremental and under-cooked reforms. We have seen what happens when we do not deliberately and purposefully plan our health system.

Reform must be evidence based

The abolishment of Health Workforce Australia in 2014 has left us today with a health workforce that is uneven at best and if you are in a public hospital emergency department or a rural or regional area then workforce supply is nothing short of woeful. Turning this situation around, ensuring adequate health care workers to support Australian patients will take years, if not decades to fully correct. To ensure the future of private health in Australia we need to be investing in the evidence that will underpin future practice today or risk a similar fate.

Reform must be holistic and long-term consequences need to be worked through

Taking short term policy decisions without thinking of the interaction they have with other policy levers or without rigorous assessment of long term is also fraught. We have seen this in action with the freeze of the Medicare rebates from 2012 to 2017.[16] On top of the decades of inadequate indexation, this has led us to a crisis – a crisis causing Australians to miss out on essential care as they struggle to find, let alone afford, a GP today.

Healthcare needs to be underpinned by good, appropriate regulation

We are about to embark on a journey that is likely to lead to greater quantum of change to the work that is done in our private hospitals than we have seen before. Telehealth, remote monitoring, remote delivery are likely to cause explosive growth in service provision done outside traditional hospital settings. This transition is not about to happen – it has started. But our governments and out workforce are not keeping pace with these changes.

Good, innovative health care needs best practice regulation, accreditation and funding systems in place to ensure that patient safety and outcomes are paramount. To allow unregulated, unchecked growth of health services provided to patients is likely to allow some of the worst behaviours of health providers and health funders to proliferate. The failure of governments across Australia to understand and take appropriate measures in our cosmetic surgery industry has shown us what happens when regulation fails patients. This cannot be the path we take for hospital substitution and out of hospital care services.

The AMA believes that now is not the time for timid reform of our health care system. We stand on the cusp of so many changes, changes that will likely see us completely reinterpret hospital care over the next decades. The past has shown us that whilst such change can deliver significant improvements in health treatment and health outcomes – this is not guaranteed.

To deliver holistic, evidence-based reforms that centre on and improve experiences and outcomes for patients we need to work together in a planned and coordinated manner. We need to purposefully and deliberately design what our future health care system will look like.

Failure to do so will condemn us to repeat mistakes of the past and our patients, our workforce and our governments cannot afford for this to happen.

REFERENCES

[1]https://www.ama.com.au/articles/ama-prescription-private-health-0

[2]https://www.apra.gov.au/quarterly-private-health-insurance-statistics

[3]Total number of insured persons with hospital treatment coverage September 2020 (11,301,501) to Dec 2022 (11,815,119) APRA membership and coverage statistics https://www.apra.gov.au/quarterly-private-health-insurance-statistics

[4]https://www.ama.com.au/articles/australian-public-hospitals-logjam

[5]Private health insurance membership trends excel sheet https://www.apra.gov.au/quarterly-private-health-insurance-statistics

[6]https://www.ama.com.au/media/ama-president-and-vice-president-ama-private-health-summit-and-failure-government-extend

[7]https://www.privatehealth.gov.au/health_insurance/surcharges_incentives/insurance_rebate.htm

[8]https://www.ama.com.au/articles/ama-prescription-private-health-0

[9]This is a very conservative assumption based on the average hospital treatment expenditure for those aged 25-64 being approximately 26% of the expenditure of those aged 65 and over. This is based on data from: Australian Prudential Regulation Authority (2021). Quarterly Private Health Insurance Membership and Benefits March 2021. Table: hospital treatment by age, Australia. Retrieved 18/08/2021 from: https://www.apra.gov.au/quarterly-private-health-insurance-statistics. Direct link to download: https://www.apra.gov.au/sites/default/files/2023-02/Quarterly%20Private%20Health%20Insurance%20Membership%20and%20Benefits%20December%202022.xlsx

[10]https://www.apra.gov.au/operations-of-private-health-insurers-annual-report

[11]https://www.apra.gov.au/quarterly-private-health-insurance-statistics

[12]https://www.ama.com.au/articles/ama-prescription-private-health-0

[13]https://www.ombudsman.gov.au/__data/assets/pdf_file/0022/290425/055ddb7dbb7c8dbf1ef302d3284f60cd7ef230e5.pdf

[14]https://consultations.health.gov.au/medical-benefits-division/consultation-on-the-private-health-insurance-phi-a/supporting_documents/Finitys%20Risk%20Equalisation%20Report.pdf

[15]Australian Prudential Regulation Authority (2021). Annual report 19/20. Retrieved 04/08/2021 from: https://www.apra.gov.au/sites/default/files/2020-10/APRA%20Annual%20Report%2019-20.PDF

[16]https://ama.com.au/sites/default/files/documents/Fees%20Gap%20Poster.pdf

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