Private Healthcare Australia
Better Cover. Better Access. Better Care.

Inquiry into promoting economic dynamism, competition and business formation

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Contact:
Ben Harris – Director Policy and Research

About Private Healthcare Australia

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have 24 registered health funds throughout Australia as members, and collectively represent 98% of people covered by private health insurance. PHA member funds provide healthcare benefits for over 14 million Australians.

About private health insurance

Over 14.4 million Australians hold private health insurance, with over $25 billion paid in premiums in 2022. The Australian Government supports these customers with over $6 billion paid through the Private Health Insurance Rebate.

Medicare was designed by the Hawke Government to incorporate private health as a key feature. Australia relies on a strong private sector to provide choice and access, and importantly, reduce pressure on the public system. There are two key streams of private health insurance – hospital cover (over $19 billion in benefits paid) and extras cover (over $5 billion), the latter covering dental and allied health services.

The most significant factors contributing to premium increases in terms of growth are, in order, medical device prices, hospital costs, medical rebates and extras costs. This ordering reflects the regulatory environment, with higher levels of regulation strongly correlated with the impact on premiums.

Introduction

Good health drives wellbeing, happiness, social connection, educational achievement and economic participation and productivity. There are individual benefits to good healthcare, and benefits for families, the community and the economy.

In the 20th Century, our world made astonishing advancements in healthcare. As health improved, life expectancy more than doubled and the global labour force expanded.[1]

In the 21st century, healthcare funding and systems have not kept up with this pace of change. The regulatory stranglehold on the healthcare system is stifling innovation and preventing consumers' from accessing modern, safer and more convenient models of care.

And, while healthcare costs continue to rise, there is little to show that consumers are getting healthier.

Not only are people living longer they are experiencing different diseases from the 1970s and 1980s, the era in which our health system was designed. Chronic conditions are now the biggest cause of death in Australia, and make up 85% of the burden of disease.[2] Almost half of Australians (47%, or 11.6 million people) between 2020-21 were estimated to have one or more chronic health

[1] https://www.mckinsey.com/~/media/mckinsey/industries/healthcare%20systems%20and%20services/our%20insights/mckinsey%20on%20healthcare%202020%20year%20in%20review/mckinsey-on-healthcare-2020-year-in-review.pdf
[2] https://grattan.edu.au/wp-content/uploads/2023/02/The-Australian-Centre-for-Disease-Control-ACDC-Highway-to-Health-Grattan-Report.pdf

conditions.[3] The Grattan Institute (2022) also noted, on average, Australians spend 13% of their lives in ill-health, more than people in most other countries.[4] These conditions, like arthritis, asthma, diabetes and mental health, can be prevented if treated early and often. Furthermore, the morbidity caused by these conditions late in life can be compressed if the preventive care is provided, ensuring people have more years of productive life.

With such public good from healthcare, it is frustrating that economic dynamism is so sluggish. Healthcare is the industry keeping the fax machine alive; there is an urgent need to increase the pace of reform.

Part of the problem is cultural – with traditionally slow diffusion of new evidence and innovation in the health sector. It generally takes 17 years for recognised best practice is healthcare to become normal practice.

Another part of the problem is the power of vested interests – the commercial aspects of healthcare mean that various players protect the benefits of funding flowing in their direction; with information asymmetry being exploited for commercial gain. Some of this behaviour is cynical manipulation, but most of it is a belief that the services being provided are worthwhile, in the absence of a robust assessment of value. Further, the emotive elements are powerful, with tragic individual stories utilised to argue for no systemic changes; a technique described in the industry as "shroud-waving."

Regulatory capture is also a significant issue in health care. Particularly under the previous government, the focus was on balancing stakeholder interests rather than public value. With large and powerful vested interests, this often meant that the public interest was relegated.

Everyone agrees health care needs serious reform. However, few believe that their particular business model is the one that needs to change. Thus, there is a policy race to the bottom, with the only real point of agreement being that somebody else should provide more funding. The policy dynamic is that single short-term interests can kill off sensible reform options that would benefit the community and the industry as a whole. The exceptional circumstances are dictating the rules, leading to an ever-increasing gap between policy settings and reality.

The current regulations surrounding private healthcare are outdated and pose a significant barrier to economic dynamism. Yet the handbrakes on reform from vested interests mean that governments have not been able to command the social license for substantial policy reform.

Grandma's not happy

In 2009, Minister Roxon acted on a review showing that the costs of performing cataract surgery had plummeted, announcing a 50% cut to Medicare rebates.

Ophthalmologists responded with a loud and aggressive campaign, "Grandma's not happy", which attracted the ire of the Consumers Health Forum, who stated, "What is particularly disappointing about the latest campaign from ophthalmologists is the way they are using marginalised health consumers as cannon fodder in a public campaign to maintain their substantial tax payer-funded incomes."

The Government backed down, cutting rebates by 10%.

[3] https://www.aihw.gov.au/getmedia/c6c5dda9-4020-43b0-8ed6-a567cd660eaa/aihw-aus-421.pdf.aspx
[4] https://grattan.edu.au/wp-content/uploads/2022/12/A-new-Medicare-strengthening-general-practice-Grattan-Report.pdf

This does nothing to improve efficiency, little to improve effectiveness, and does not increase public value. We have seen incremental reform, compromises, half-measures, and policy band aids to address urgent issues. Governments are often told they need to fix the problems, yet criticised relentlessly if they are brave enough to propose any specific changes.

The fact the nominally 'private' part if the system is bolted into Medicare through co-funding with the Medicare Benefits Schedule (MBS) and other regulatory mechanisms, increases the perceived risk of reform. It also means we need to be pulling in the same direction as the Federal Government to ensure the system remains accessible, flexible and sustainable.

Targeted investment in technology, health prevention programs and out of hospital care are important measures to reduce the burden of disease on society and keep our people and economy healthy.

Reviews without reform

The Australian Health Policy Collaboration paper, Australian Health Services: Too Complex to Navigate looked at the recommendations from 16 major Australian health reviews over the last 35 years.

This report shows that there is significant agreement on the key priorities for action and offers a clear roadmap to improving Australia's health system.

Few of these priorities have been implemented.

Health funds are already investing in new models of care, but outdated regulations are preventing them doing more. The Federal Government must remove the red tape that is preventing private health funds from helping to keep our members healthy and providing the more than 14 million Australians with greater choice and access to higher standards of care.

Waste and low value interventions are rife in healthcare. Cost of living pressures now mean there is greater urgency on reducing waste and ensuring value for money – business as usual is not sustainable, as it risks becoming unaffordable for consumers. Over 40% of people with private health insurance earn less than $50,000 per annum; this cohort in particular are vulnerable to health inflation. Recent polling by YouGov shows that people on lower incomes are increasingly worried about paying for insurance[5], so reducing inefficiency and waste, and curtailing low value care, should be a priority for regulators.

We are also increasingly vulnerable to external shocks; Australia's overreliance on the importation of medical devices and pharmaceuticals from international suppliers means that kinks in the supply chain caused by war, climate change and trade disputes can have a disproportional impact on consumers.

Many more products could be made in Australia, particularly generic[6] medical devices and medicines. However, government regulations affecting the supply chain make it almost impossible for new entrants to compete against the multinational companies that dominate these sectors. Localising the manufacturing of medical supplies will also help to avoid supply chain disruption and promote a dynamic business environment.

[5] YouGov, preliminary results, due to be released in April 2023.
[6] Generic is defined as a product which is cheap to manufacture with low COGS and no or minimal IP attached so the global market is commoditised.

Response to the Terms of Reference

a. The effect of a diverse and dynamic business environment on:

- productivity, prices and better-paid jobs
- our supply chain resilience to disruption

Australia's health system supply chain is vulnerable. Over 90% of medicines are imported to Australia[7] and multinational medical device companies make up over 95% of medical devices subsidised through the Prostheses List.

This makes Australia vulnerable to supply shortages outside of our own control, such as a global pandemic or war in Ukraine. An obvious example is the supply shortages of Personal Protective Equipment (PPE) experienced across the country by health providers throughout the pandemic. The World Health Organisation's recommendation of P2 and N95 masks meant that in March 2020, the government had to import 54 million masks from overseas manufacturers.[8] Australia didn't have the resources and infrastructure to manufacture them locally. Limited domestic supply of healthcare medicines, devices and consumables is a major national security[9] and health risk.

The Government must focus on increasing local manufacturing of medicines and health equipment in Australia to avoid supply chain disruption and help promote a diverse and dynamic business environment.

For medical devices, Australians regularly pay 30-100% more than consumers in comparable countries such as New Zealand, the UK, South Africa and Europe. The Australian Government sets these high prices, which as well as costing consumers hundreds of millions of dollars each year, hurt domestic manufacturing. The Prostheses List's high prices support a network of sales representatives and ensure that multinational device companies dominate the domestic supply chain.

The footprint of the device industry in Australia predominantly involves salespeople, many of whom are trained to assist in surgery and help reinforce preference for their device brand with the surgeons they work with. While estimates of the number of medical sales representatives are difficult to verify, in high priced segments such as cardiac and orthopaedics, there are frequently more than one sales representative employed per surgeon. More sales staff does not improve the outcomes for patients. In fact, evidence indicates higher device revision rates in the private sector than in the public sector in peer matched cohorts.[10]

With mandated high prices allowing incumbent companies to maintain a chokehold on the supply chain at point of sale – the operating theatre – new entrants struggle to gain headway. A significant 'grey economy' has evolved as a direct consequence of mandated fixed high prices per item, with

[7] https://defense.info/highlight-of-the-week/australias-medical-supply-chain-addressing-strategic-vulnerabilities/
[8] https://pursuit.unimelb.edu.au/articles/more-transparency-needed-in-ppe-supply-chains
[9] https://defense.info/highlight-of-the-week/australias-medical-supply-chain-addressing-strategic-vulnerabilities/
[10] Harris I, Cuthbert A, Loriner M, de Steiger R, Lewis P and Graves S., "Outcomes of hip and knee replacement surgery in private and public hospitals in Australia", *ANZ Journal of Surgery,* 2019.

multiple rebates and benefits being paid under the counter to doctors and hospitals to secure these customers for the multinationals.

Where new entrants seek to provide an equivalent product to consumers at a lower price, the government has previously stopped them. The Australian Government even fought a Federal Court action against Applied Medical when that company sought to provide devices at a lower price. Applied Medical told the Senate in 2017:

> *"Having exhausted all avenues to cooperate with the Government to bring about lower prices for consumers, we launched a Federal Court challenge to the Department's failure to engage with the substance of the evidence in our application. … The supreme irony of our litigation was that, in effect, we were fighting to bring substantial savings to consumers and the public purse while the Minister was fighting a device supplier to maintain inflated margins."*[11]

Tax minimisation has also created an uneven playing field for Australian medical device enterprises who cannot compete due to their inability to utilise the range of tax strategies used by multinational companies. These strategies, outlined in a recent submission to the Australian Government, include debt shifting, corporate inversion, management fees, the use of intangible assets and transfer pricing.[12]

Going to court to keep prices high

In 2016, the case Applied Medical Australia Pty Ltd v Minister for Health [2016] FCA 35 (5 February 2016) was brought before the Federal Court after the government refused a request from Applied Medical to lower the minimum benefit price for a group of prostheses on the Prosthesis List from $412 to $99.

Applied Medical had argued that $412 was too high, and that the prostheses in question could be provided at a significantly lower price. The inflated figure, the company claimed, was the result of a poorly designed mechanism for selecting the minimum benefit.

From Grattan Institute, at https://grattan.edu.au/news/how-to-reform-the-prosthesis-market/

Despite being a highly valued and growing commercial sector, medical devices are disproportionately under-represented in Australian owned enterprises because of the inability to compete against powerful overseas interests with favourable tax structures. Our only globally recognised medical device enterprise, Cochlear, if launched today, would not be able to compete with international suppliers purely due to the inability to manipulate tax payments across jurisdictions.

b. The extent to which anti-competitive behaviour and changes in industry structures have contributed to rising market concentration in Australia

Australia's healthcare regulatory structure has the same effect on competition as oligarchy. An overregulated private healthcare system limits consumer choice and is a major barrier to innovation in healthcare.

[11] Senate submission 2017
[12] https://www.privatehealthcareaustralia.org.au/pha-submission-to-treasury-on-multinational-tax-integrity-and-tax-transparency/

Tens of thousands of pages of regulations governing private healthcare has driven less competition, protected incumbents from new entrants, created a health system that lags behind international benchmarks for new models of care, and restricted funds from investing in best practice care.

The Productivity Commission's latest *5-year Productivity Inquiry: A competitive, dynamic and sustainable future* (Inquiry Report) emphasised that 'Governments should focus on sectors where regulations unnecessarily impede new entrants and where various forms of government involvement … can inhibit contestable and competitive markets, increasing costs while diminishing outcomes for consumers.'[13]

The private health insurance sector is a clear target for such an approach. The Inquiry Report made it clear that private health funds have a prominent role to play in supporting health prevention through investment in innovative models of care.[14] However, the Report recognised the regulatory barriers preventing funds from doing this.

The Inquiry Report noted the main barrier to health funds facilitating innovative models of care is the current regulatory restrictions on out of hospital services.[15]Out of hospital care has significant potential to improve patient experience and choice, promote better clinical outcomes and reduce healthcare system costs. Private Healthcare Australia's 2023 Federal Budget submission[16] clearly outlines how current financing and regulatory models limit innovation in deploying evidence-based, best practice care and the ability to capture these benefits.

A major limitation is the lack of incentives for inpatient care to be shifted to out-of-hospital. This is a product of outdated regulations which no longer serve their intended purpose and are preventing consumers from accessing higher standards of care.

Removing or reforming second-tier default benefits will increase access to modern, quality care by removing incentives to provide care in already overserviced areas with old-fashioned inpatient models.

Second tier default benefits were introduced by the Howard Government in response to legislation introduced by former Health Minister Carmen Lawrence, which permitted health funds to take responsibility for offering value for money for their customers by contracting with hospitals. Second tier benefits mean that if a hospital falls out of contract with a fund, 85% of the benefits paid under the average contract price in that state will still be payable. This in effect sets a floor price for hospital care and has led to some very poor-quality facilities being funded.[17]

There is little incentive for providers to offer out-of-hospital care while the government continues to provide access to higher benefits for keeping patients in hospital under second-tier default benefits. These legislated benefits have led to higher market concentration of hospitals in already oversupplied urban areas. Ludicrously, the Federal Government currently requires health funds to pay higher benefits for people in the northern suburbs of Sydney than in northern Tasmania. Further, default

[13] https://www.pc.gov.au/inquiries/completed/productivity/report/productivity-volume3-future.pdf
[14] https://www.pc.gov.au/inquiries/completed/productivity/report/productivity-volume3-future.pdf
[15] https://www.pc.gov.au/inquiries/completed/productivity/report/productivity-volume3-future.pdf
[16] https://www.privatehealthcareaustralia.org.au/wp-content/uploads/PHA-Pre-Budget-Submission-2023-24-Final.pdf
[17] For example, the Cosmos Cosmetic Clinics, which featured in Nine newspapers and 60 Minutes in 2022, still attract second tier default benefits.

benefits support hospitals which provide low quality services, as health funds cannot refuse payments for hospitals providing a poor standard of care.

Second tier default benefits were introduced a generation ago, following intense lobbying from the private hospital sector. The argument was consumers had just received a benefit from the Howard Government with the introduction of the private health insurance rebate, and default benefits were needed to ensure that private hospitals got a cut and to undermine the Keating Government reforms introducing value-based hospital contracting. The government at the time received strong political and ideological support from the commercial private hospital sector. There was never an economic rationale provided for this measure.

Over the last three years, health funds have repaid over $2 billion to customers as a result of our promise not to profit from lower-than-expected utilisation of benefits due to the pandemic. This promise has been delivered direct to consumers, but we have seen many examples, both public and private, of health care providers seeking these "profits" to be distributed to them instead of direct to customers.

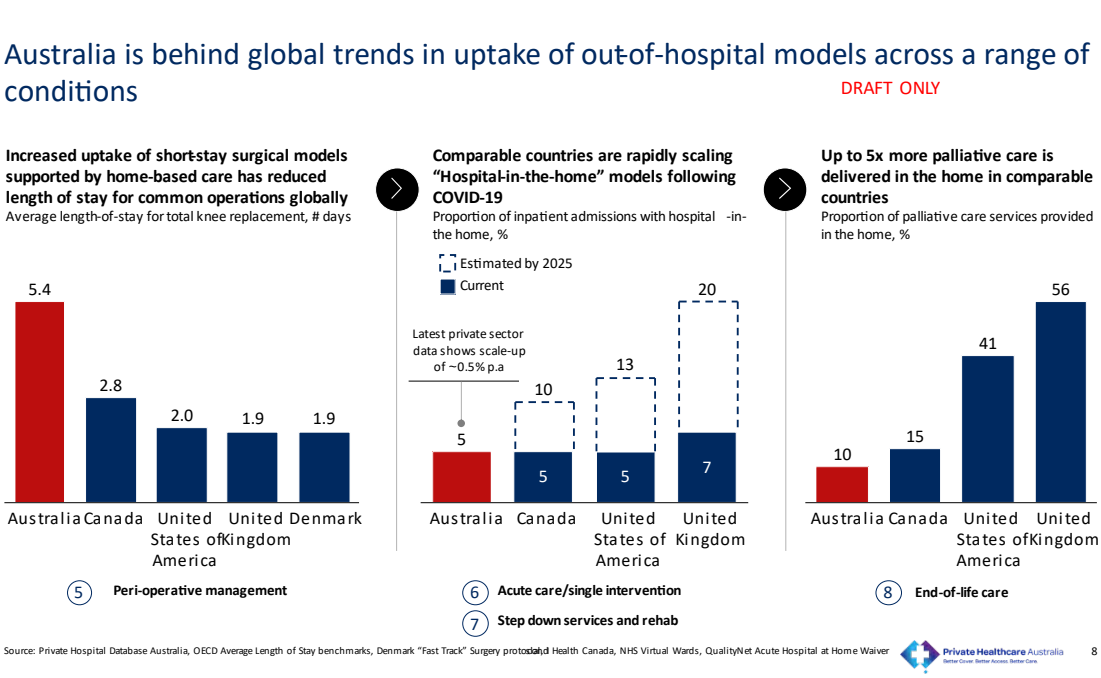
To further increase accessibility of out of hospital care, the Government should also allow health funds to support specified primary care programs. Current laws prohibit health funds supporting chronic disease management programs that utilise nurses, general practitioners, mental health peer support workers and a range of other providers.

Health funds would also like to work with primary care to improve access to a range of chronic health conditions, such as mental health and alcohol and drug treatment, joint health support, weight loss support, and heart health. Current regulations prohibit such activity, to the detriment of consumers.

Allowing a greater focus on preventive care through chronic disease management programs would better support consumers, and in the longer term, reduce the need for hospitalisations.

c. The extent to which economic barriers—such as regulatory costs and barriers to finance, infrastructure, suppliers, customers and workers—contribute to rising market concentration and slowing business formation rates in Australia.

Out of hospital care is the future of health, except for the development of new higher quality and more convenient models of care. Unfortunately, Australia is behind global trends in uptake of out of hospital models across a range of conditions. Much more care is delivered in hospitals rather than in community-based alternatives.



Consumers benefit when their care is managed outside of the hospital. Better primary preventive care for patients with chronic conditions reduces both the complication rate, costs for consumers and need for hospital care.[18]

Health funds understand this. They are already investing in programs that will keep their members healthy and out of hospital. But further Government support is necessary – both through active regulatory support and stripping away older, out-of-date regulation.

Private health funds have a vested interest in keeping their members healthy. Aside from the obvious physical and mental benefits, if their members are healthy, they'll claim less, reduce pressures on the health system, and more actively participate in the community and workforce.

To better support health fund participation in out of hospital care, the removal of regulatory barriers is required. Private Healthcare Australia's 2023 Federal Budget submission[19] highlights a range of priorities, including regulations that entrench low value care in hospitals, limitations on best practice mental health care as funds may not pay for peer support workers, hospital default benefits and high prices for medical devices only able to be provided in hospital.

The Productivity Commission Inquiry Report agreed that 'It makes sense to keep people out of hospital where possible, but hospitals have no incentives to prevent hospitalisation (and are in any case restricted in what they are allowed to do in primary health).'[20]

Private Healthcare Australia will soon release a detailed report on the current state of out of hospital care and recommendations for change, which will be provided to the House of Representatives

[18] https://www.mckinsey.com/industries/healthcare/our-insights/the-hospital-is-dead-long-live-the-hospital
[19] https://www.privatehealthcareaustralia.org.au/wp-content/uploads/PHA-Pre-Budget-Submission-2023-24-Final.pdf
[20] https://www.pc.gov.au/inquiries/completed/productivity/report/productivity-volume5-innovation-diffusion.pdf

Standing Committee on Economics. This report estimates there is $1.8 billion in value at stake though substitution of inpatient stays with home care and/or hospital avoidance.

d. The extent to which businesses consolidating their market power has undermined productivity, stifled wages, made markets more fragile and led to higher mark-ups.

The consolidation of market power by businesses has been traditionally understood as mergers and acquisitions, or the consolidation of power from big corporations. For the private healthcare industry, regulatory power is the biggest contributor to undermining the productivity of healthcare in Australia and has similar effects.

In the last 20 years, regulations governing private healthcare have blown out. Overregulation has created constraints on consumer choices, decreased competition and directed consumers and health funds to pay for options that can be of a lower standard and quality of care.

The key driver for this has been the influence of powerful vested interests whose objective is to compel health funds to pay for everything they ask for regardless of cost, quality or clinical evidence. These groups include big hospital groups, procedural medical specialists and the multinational medical technology companies.

Often the intention of regulators in acquiescing to these demands has been honourable – to provide access for consumers without additional out-of-pocket costs, but there are multiple negative unintended consequences created by compelling insurers to pay benefits without a ceiling and in all circumstances without question.

Over a period of many years, representatives of vested interest groups have become permanently embedded into health department consultations and processes, in some cases with minimal scrutiny. This again leads to regulators being captured by stakeholder interests, to the detriment of the public interest.

Low value care

Low value care provides little or no benefit (or risk of harm) to the patient yet incurs disproportionately high costs. Spinal fusion (excluding for congenital spinal deformities) is a controversial area of medicine, with several commentators describing it as low value care. The procedure is now rare in public hospitals, and the ACQSHC has highlighted inappropriate variations in practice in the private sector.[1]

In 2018 the government announced plans to stop surgeons billing Medicare for spinal fusions to treat uncomplicated chronic low back pain, only to reverse the decision in 2019.[1]

The original decision was based on an MBS Review, the ACQSHC report, and Choosing Wisely – "Do not refer axial lower lumbar back pain for spinal fusion surgery."[1]

In Australia, rates of spinal fusion surgery increased by 167% in the private sector between 1997 and 2006, despite almost no increase in the public sector.

More examples of low value care are outlined in Private Healthcare Australia's 2023 Federal Budget submission.

The current regulatory system strongly favours the incumbents concentrating their power. For example, current Federal Department of Health and Aged Care consultation processes line up one or two representatives from the health funds against all of the different provider groups, so their perspective is consistently drowned out.

An example of this has been the Prostheses List Advisory Committee (PLAC) which recommends medical technology for which benefits must be paid by DVA, health and other insurers. Until very recently this committee was comprised of stakeholder representatives, including a number from the suppliers of medical technology. After PHA campaigned for years for reform of the system, it has finally been replaced by a committee of independent subject matter experts.

Objective consumer opinion derived from independent consumer research is rarely sought. Instead 'professional' consumer representatives are drawn from consumer lobby groups which often receive funding and other support from the multinational pharma and MedTech sectors. This ignores the fact most healthcare consumers do not identify as 'sick' and has the effect of introducing a strong bias in favour of interventional treatment. There is no doubt the voices of people with serious illness are important and need to be heard, but the inherent bias in this approach should be recognised and balanced by independent consumer research.

The introduction of regulations governing private health insurance - such as price controls on medical devices, second-tier default benefits, risk equalisation and taxation incentives - were designed with the best of intentions - to improve access to and quality of care for Australians.

However, the combined effect of these regulations has been to create a 'passive payment' environment for the health funds, so they are left with few levers to manage costs and quality, in spite of their members consistently rating premium affordability as their major concern. This has put significant unnecessary upward pressure on premiums and encouraged low-value and wasteful care in the private sector.

Current regulations have simply not kept up with best practice care and are no longer fit for purpose.

Continuing with business as usual is to support an out-of-date healthcare system, overrun hospitals, higher premiums and out-of-pocket medical costs, low value and poor-quality care for consumers.

e. Drawing on international examples, how Australia could lower economic barriers to competition and business formation, further limit anti-competitive behaviour, and better manage changes in industry structure that would entrench, increase or extend market power.

Australia is a long way behind global trends in uptake of out-of-hospital models across a range of common health conditions.

Increased uptake of short-stay surgical models supported by home-based care has reduced length of stay for common operations globally. Comparable countries, such as Canada, United Kingdom (UK) and United States (US) are rapidly scaling "Hospital-in-the-home" models following COVID-19. They also have five times more palliative care services delivered in the home compared to Australia.

In the UK, 97.5% of primary care practices provide structured chronic disease management where patients at highest admission risk receive intensive out of hospital care chronic disease management with assigned Case Managers. In France, over 1,000 chronic disease management provider networks provide coordinated care for patients with complex needs. In the US, uptake of chronic disease

management programs is high with the top 20 providers reaching approximately 50 million consumers to date.

Increased global adoption of out of hospital care has been driven by four key drivers:[21]

1. **Demand** - we have a growing and ageing population and as a result, increased demand for health services. There is also an increased consumer interest and expectation for more flexible health services.
2. **Supply** – countries with increased uptake of education for out of hospital care workforce and support have seen increased uptake of out of hospital models. Uptake of new technologies is also driving remote patient care and countries with higher clinician approval of out of hospital care have also seen increased uptake. For example, in the US, clinicians agreed that between 15-40% of care currently being provided in clinics could be shifted to out of hospital.
3. **Funding –** Increased commitment of funding and investment from both government and the private sector is creating more certainty for providers and new models of funding are incentivising a shift of care to out of hospital models.
4. **Regulation** – Changes to regulations to explicitly increase out of hospital care has driven growth. Regulations that also enable use of specific technologies, such as, the adoption of regulatory change in France to allow more telecare, have also driven increased uptake.

Investment in artificial intelligence for healthcare is another untapped market for healthcare in Australia that should garner further investment. Many countries, such as Finland, Germany, UK, China, Israel and the United States are investing heavily in AI-related research and the US has the most competed AI-related healthcare research studies and trial globally.[22] The potential for AI in healthcare is significant from apps that can help patients manage their own health and wellbeing; healthcare operations support and bed management, to better predicating risk of disease and hospital admissions.[23]

Our preliminary assessment of barriers to growth drivers particularly for out of hospital care suggests that regulation and funding are the biggest challenges for increased uptake.

Australia should borrow what is working well in healthcare systems overseas to remove entrenched industry barriers and support greater innovation of healthcare.

Conclusion

The idea that healthcare is not impacted by the effects of market concentration and competition, or the benefit of economic dynamism is a myth. While healthcare is vital to the health of our people and economy, it should not be immune to critique or transformation.

Improved competition through regulatory reform and investment in technology has the potential to unleash a modern healthcare system in Australia that will increase consumer choice and improve health outcomes.

[21] Private Healthcare Australia Out of Hospital Care Reform Report (to be published in 2023).
[22] https://www.mckinsey.com/industries/healthcare/our-insights/transforming-healthcare-with-ai
[23] https://www.mckinsey.com/industries/healthcare/our-insights/transforming-healthcare-with-ai

Right now, our healthcare system is designed to keep people in hospital beds. Consumers don't want to stay in hospital if they don't have to, and private health funds have a vested interest in this as well.

Australians want private health to be high quality and accessible, with minimal out of pocket costs and low insurance premiums.

Removing red tape and improving economic dynamism is the sector will provide better support for patients, a reduction in hospital admissions, more consumer choice, fewer dollars wasted, further investment in healthcare innovation, and greater focus on wellbeing and illness prevention.