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Submission on promoting economic dynamism, competition and business formation

As outlined by Committee Chair, Dr Mulino and Mr Brennan, Chair of the Productivity Commission during the public hearing on 16 March, the non-market sector (those areas which are heavily funded, regulated or delivered by government) is a substantial and growing share of the overall economy.

However, measured productivity growth in this sector is particularly slow - effectively zero since the turn of the century. Even in the market service sector, Australia's performance is below the average compared with our global peers.[1]

Healthcare is a key component of the non-market sector both because of its size, at 10.7% of total economic activity[2], and because of the impact that it has on life outcomes, participation, productivity, and resilience in the economy as a whole. Fostering dynamism and productivity growth in this sector presents a significant opportunity. Grasping it will need to include regulatory reform and changes to the underlying incentives that drive behaviours.

The issues being examined by this inquiry, including lack of competition, rising market concentration and slow rates of new business/service formation due to economic barriers are evident in the healthcare sector, where they also result in higher mark-ups/prices, poor productivity, fragility and access challenges. As Mr Brennan highlights in his evidence *"small flaws in the incentive structure can end up expanding into pretty significant problems"*.

This submission provides examples drawn from public policy work undertaken by Bupa with research and analytical support from economics consultancy Evaluate, on how to make private healthcare and private health insurance more productive and increase overall public welfare. Copies of relevant reports and submissions to other consultations are provided as appendices.

Bupa also commends the Productivity Commission's recently published 5-year Productivity Inquiry report, recommendations and reform directives to the Committee as health care is well incorporated into its analysis and policy agenda for a more productive and inclusively prosperous Australia.

In particular, we support recommendation 3.1 and strongly agree there are steps that could be taken right now to improve aspects of the system and unlock incremental gains while a broader review of Australia's risk protection and social insurance arrangements is carried out.

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[1] 5-year Productivity Inquiry: Advancing Prosperity Inquiry report p5
[2] AIHW *Health expenditure Australia 2019-20* available at: https://www.aihw.gov.au/reports-data/health-welfare-overview/health-welfare-expenditure/overview

Rather than attempting to balance various sectoral interests (which has been a hallmark of past reform efforts) prioritising consumer interests should ensure genuine productivity improvements are achieved, with better health and economic outcomes to the maximum benefit of all Australians, whether using private or public health services.

Arrow and non-marketability in healthcare

The Evaluate report in Appendix 1 outlines the foundations of contemporary economic thinking with respect to healthcare which are found in the American Nobel laureate Kenneth Arrow's 1963 paper *Uncertainty and the Welfare Economics of Medical Care*.[3] It is sufficient to note here the conclusion that healthcare is a good which suffers exceptional levels of information asymmetry and uncertainty, compounded by highly rationed supply of medical expertise and intellectual property.[4] A consequence of this is that all payers in the 'market' (governments, insurers, private individuals) are price takers. These are the problems that government regulation and both public health and private health insurances are seeking to address.

Unfortunately, the regulatory structures for private health insurance (PHI) in Australia fail to address these problems and market limitations, meaning insurers face many of the same information asymmetries and competition limits as individuals.

In presenting the examples and solutions that follow we have considered and sought to distinguish between:

- The rules and structures which are necessary or desirable for maximising overall public welfare and correcting market failures;
- Those introduced to address specific problems, but which have had unintended consequences, or are now causing more harm than they are solving; and
- Gaps in the rules which are driving inefficiency, such as when one party to a contract is constrained and the other is not.

Supply-side asymmetries and default benefits

Under the current regulatory framework including default benefits arrangements, private health insurers have limited capacity to control input costs or ensure efficiency and value for money. Private health insurance premiums are regulated, however there is no similar regulation of the costs of covered procedures and medical items, including on out-of-pocket costs, resulting in both private health insurers and fund members being price takers.

A combination of regulatory and financial impediments creates unwarranted distortions that benefit in-patient providers. They limit the capacity of insurers to ensure service quality and value, inhibit innovation and stifle the creation of community-based care options as investment predictably favours the sector where there is a known and guaranteed floor price.

Many of the services currently provided in a hospital setting could be provided in alternative community settings. But the definitions of hospital treatment and hospital-substitute treatment, as they apply to PHI have not kept pace with this reality. For example, section 121-5(1)(c) of the Private Health Insurance Act 2007 (The Act) only allows Hospital policies to cover elements of an episode of hospital care outside the physical boundary of a hospital (for example hospital-in-the home) as long as a hospital is involved in the delivery of the services (treatment is provided, or arranged, with the direct involvement of a hospital).

[3] Kenneth J Arrow, "Uncertainty and the Welfare Economics of Medical Care", *The American Economic Review*, 1963 (53:5), pp.941-73.
[4] Evaluate 2021, pages 9-10

This is coupled with high minimum and default benefits for admitted services, creates a perverse incentive for healthcare providers to maintain a high level of demand for in-hospital services rather than investing in alternative models of care that are not only more cost effective but also more convenient for consumers. Australians cannot afford to be propping up such outdated models of care.

Default benefits arrangements as they currently stand do not serve consumers well nor do they achieve the policy aims intended. They have failed to encourage investment in areas of high unmet need, nor do they ensure quality and safety in the manner patients deserve. Unlimited out-of-pocket fees are allowed and benefit payment is mandatory even in circumstances where the care provided results in patient harm. They allow providers of low-value or poor quality to 'free ride' on the performance of higher quality, better value providers, undermining continuous improvement efforts.

Given this their removal or significant reform and retargeting to areas of high unmet need is urgently needed. More detail on current default benefits arrangements and their impact on access to and choice of services, quality market dynamics, innovation and affordability, as well as reform options is available in Appendix 2.

Medical services and out-of-pocket costs

In the March 2021 quarter, more than 97% of medical services covered by private health insurance had no gap (89.9%) or a known gap (7.7%).[5] The Grattan Institute has pointed out that just 7% of medical services account for 89% of medical gaps.[6]

Egregious billing is practiced by fewer doctors than ever before. However, thousands of people still pay significant gap payments each week. Many of these consumers are surprised, shocked and disappointed by receiving large bills that they were not expecting.

There is very little data available on the practice on splitting billing between patients, health funds and government. This is not surprising given the nature of the practice is to deceive. The IPSOS survey noted that just under one in twenty (4%) of respondents indicated a fee for a single service was split across two or more invoices for one person/organisation. [7] This may be an indication of a provider seeking to avoid disclosure of the full fee.

The survey by IPSOS in 2018 suggested booking and administration fees are charged in about 11% of hospital admissions and other 'hidden' fees in about 5% of admissions.[8] Just fewer than one in ten (8%) of those who had claimed against their private hospital insurance said they had been charged a booking fee. Of those, 13% claim to be charged multiple booking, admission or other types of administration charges. [9] Common types of booking, admission or other administration charges as detailed by respondents included:

- Hospital admission fees/charges, hospital stays, and hospital services and consumables
- Emergency hospital administration charges
- Booking fees/hospital booking fees, and/or
- fees to confirm the surgeon or room. [10]

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[5] Australian Prudential Regulatory Authority 2021, *Quarterly Private Health Insurance Statistics*, March 2021, Available at https://www.apra.gov.au/sites/default/files/2021-05/Quarterly%20private%20health%20insurance%20statistics%20March%202021.pdf
[6] Duckett S, Nemet K 2019. *Saving private health 1: reining in hospital costs and specialist bills*. Grattan Institute. Available at https://grattan.edu.au/wp-content/uploads/2019/11/925-Saving-private-health-1.pdf.
[7] IPSOS 2019. *Medical out of pocket: final report*. March.
[8] Ministerial Committee on Out-of-pocket Costs 2018. Report. Canberra, November. Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/3A14048A458101B0CA258231007767FB/%24File/Report%20-%20Ministerial%20Advory%20Committee%20on%20Out-of-Pocket%20Costs.pdf.
[9] IPSOS 2019. *Medical out of pocket: final report*. March.
[10] IPSOS 2019. *Medical out of pocket: final report*. March.

Seven percent (7%) of respondents reported that they were charged a 'deposit' to lock in their surgery on their most recent hospital admission. [11]

The Consumers' Health Forum undertook a self-selected survey in 2018, which found, "An unexpected and highly concerning finding was that some surgeons are asking consumers to pay upfront before surgery. Consumers described experiences of being told that they would not be able to proceed with their appointment or with surgery unless they were able to pay up front."[12]

Bupa supports the proposals of Private Healthcare Australia to reduce surprise billing and outlaw the practice of split billing:

- legislation to protect consumers by ensuring that consumers are not liable for out of pocket costs that have not be disclosed at least seven days in advance of a non-emergency procedure, or two days after booking the procedure in cases where the procedure is booked within the seven day period.
- legislation to protect consumers by making it an offence to fail to detail the full cost of a service covered by Medicare or by private health insurance to payers.

Medical devices

Australia's private patients pay the highest prices in the world for medical devices. They also pay more than Australia's public patients for comparable medical devices with no evidence this differential is driven by clinical outcomes.[13]

The previous government's policy was that Australians should pay more for medical devices than people in other countries and for Australians with private health insurance to pay higher prices for medical devices than Australians without private health insurance. The unilateral deal signed by the previous health minister with multinational device companies introduced a 7-20% surcharge for private patients over the public price of medical devices.[14] There is no clinical reason private patients should pay a premium for the same medical device. It is a wealth transfer away from Australian consumers and erodes the value and productivity of private health care.

If the government continues with previous government's deal with the multinational device companies for the term of the agreement, it should immediately begin work on ensuring consumers are better protected from 2026. Bupa supports the recommendations in Private Healthcare Australia's Federal Budget Submission 2023 for a review of the program should be commissioned which is truly independent, objective and not subject to lobbying or capture by those who stand to benefit financially from maintaining the status quo.

[11] IPSOS 2019. *Medical out of pocket: final report*. March.
[12] Consumers' Health Forum 2018, Out of pocket pain: research report. Canberra. Available at https://chf.org.au/sites/default/files/20180404_oop_report.pdf.
[13] https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/nationalarrangements-clinical-quality-registries
[14] See Memorandum of Understanding for the policy parameters of the Prostheses list reforms | Australian Government Department of Health

Remove restrictions and allow market completion

The supply of health care based on outdated financing and regulatory platforms, no longer matches the community demand, particularly for the 45% of Australian's who choose to insure themselves against illness and injury.

Bupa wants to support our customers in their efforts to maintain their health and wellbeing. When they require more acute support, we want them to have a seamless journey through the health system. We want the ability to offer care choices that align to their needs and preferences. These aspirations are particularly relevant to younger cohorts who are looking for greater relevance and value in private health insurance.

As discussed in the section on supply side asymmetries, restrictions on the type of care that may be covered by private health insurance are out of date, stifling innovation and more preventative approaches across many areas, including chronic disease management and mental health care.

Regulatory reform to funding mechanisms is essential to both encourage insurers to invest in developing and refining alternative models of care and enable them to scale successful interventions. This can both reduce costs (and thus premiums) or allow more treatment to be offered for the same cost. It also offers more options for innovation competition and differentiation of specific PHI products. This would have significant benefits in areas such as chronic disease management and prevention, supporting healthy behaviours across the lifespan.

In the first instance, the government should remove the prohibition on utilising primary care workers, mental health nurses and peer support workers by removing the approved provider list for chronic disease management programs.

Conclusion

Private health insurance contributes $61 billion to the Australian economy each year, which equates to 3.11% of our GDP, and adds to economic wellbeing by helping people remain healthy and productive.[15] Because this contribution to economic growth results from productivity effects not fiscal activity, the same or higher economic benefits are available at lower prices via a broader membership base or by removing waste and inefficiency. Bupa has identified multiple pathways, including those outlined here to achieving a more dynamic and productive private health care sector that maximises overall public welfare by being simple, relevant, and affordable for consumers.

Appendix 1: Evaluate (2021) A sustainable private health sector: an economic study

Appendix 2: Bupa submission to consultation paper on Private Health Insurance Default Benefits Arrangements

[15] Evaluate 2021, A sustainable private health sector: an economic study, pages 28-29 (Appendix 1)