Narrabundah Partners
Consultants and Advisers

13 July 2017

The Secretary
Senate Community Affairs References Committee
Parliament House
Canberra ACT 2600

Dear Ms Radcliffe

Reference: Value and affordability of private health insurance and out-of-pocket medical costs

I am pleased to attach my submission in response to the above reference.

As CEO, for seven years, of the then industry regulator, PHIAC, I occupied a privileged position from which to observe this industry. Much of my what follows draws upon that experience.

While my submission covers a wide range of issues, there is only one recommendation, viz:

> **There should be a full and broad Productivity Commission inquiry into all aspects of the private health insurance sector forthwith. Such inquiry to examine, amongst other things:**
>
> - **whether PHI can and should be more integrated into the general health system;**
> - **effectiveness and value for money of government rebates and other forms of non-financial support for participants in the industry (e.g. second-tier arrangements for private hospitals, prosthetics pricing and Lifetime Health Cover);**
> - **the state of competition within the industry and barriers to better competition;**
> - **the needs of consumers at all stages of the PHI cycle including access to reliable and timely information about premiums, preferred provider arrangements and alterations to coverage; and**
> - **operation of the portability scheme.**

While I respect the interest this committee (and the parliament more generally) continues to show for the PHI sector, it will be apparent from what follows that this is a peculiarly complex and multi-layered industry. Experience has shown that seriatim and fragmentary examinations by inexpert groups do not lend themselves to the kind of industry-shaping reform that Australia's health system needs. Rather what we require is a well-resourced, comprehensive and expert analysis which is conducted at arm's length from both politics and the many interest groups that cluster around PHI.

This was the experience in 1997 when the Productivity Commission (then Industry Commission) last considered this topic. Substantial and enduring reform ensued. The time has come to do that again.

Yours sincerely

Shaun Gath
Principal, Narrabundah Partners
(former CEO, Private Health Insurance Administration Council)

Narrabundah Partners

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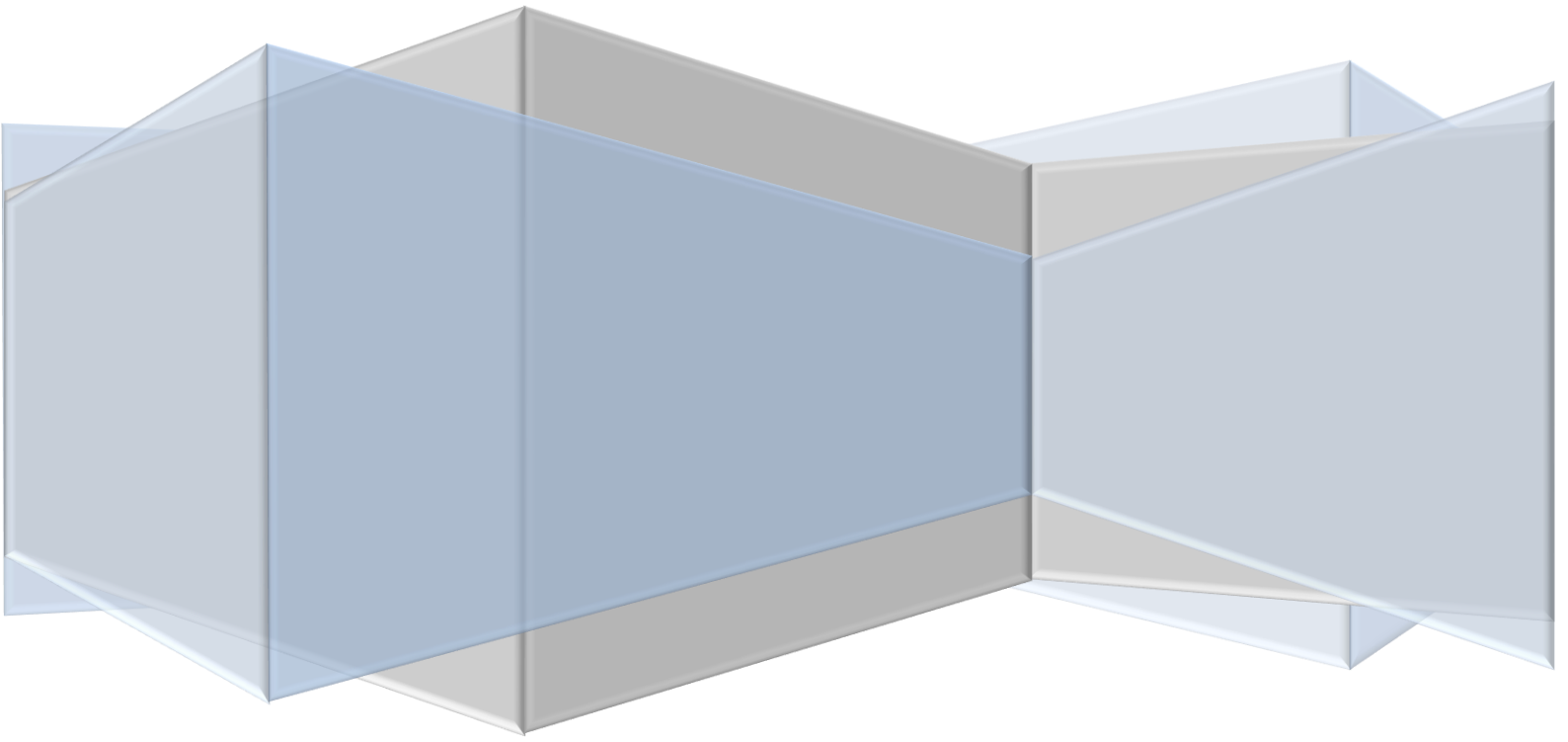
Value and Affordability of Private Health Insurance and Out of Pocket Costs

Submission to Senate Community Affairs References Committee

Shaun Gath, Principal, Narrabundah Partners

13 July 2017



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Narrabundah Partners
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Introduction

I am pleased to be able to contribute to this wide-ranging examination of the private health insurance (**PHI**) sector and, in particular, to a number of issues directly affecting consumers of Australian PHI products.

My background.

I bring three perspectives to this submission.

First, from 2008 to 2015, I was the Chief Executive Office of the PHI industry regulator, the Private Health Insurance Administration Council (**PHIAC**). PHIAC was abolished as part of machinery of government changes announced in the 2014 budget. During my time at PHIAC, the industry underwent a number of important changes including:

- conversion of the industry to a majority "for profit" structure after many decades operating primarily on a not-for-profit model;
- corporatisation (in 2009) and sale by IPO (in 2014) of the government-owned insurer Medibank Private;
- redesign of the capital adequacy standard; and
- changes to the system for oversight of annual premium increases.

In that time, I also gained a detailed understanding of the industry, the various insurers that comprise the industry and. in the course of working with four ministers, a good appreciation of the policy and political imperatives that surround the PHI sector.

Second, as a senior lawyer (prior to my appointment to PHIAC, I was a partner in a major Australian law firm), I have an understanding of some of the important legal – and, in particular, constitutional – issues that apply to regulation of the health sector. These questions are more that usually relevant in the current setting.

Third, prior to my most recent time in private legal practice I served for over four years as General Counsel to the Health Insurance Commission (1997-2001). At the time, the HIC was the Commonwealth statutory agency responsible for running Medicare and the Pharmaceutical Benefits Scheme amongst other things. As result, I am also well-versed in issues affecting the public health payments system.

For the first two years at the HIC, the position also incorporated the role of General Counsel of to the then largest private health insurer, Medibank Private.

PHI in Australia – Framing the discussion

Before turning directly to the matters raised in the terms of reference, I want to share some broader reflections on the Australian PHI sector and, in so doing, provide some information which I hope

will go some way to allaying some of the anxiety and misunderstanding about the sector which is sometimes evident in the wider Australian community.

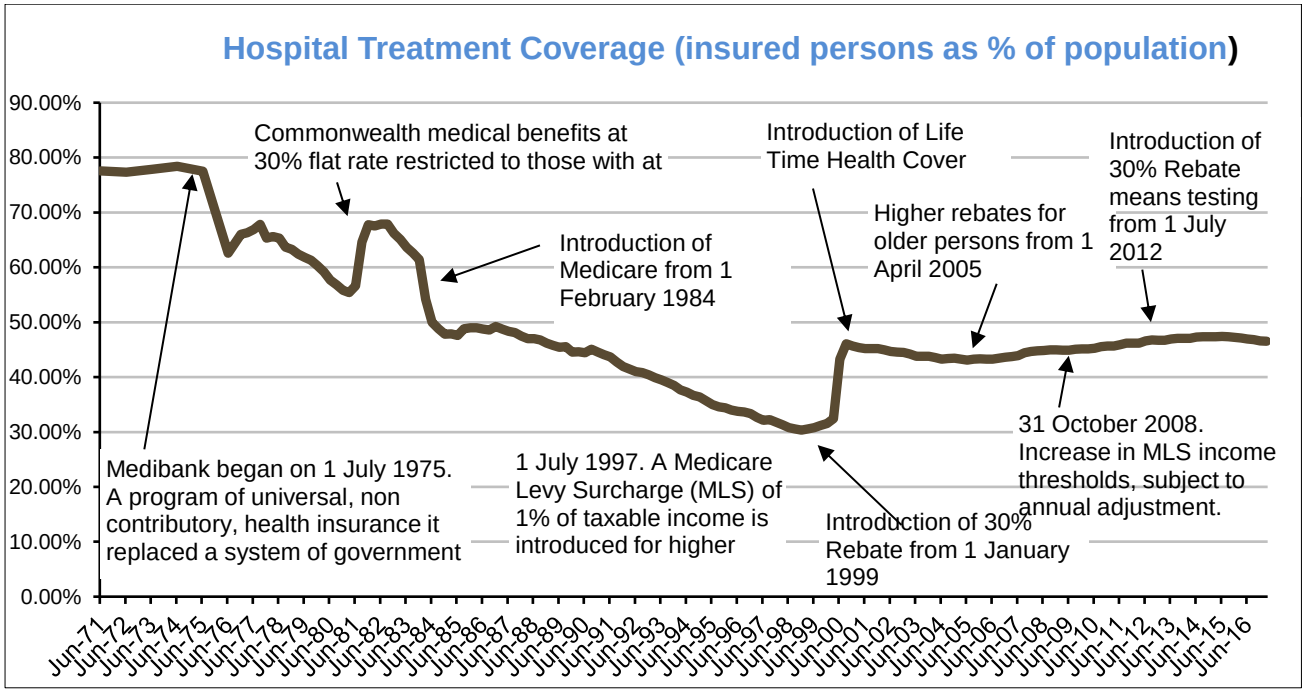
In particular, while the inquiry will inevitably – and quite properly – focus on areas for improvement, I believe it is important to acknowledge at the outset that Australians generally are fortunate to have one of the world's best health systems. After considerable exposure to both the public and the private domains of Australia's health system, I firmly believe that our current model of mixed public/private system funding of health services is, on the whole, an effective way to harness the best both those sectors have to offer to the ultimate benefit of the Australian community.[1]

Obviously, it follows from that, that I consider that private health insurance has a continuing role to play in the sector as one of the most important sources of private funding of health services.

That said, there are clearly aspects of our current system that can be significantly improved. A matter to which I will return a little later in this submission.

A quick glance in the rear-view mirror…

If the story of PHI in Australia can be summarised in a single image it is in the following chart, which tracks hospital treatment coverage as a percentage of the population over the last 46 years:[2]



This chart reveals several key facts about PHI in Australia:

[1] This view is informed by the particular features of the Australian health system which, unlike many European models, relies heavily on a *private* medical workforce and the constitutional constraints imposed by the stipulation that public funding not amount to a form of "civil conscription" of that workforce. See T Faunce, "Constitutional Limits on Federal Legislation Practically Compelling Medical Employment", (2009) 17 *Journal of Law and Medicine* 196.

[2] Source: Australian Prudential Regulatory Authority, *March Quarter 2017 Statistics*.

- **First**, in 1971, PHI coverage levels were at almost 80 per cent of the population. This extraordinary figure[3] is a defining starting point for any person seeking to understand PHI in Australia. It reflects the fact that, unlike many other rich countries, Australia did not have a universal single-payer system until the mid-1970s ("Medibank" operated from 1975 until 1981) and the current system, known as "Medicare", dates only from 1984. This relatively recent experience compares starkly with that of many European economies where, to take a well-known example, the British National Health Service (**NHS**) commenced almost forty years earlier in 1948.[4]
- **Second**, the introduction of universal, centrally-provided health insurance, first, in 1975 and then, more enduringly, in 1984 did not, as many predicted, result in a precipitous and terminal collapse in PHI membership levels. Instead, after an initial downward adjustment there was a period of what can fairly described as "gradual decline". In the period between 1984 and 1997 coverage levels went down from about 50 per cent to about 30 per cent, dropping, on average, less than 2 per cent a year over that time. Yet, all this time, Australians had access to an essentially "free" system of primary and hospital care, if they chose to use it.[5]

  Arguably this reflected the strong – perhaps even illogical – attachment many Australians (particularly older Australians) had to their private health insurance cover. The reasons why this might be so have not been fully explored[6] (and with the passing of the relevant generation, may never be) but are likely to be anchored in:

  - a long-standing commitment to private health insurance cover as a kind of personal identity, particularly amongst Australians who regarded themselves as middle-class and self-sufficient;

  together with:

  - a well-established and politically resourceful private health care sector, led by the existing private health funds, powerful private hospitals and well-connected medical lobbies (a legacy of the long post-war period when there was limited publicly funded health care);
  - strong cultural attachment to a model of health care centred around private treatment options (whether through admission to a private hospital or use of a doctor of choice or, commonly, both); and

[3] Certainly, by European standards, where PHI coverage levels rarely exceed 10 percent.

[4] The NHS started in 1948 under the then Atlee Government. The equivalent French scheme dates from 1945. The German system traces its origins back to the chancellorship of Bismarck in the late 19th century. It is worth noting that Australia did in fact amend its Constitution in 1946 to insert section 51(xxiiiA). This provision, which essentially enabled the modern welfare state in Australia, allows the central government to make laws for a wide array of payments (including medical insurance payments similar to those then taking hold in Europe), but shortly afterwards, there was a change of government where such reforms remained out of favour for the next 23 years.

[5] It was at the time (and remains today) a central proposition of the Medicare Principles that all Australians have access to the benefits of Medicare irrespective of their insurance status.

[6] The 1997 report of the Industry Commission, *Private Health Insurance*, (Report No 57) is arguably the most helpful contemporary document but does not dwell on this issue.

- a concern – drawn out of the tumult of the 1970s – that the universal cover model was politically fragile and would be dismantled as soon as a new conservative government came to power.[7]

Arguably, these factors, have not yet entirely exited the national psyche.[8]

- **Third,** following a milestone report into the PHI industry by the Industry Commission,[9] there were a series of significant interventions in the late 1990s. As the chart shows, these collectively constituted an important turning point which arrested the decline in coverage levels. The measures, were:

  - in ***1997***, a tax penalty, known as the Medicare Levy Surcharge, initially set at 1 percent for higher income earners who did not have private health insurance;[10]
  - in ***1999***, introduction of a 30 percent government rebate on premiums;[11] and
  - in ***2000***, commencement of a policy known as Lifetime Health Cover (**LHC**) which made premiums progressively more expensive for people who delayed taking out cover after they had turned 31 years.

  While each played a role, the chart shows that the initiative which produced the single biggest jump in coverage levels was the LHC policy in 2000. Overnight, insurers were swamped with new members and, despite this growth, the industry experienced two or three difficult years, with notably, the then government-owned insurer Medibank Private needing a special injection of funding from the government.[12] The three policy settings established at that time continue, in my view, to be important drivers of the industry's activity and growth.

- **Fourth,** starting from around 2001 (and after the tumult of the preceding three decades) PHI coverage levels have been very stable, hovering in the mid-40s with slow increases over most of that time and small declines in recent quarters. It is worth recalling too that this period includes the Global Financial Crisis of 2008. Unlike many other financial markets whose prudential resilience was severely tested, the Australian PHI sector was not significantly

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[7] This concern had some basis in fact since at the time of its introduction both Medibank and its successor program Medicare were fiercely opposed by the conservative parties and the medical profession. For a number of elections following the commencement of Medicare, it was the policy position of the conservative parties that Medicare should be abolished with a return to a more privately funded model of care. This position finally changed in 1996, some twelve years – and four elections – after Medicare was introduced. See generally: Anne-marie Boxall and James Gillespie, *Making Medicare: the politics of universal health care in Australia* (UNSW Press, 2013).

[8] This is arguably underscored by the experience of 2016 federal election campaign in Australia which placed great emphasis on health care issues and, in particular, a suggestion by the Australian Labor Party that Medicare would be imperilled if the Coalition Government was returned to power. Members of the committee are better placed than I am to judge whether that claim was warranted. It does appear to be agreed across both parties, however, that that claim had some political resonance. See e.g. The Conversation, *"Medicare" campaign shows the power of negative advertising*, 4 July 2016:https://theconversation.com/mediscare-campaign-shows-the-power-of-negative-advertising-61990

[9] (Now known as the Productivity Commission) See: Industry Commission, *Private Health Insurance*, (Report No 57).

[10] The rate has since been increased for higher income earners and is either 1, 1.25 or 1.5 per cent depending on income.

[11] The rebate in question is no longer set at 30 percent of actual premiums. Instead the rebate is a set amount which now only inflates by the value of the consumer price index each year. The difference between CPI and health sector inflation (which is often in the range of 5.5 to 6.0 percent) has meant that the value of the rebate has gradually reduced as PHI premiums have increased. At present the rebate assists with about 25 percent of PHI premium costs for relatively low-income earners. The rebate is no longer available to higher income earners.

[12] M Metherell, "Medibank loss comes at a 13% premium", The Age, 28 September 2002; Joint Ministerial Announcement, "Government to retain ownership of Medibank Private", 17 June 2003; A Stafford, "Medibank: in sickness and in health", *The Age*, 27 April 2006.

impacted at that time. The last decade has been marked by steady, but not excessive, profitability,[13] strong capital adequacy and a degree of measured predictability – at least as far as the industry was concerned – around the premium-setting process.[14] Perhaps the most tangible marker of this period of general stability was the fact that the Australian Government was able to privatise the largest insurer, Medibank Private, without the concern that there would be either an investor or a consumer backlash.[15] In the event, the sale of MPL was completed very successfully in 2014 with almost $5.7 billion raised.

Crisis? What crisis?

With that background, I must also address the wide held, but factually unsustainable, suggestion that that the PHI sector in Australia is in, or is about to encounter, some kind of existential "crisis".

Instances of this suggestion are too numerous to catalogue,[16] but one recent example will suffice. On 14 January 2017, *The Australian* carried the headline:

> *Private health insurance nears crisis point as costs soar*

The proposition advanced in that article (quoting numerous sources) is that affordability issues facing PHI products – and in particular their long-standing propensity to inflate at a rate greater than general inflation – will inevitably lead to some kind of prudential crisis for PHI.

In fact, PHI in Australia is not facing an imminent prudential crisis, nor is it remotely close to experiencing such a crisis.

These are the facts:

- **First**, the number of people covered by PHI has, as just been noted, increased (albeit slowly) in recent years with only a minor downward movement in the most recent quarters. In raw numbers, more people are covered by a PHI product that ever before in Australian history. In this context, it is regrettable that some commentators have been known to quote the numbers exiting the industry while overlooking to mention the equal or usually larger number who are joining it.[17] The result is, often, a level of public confusion which is not justified on the facts.
- **Second**, the fact that people are "downsizing" or reducing the scope of their cover should not, of itself, be a reason for concern. On the contrary, it is evidence of rational market conduct by consumers which is likely to encourage a competitive (read "pricing") response

[13] Industry net margins have generally been in the range 3 to 6 per cent. See below. That said, another measure of profitability, return on capital/equity, has been quite high compared to other financial services industries. The larger for-profit funds have, for a number of years, reported numbers in excess of 30 per cent on this measure. See discussion below at pages 8 -11.

[14] PHIAC assumed primary responsibility for advising the Minister for Health on premium matters in 2012. Prior to that time there had been quite a deal of industry anxiety about the pricing process including issues associated with lack of transparency and unpredictability of outcome. See further discussion below at pages 17 to19.

[15] This stands in contrast to earlier proposals to privatise the business which were abandoned due to market instability or shortcomings in the business case. See: N Minchin, *Press Release*, "Government to retain Medibank Private Membership", 17 June 2003.

[16] Amongst many that could be cited: "Private health insurance: the sad history of a system in crisis", www.onlineopinion.com.au, 26 February 2003; S Parnell, "Millions cut costs by dumping their health insurance policies" *The Australian*, 17 March 2015 (to hear a radio interview by the author addressing this claim: http://www.2gb.com/audioplayer/95606).

[17] See, for example, S McDonald, ABC News, "Federal Government launches public consultation in review of private health insurance" 8 Nov 2015, which starts:

> Half a million Australians dropped or downgraded their private health insurance in the last financial year, causing "alarm" for the Federal Health Minister who says consumers are not getting value for money from their policies.

from the industry itself. That said, downsizing inevitably does have some impact on premium revenue, which no insurer will be happy about. That is understandable. Hence the grumbling. Significantly, from a prudential perspective, this is not a cause for concern as it actually results in a more efficient alignment of risk to premium.

- **Third**, the industry currently holds over $6 billion in excess of the statutory capital requirement. Based on an annual premium income of around $23 billion, this is a very substantial capital buffer *over and above* that which is required for regulatory purposes. Before it was abolished in 2015, PHIAC took a number of steps around capital management including repealing an overly risk-averse capital standard that had been in place since the traumas of the early 2000s (when, as noted, a number of funds teetered on the brink of insolvency).[18] The new standard not only more correctly matches statutory capital provision to risk, but places primary responsibility for analysing and matching capital to risk on the boards of the various funds. This decision alone released over $1.5 billion from the metaphorical box marked "statutory capital, do not touch" and provided the industry with a massive capital injection.[19]

Challenges? Aplenty…

This does not mean – nor should I be taken to be saying – that PHI in Australia does not face some important challenges. What follows are just some of them.

(i) Consumer "loss of value" issues

There is little doubt that the Australian PHI sector is engaged in a constant struggle to assure (and then reassure) its members that it does represent value for money. This is a key challenge given that a considerable number of members undoubtedly feel that they are, essentially, "economic conscripts" to a system where the alternative is to pay more tax for no benefit whatsoever.

In recent times, this sense of "value" has focussed around two central question, namely premiums (discussed below) and out-of-pocket costs incurred, usually, after surgery in a private hospital. Despite being a feature of the PHI sector since its inception, the question of out of pocket costs (or "gaps") continues to be very challenging for the insurers and the general perception of the industry.

As senators would know, this subject prompted an inquiry by this Committee in 2014,[20] which traversed the main issues, but did not develop any substantive recommendations.

Research undertaken by PHIAC in 2015[21] showed how the issue was impacting differentially across various specialities with the greatest concern in the areas of urology (often associated with prostate procedures on men), plastic surgery and orthopaedic procedures as shown in the following chart:

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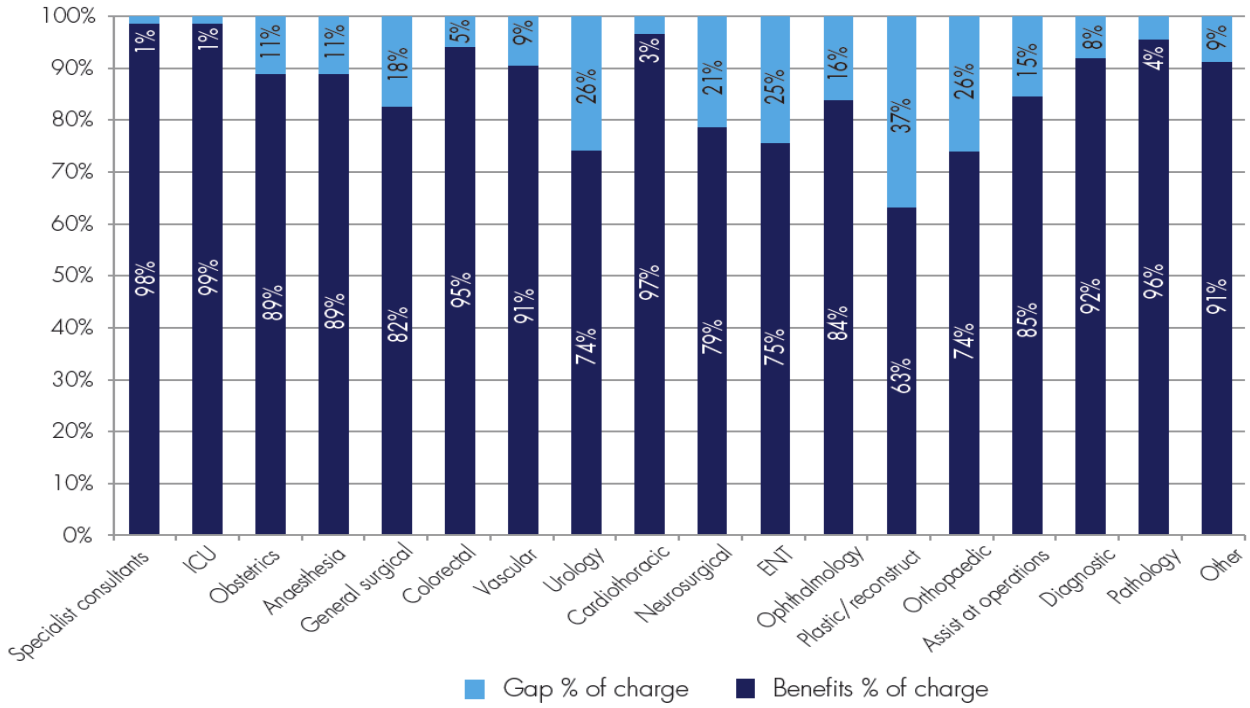
[18] Indeed, history records that three insurers were not able to survive that period and were, following PHIAC intervention, absorbed into other insurers. The insurers affected were GMF (absorbed into HBF); IOR (absorbed into HCF) and Federation Health (absorbed into Latrobe Health).

[19] The more telling question, perhaps, is what have the insurers done with this money? Some, such as Medibank Private, have given a substantial component of it to their shareholder (through the initial public offering in 2014) or by way of a direct special dividend to shareholders (as did NIB). Not-for-profit funds, which face greater legal restrictions on use of capital, have generally retained the windfall accounting substantially for the amount held by the industry at the moment.

[20] Senate Standing Committee on Community Affairs, *Out of pocket costs in Australian healthcare*, Final Report 22 August 2014.

[21] PHIAC, *Barriers to entry in the Australian private health insurance market*, Research Paper No 3, June 2015.

34. Medical benefits and out-of-pocket by speciality group, March quarter 2015



The major health insurer BUPA has, to its credit, also been very active on the issue. Without naming particular doctors, in 2016 the insurer published a list of procedures where gap expenses can exceed $5000 and the incidence of those charges expressed as a percentage of the total procedures performed.[22] This is the summary table they produced, reflecting the national position:

	Gap fee				
Procedure	***$0***	***$<500***	***$501–$2,000***	***$2,001–$5,000***	***$5,001–$10,000***
Knee replacement (both knees)	37%	13%	2%	39%	8.9%
Prostatectomy, radical	17%	11%	8%	35%	28%
Breast reduction	27%	6%	3%	33%	28.7%
Incision of femur/pelvic bone	36%	21%	14%	29%	0.6%
Shoulder replacement	50%	16%	4%	29%	0.8%
Excision of intervertebral disc/s	35%	33%	4%	26%	1.4%
Hip replacement	60%	10%	5%	25%	0.3%
Knee reconstruction	56%	11%	8%	24%	0.1%
Prostatectomy, radical and pelvic lymphadenectomy	26%	10%	7%	23%	29.7%
Knee replacement	63%	10%	6%	20%	0.5%

[22] S Parnell, "Patients bleed $10,000 in surgery fees", *The Australian*, 11 May 2016; Bupa Australia, "Revealing the gap for health insurance customers", *Press Release*, 11 May 2016.

Bupa's more detailed statistics[23] demonstrate that there are some geographical weightings to the incidence of major gap charges, with instances in Victoria, Western Australia and Queensland to the fore.

Resolution of the issues that surround excessive "gap" payments by consumers is not easily achieved in the Australian context. This is due in part to restrictions that apply under the Australian Constitution to the making of laws that directly regulate the fees that medical practitioners can charge.[24] Absent a legislative solution, therefore, it is evident that the solution will need to be market-based. But that approach also presents problems. As I observed in a newspaper article published last year:[25]

> Competition in the [Australian] referred medicine area is hopelessly weak. Most patients have neither the opportunity nor the inclination to challenge their GP on choice of specialist nor the venue for treatment. And even if they wanted to, the information they need is just not readily available.

Overcoming this informational asymmetry is at the heart of achieving dynamic markets for medical services. It may also provide the basis for an enlarged role for the private health insurers themselves who are currently "walled off" by legislation from most key parts of the decision-making processes.

Greater involvement of the funds in assisting their contributors to select efficient and effective post primary medical pathways would almost certainly contribute significantly to the revival of what is currently an inefficient and torpid market.

That said, such a move would also, almost certainly, be highly controversial.[26]

Margin/Profitability

PHI in Australia is not an especially profitable business according to traditional insurance business measures.[27] Net margins (after tax) have stayed in the range 3 to 6 per cent for the last decade or so with the average return around 5 per cent. The chart below shows how industry margins have moved around over the last twenty years – starkly illustrating the impact on profitability which occurred at the time of the Lifetime Health Cover policy in 2000 and its difficult sequel for the whole industry.[28]

[23] The full list is extracted at **Appendix A**. See also: www.bupa.com.au/about-us/media-centre/media-releases/ci.revealing-the-gap-for-health-insurance-customers.7030news

[24] T Faunce, "Constitutional Limits on Federal Legislation Practically Compelling Medical Employment", (2009) 17 *Journal of Law and Medicine* 196.

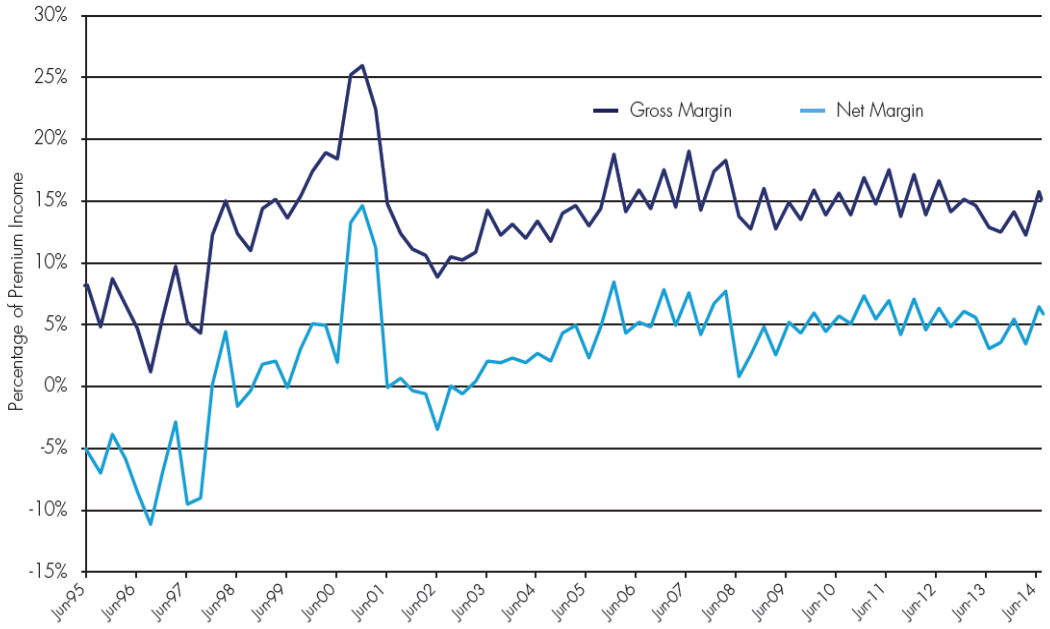
[25] S Gath, "Private health insurance may be broken, but it can be fixed", *The Australian*, 18 April 2016.

[26] Any such proposal would almost certainly draw criticism from the medical profession on the ground that it would be bringing Australian health care arrangements closer to the "managed care" model in operation in the United States.

[27] According to IBIS World, *Health Insurance in Australia* (2012) the net margin in the wider insurance industry is closer to 12 per cent.

[28] PHIAC, *Barriers to entry in the Australian private health insurance market*, Research Paper No 3, June 2015.

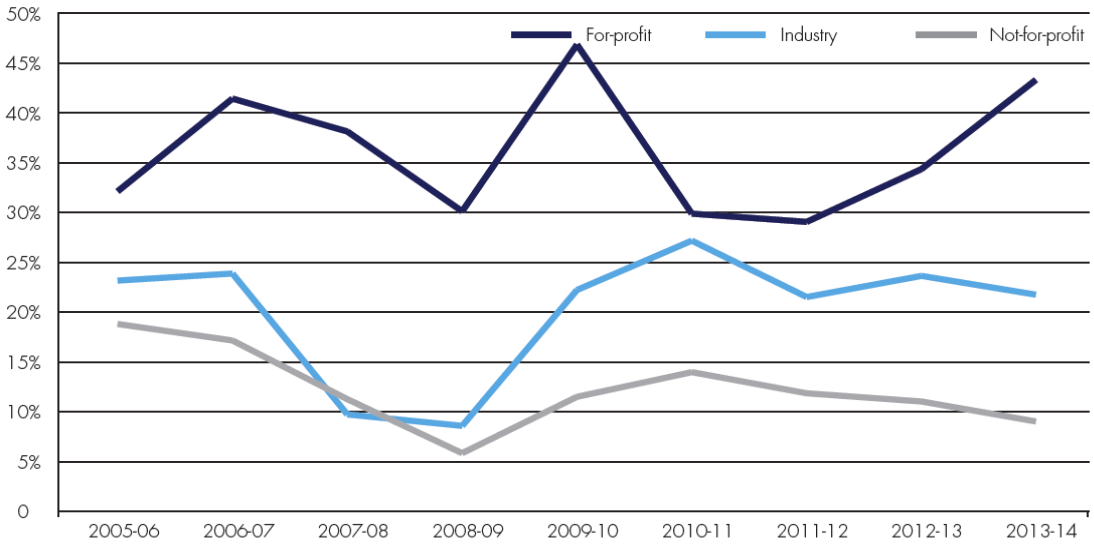
15. Industry margins June 1995 to June 2014



Margins at these levels are compatible with reasonable prudential settings and, indeed, have allowed most funds to improve their capital position over time, resulting in return on capital in the order of 8 to 60 percent across the various for-profit insurers in recent years.

As the following chart shows, the rate of return in the "for-profit" component of the industry has been markedly higher than the industry average.

16. Return on capital for 2002-03 to 2013-14



Seen within their various sub categories (not-for-profit vs for-profit; and open vs restricted), there has been some variability in net margin, with the for-profit funds achieving the highest net margin rates.

The following chart describes the results for the 2013-14 financial year.

17. Profitability of the insurers across various measures, 2013-14

	Industry–wide	Open: Not-for-profit	Open: For-profit	Restricted: Not-for-profit	Restricted: For-profit
Number of PHIs	34	15	7	10	2
Gross Margin (a)	12.6%	14.1%	15.9%	12.3%	18.1%
Management expenses (b)	8.5%	8.6%	8.4%	7.1%	10.4%
Net Margin (c)	4.1%	5.4%	7.5%	5.2%	7.7%

(a) Gross margin is the difference between total contribution income and the total cost of benefits. Average gross margin under each insurer category were calculated by taking the sum of gross margins across the range of private health insurers in each category and dividing by the number of insurers in that category.

(b) Management expenses are the operating expenses incurred in the course of normal insurer operations. An average of management expenses under each insurer category has been estimated.

(c) Net margin is equal to the gross margin less management expenses. The above estimates similarly refer to the average net margin under each insurer category.

Note: All averages are simple averages and have not been weighted by market share. Industry-wide estimates for each measure reflect the average across the 34 insurance providers.

The following table shows how those results (on a gross margin basis) play out across various jurisdictions and as between hospital and general cover products.

This also clearly reveals the greater profitability that exists within general treatment products. About 55 per cent of Australians have some kind of general cover. These products, which arguably involve no true underwriting, are now central to industry profitability.

18. Gross margins by treatment type and by state/territory 2013–14

State/territory	Hospital treatment per cent	General treatment per cent	State/territory total per cent
New South Wales	9.1	21.0	9.7
South Australia	17.1	18.0	17.4
Victoria	9.6	21.0	12.3
Tasmania	11.0	23.7	14.2
Queensland	10.6	20.0	13.2
Western Australia	11.0	22.2	14.6
Northern Territory	26.0	30.5	27.6
Australian Capital Territory	19.0	30.4	17.7
Australia	10.7	21.0	12.4

And these are the actual ROC results for all the insurers in the period 2012-14.[29]

[29] PHIAC, *Barriers to entry in the Australian private health insurance market*, Research Paper No 3, June 2015.

5. Returns on health benefit fund capital (HBFC) of market participants in the Australian PHI market 2012–2014

Return on health fund capital 2012–13	
Industry average	18.3%
BUPA Australia Pty Ltd	52.3%
National Health Benefits Australia Pty Ltd	33.2%
NIB Health Funds Ltd	27.2%
Australian Unity Health Ltd	25.1%
Police Health Ltd	22.6%
Grand United Corporate Health Ltd	20.9%
HBF Health Ltd	18.9%
Railway & Transport Health Fund Ltd	16.8%
Medibank Private Ltd	16.3%
Doctors' Health Fund Ltd, The	14.4%
Health Partners Ltd	14.4%
Lysaght Peoplecare Ltd	14.2%
Transport Health Pty Ltd	13.9%
Health Insurance Fund of Australia Ltd	12.9%
GMHBA Ltd	12.8%
CUA Health Ltd	12.7%
Healthguard Health Benefits Fund Ltd	12.4%
Defence Health Ltd	11.6%
Reserve Bank Health Society Ltd	11.5%
Hospitals Contribution Fund of Australia Ltd, The	11.3%
CBHS Health Fund Ltd	10.9%
Navy Health Ltd	10.2%
St Luke's Medical & Hospital Benefits Assocn Ltd	10.2%
ACA Health Benefits Fund Ltd	10.0%
Westfund Ltd	9.5%
Queensland Country Health Fund Ltd	9.4%
Queensland Teachers' Union Health Fund Ltd	9.3%
Health.com.au Pty Ltd	9.1%
Mildura District Hospital Fund Ltd	6.3%
Health Care Insurance Ltd	6.2%
Cessnock District Health Benefits Fund Ltd	5.9%
Latrobe Health Services Ltd	5.5%
Teachers Federation Health Ltd	5.5%
Phoenix Health Fund Ltd	3.7%

Return on health fund capital 2013–14	
Industry average	17.1%
BUPA Australia Pty Ltd	60.5%
NIB Health Funds Ltd	31.0%
National Health Benefits Australia Pty Ltd	30.9%
Australian Unity Health Ltd	22.9%
Doctors' Health Fund Ltd, The	20.7%
Medibank Private Ltd	20.2%
Police Health Ltd	16.9%
CUA Health Ltd	13.0%
Lysaght Peoplecare Ltd	12.6%
GMHBA Ltd	12.5%
CBHS Health Fund Ltd	11.5%
Transport Health Pty Ltd	11.5%
HBF Health Ltd	11.3%
Health.com.au Pty Ltd	10.1%
Queensland Country Health Fund Ltd	10.0%
Navy Health Ltd	9.7%
Healthguard Health Benefits Fund Ltd	9.6%
Defence Health Ltd	8.5%
Latrobe Health Services Ltd	8.2%
Teachers Federation Health Ltd	8.0%
Grand United Corporate Health Ltd	8.0%
Health Partners Ltd	7.7%
Health Insurance Fund of Australia Ltd	7.7%
Hospitals Contribution Fund of Australia Ltd, The	7.5%
Reserve Bank Health Society Ltd	7.1%
ACA Health Benefits Fund Ltd	6.7%
Queensland Teachers' Union Health Fund Ltd	5.9%
Phoenix Health Fund Ltd	5.3%
Westfund Ltd	5.0%
Railway & Transport Health Fund Ltd	3.7%
Mildura District Hospital Fund Ltd	3.3%
St Luke's Medical & Hospital Benefits Assocn Ltd	3.2%
Health Care Insurance Ltd	2.3%
Cessnock District Health Benefits Fund Ltd	0.8%

Source: Based on return on fund capital calculation from the operations of private health insurers annual reports 2012–13 and 2013–14 (PHIAC (2013a) and PHIAC (2014))

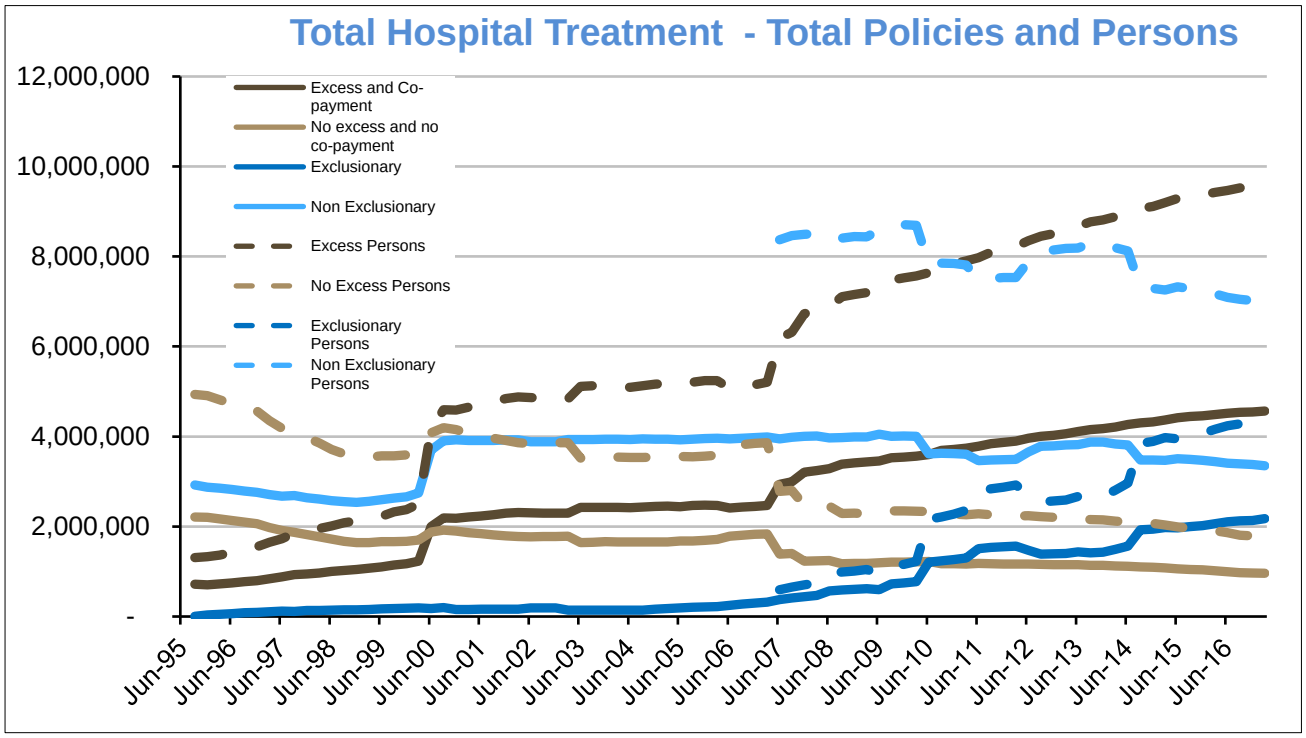
Note: For-profit insurers highlighted.

As can be seen this is an area where BUPA has been notably successful.

(ii) Changes to underwriting risk

An important observation to make at this point is that while several key indicators (namely coverage levels and profitability) have been relatively static over recent years, the *nature of the insured risk* itself has been altering quite dramatically.

This is most clearly demonstrated by the following table which shows the growth in recent years of policies containing some form of excess or co-payment arrangement and, more recently, the growth in policies with particular categories of treatment excluded.[30]



Since 1995, Australian law has only required a fairly limited number of types of cover to be included in a complying health insurance product (including, importantly, psychiatric treatment costs),[31] thus allowing the insurers to design products where most potentially expensive treatments *are excluded*. Common treatments excluded include cardiac services, assisted reproductive services, hip and knee replacements, and some categories of treatment not likely to be required by persons of a particular age.

Naturally, reduced coverage (or accepting an excess) will mean that the contributor will have a cheaper premium, but it is one of the current challenges of the industry to ensure that all contributors truly understand that paying less also means that *you get a whole lot less cover*.

The disjunction between consumer expectations and the sometimes-harsh reality of the type of cover purchased has been the subject of much discussion and commentary and does represent an important reputational challenge for the industry.[32] PHIAC examined the issue closely in its report, *Risk*

[30] Source: Australian Prudential Regulatory Authority, *March Quarter 2017 Statistics*.

[31] There are only three compulsory cover requirements under Australian law. Apart from psychiatric care, the other two are rehabilitative and palliative care: s72(2) of the *Private Health Insurance Act* 2007.

[32] The proliferation of such products, although lawful, has led some, including the Minister, Ms Ley, to describe important parts of the industry as retailing "junk" products: Address to National Press Club (QandA session), 27 October 2015: http://www.abc.net.au/news/2015-10-28/national-press-club-sussan-ley/6893646; J Gardiner, "Health Minister Sussan Ley attacks 'junk' private health insurance, *Sydney Morning Herald*, 28 October 2016.

Sharing in the Australian private health insurance market[33] as has the Private Health Insurance Ombudsman in a number of recent reports on the State of the Health Funds.[34]

One of the practical consequences of the alteration in risk coverage has been the difficulty presently being encountered in implementing the former Minister, Sussan Ley's, proposal that there should be a set of comparability standards based on the US concepts of "gold", "silver" and "bronze".[35] While few would argue that this is not an idea worth pursuing, its implementation has been complicated by the need to manage the difficult line between acceptable minimum levels of cover (for which the label "bronze" would presumably apply) and those falling below this threshold which have come to be known – courtesy of the former Minister's own nomenclature – as "junk"[36].

One option which has emerged in the Private Health Ministerial Advisory Committee, which has been charged with addressing this conundrum, has been a proposed new category – lower down the ladder than "bronze" – tentatively to be known as "basic bronze".[37]

Whether products falling in this category are actually better than those reviled by the former minister as "junk" remains to be seen.

(iii) M&A

Despite appearances, PHI in Australia is *not* an active M&A opportunity.

Recent experience of financial services markets consolidations (e.g. credit unions) and the profile of the industry – dominated as it is by two giant funds, with a long "tail" (see the chart below) – suggests that there must be at least several weak and/or easy targets for takeover. That impression is misplaced. Following the departure of a failed start-up attempt in 2015,[38] the remainder of the industry in 2017 is, as has been noted, very well capitalised – even down to the smallest funds.

Further, most of the smaller funds, being not for profit, operate as companies limited by guarantee which makes them very difficult to take over other than by paying very dearly.

Recent attempts at takeover with any hostile intent have invariably failed, as NIB found when it sought, unsuccessfully, to take over the Geelong-based fund GMHBA in 2010.[39]

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[33] Private Health Insurance Administration Council, *Risk Sharing in the Australian private health insurance market*, Research Paper No 4, 2015.

[34] See for example, Commonwealth Ombudsman, *State of the Health Funds* 2015 at p. 8ff.

[35] S Ley, *Coalition's plan to ensure private health insurance delivers value for money*, 12 June 2016.

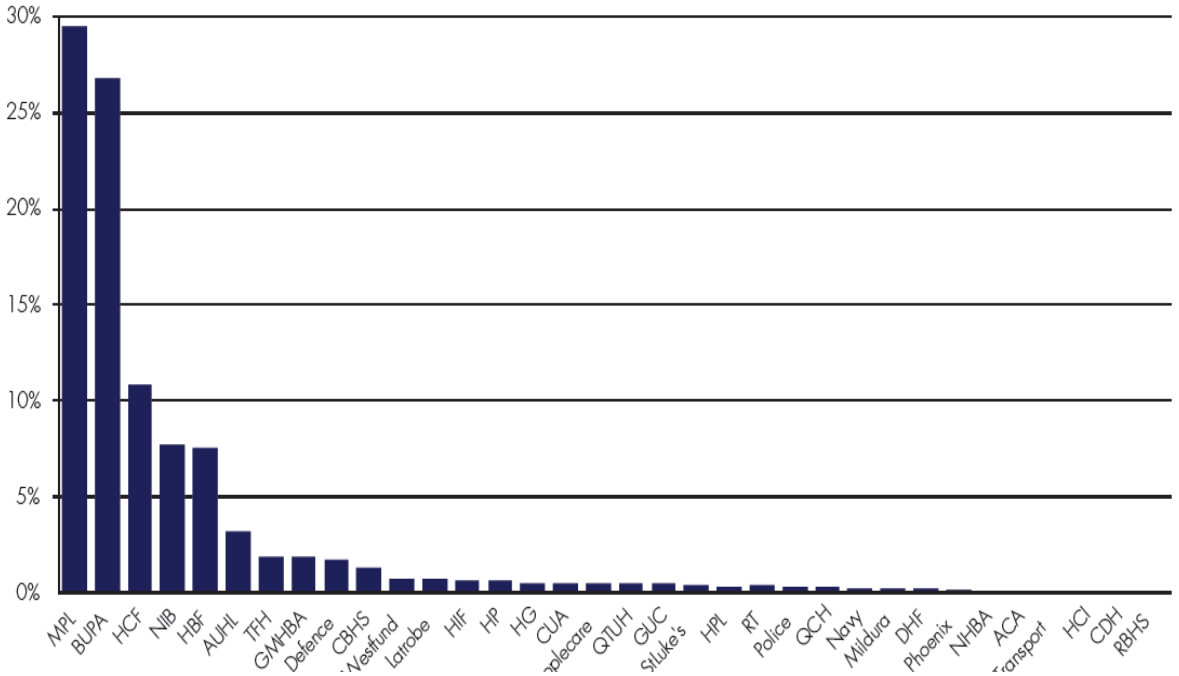
[36] See newspaper coverage of Ms Ley's remarks to the National Press Club in October 2015: *Sydney Morning Herald*, "Health Minister Sussan Ley attacks 'junk' private health insurance", 29 October 2015.

[37] Parnell, S, "'Basic Bronze' idea to cut health premiums", *The Australian*, 1 May 2017.

[38] *health.com.au* entered the industry in 2009, but despite running a low cost, web-based model was unable to find a substantial foothold in what is undoubtedly a very mature market in Australia. The fund was sold to the Geelong-based insurer GMHBA in July 2015. No policy-holders suffered any detriment in the transfer, although investors in the holding company certainly did: B Butler, "NIA investors burnt as fund sells health.com.au to GMHBA", *The Australian*, 28 July 2015.

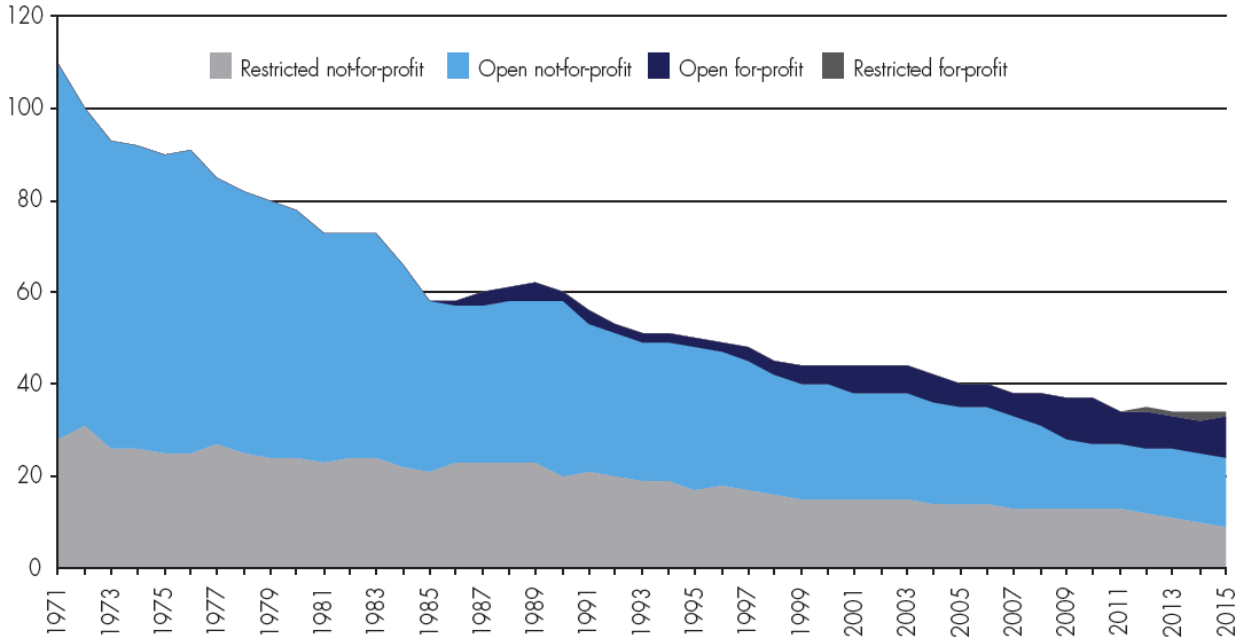
[39] E Johnston, "NIB quits its latest attempt at takeover", *Sydney Morning Herald*, 9 December 2010.

13. Market share of individual insurers by total policies in Australia, June 2014



The chart below shows the consolidation that has taken place in the industry over the last 45 years and confirms that, in the last decade at least, the pace of amalgamation has been very slow indeed. With the possible exception of the two ASX listed insurers (Medibank Private and nib) who are both subject to the normal rules for listed entities, that is likely to remain the situation for the foreseeable future.

11. Number of health insurers 1971-2015(a)

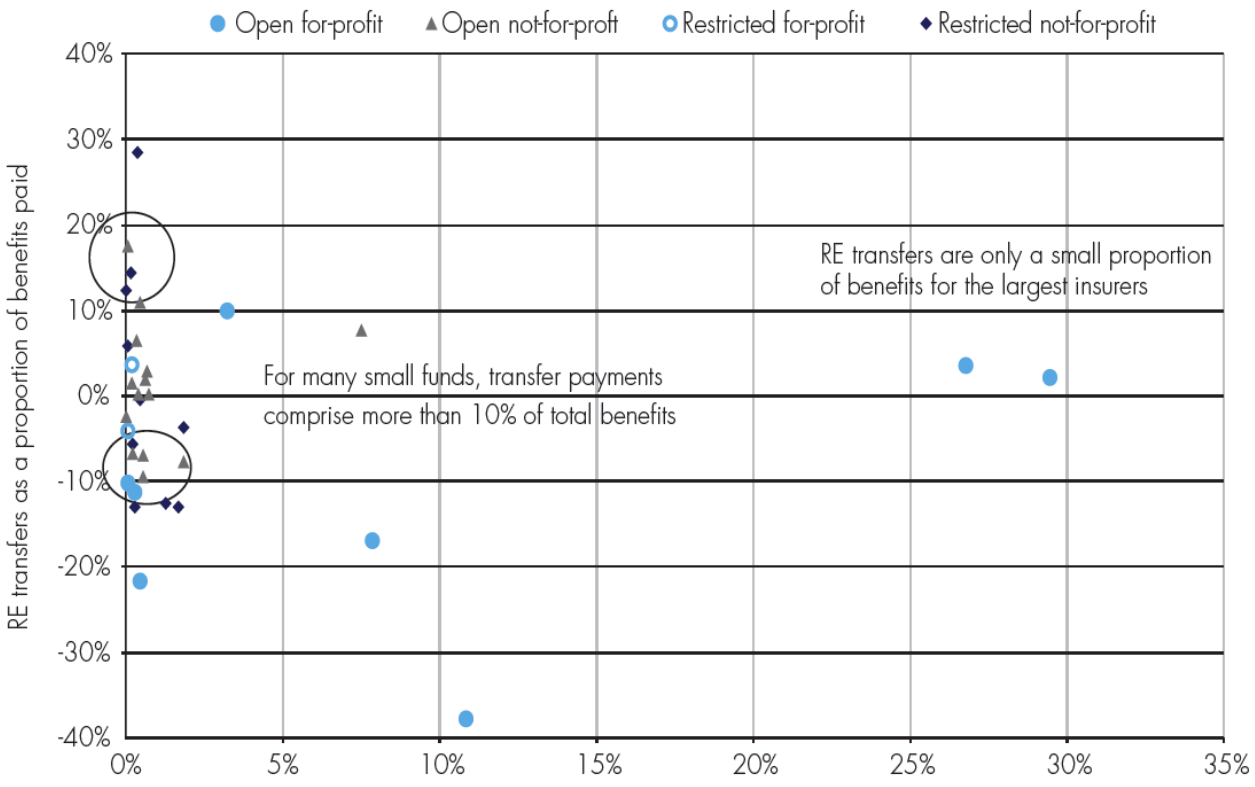


(iv) Risk Equalisation

Another unusual feature of the Australian system of private health insurance – and a source of frustration to many within the industry – is the centrality of a process of risk equalisation (**RE**). The scheme, which is administered by the regulator, APRA, provides that *all* claims paid to contributors over the age of 55[40] together with certain expensive claims from younger members are to be pooled and shared proportionally across the industry. The scheme supports the "community rating" principle that is a fundamental feature of PHI in Australia. Under community rating, insurers are prevented from risk rating individual members for factors such as age and disease profile. Also, subject to a maximum waiting period of 12 months, no insurer can refuse cover on the grounds of a pre-existing condition.

Risk equalisation, and the rules that govern it, is a highly contentious issue within the PHI industry. As the chart below shows, some insurers – due to the demographic profile of their membership – are reliably "contributors" to the risk equalisation pool while others are reliably "recipients". For some of the smaller funds RE transfer payments can amount to 10 per cent of benefits. The larger funds are less volatile although they can fall on either side of the "receive/contribute line" depending on experience in a given quarter.

10. Net risk equalisation transfers as proportion of benefits paid, by market share 2013-14

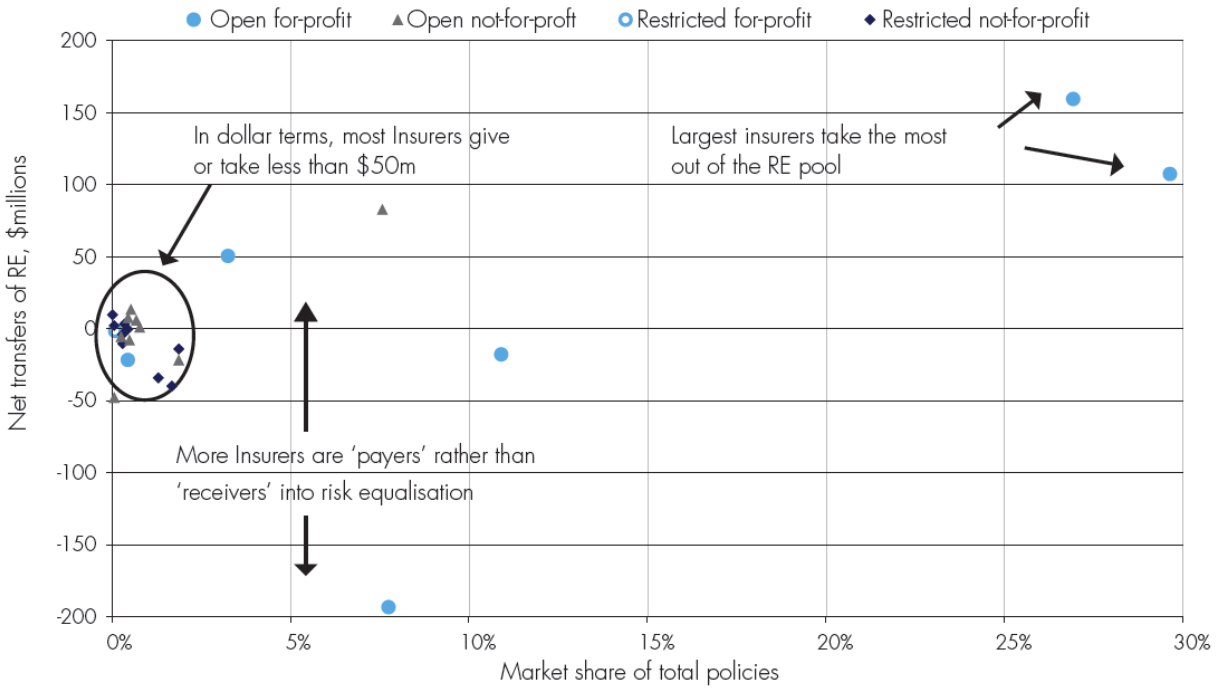


The value of claims subject to risk equalisation processes has grown significantly in recent years and has become an increasing source of frustration to more "entrepreneurial" funds due to the tendency of RE payments to erode profit or market advantage. Others argue, with some legitimacy, that it is a

[40] On a staged scale, starting at 15 per cent of the value of the claim for contributors between 55 and 59 and stepping up gradually until it reaches 82 per cent for claimants over 85 years.

necessary adjunct to their fund's willingness to more openly court potential members from groups who are likely to require medical treatment and that ultimately all costs must be fairly borne within, and across, the industry.

9. Net risk equalisation transfers, by market share 2013-14



Changes in the demographic mix, and particularly changes in life expectancy have led to calls for the rules of RE to be revisited.[41] Strong arguments are put that the starting age for RE purposes should be increased to at least 60. Equally strong arguments, however, are made that such a fundamental change to the risk profile of many smaller funds, if implemented quickly, would be prudentially risky.

The government has been generally loath to enter into this highly technical and very contentious debate. This reluctance is understandable when it is recalled that for the most part, an "industry position" has been impossible to ascertain. That said, it is perhaps noteworthy that last year Mr Rob Bransby, the President of the largest industry association, Private Healthcare Australia, wrote, in the *Australian Financial Review*:[42]

> […] At present, reinsurance arrangements mean that a large portion of the benefit of any funds' efficiencies go to its competitors via the reinsurance pool. Changes to reinsurance arrangements so that they were prospective not retrospective would lead to very substantial innovation in disease management and preventive care programs. Retrospective payments are determined by past admissions to hospital, effectively incentivising treatment in the most expensive setting of care. A prospective system would mean a member's risk of high claiming is assessed before they get sick, either on joining, or when they reach a certain age. The draw-down would be made on this basis, with the fund

[41] F Paolluci and Ors, "Risk equalisation and voluntary health insurance markets: The case of Australia", *Health Policy*, 2010, Nov; 98(1): 3-14

[42] R Bransby, "Five reforms to make private health insurance cheaper", *Australian Financial Review*, 30 May 2016. Mr Bransby has recently retired from his position as Managing Director of the Western Australian-based fund HBF, but at the time of writing, continues in the role of President of PHA.

incentivised to support preventive medical care to stop admissions to hospital caused by poor management of chronic disease.

Whether Mr Bransby's views will emerge as a proposal for reform supported by the majority of the industry remains to be seen.

(v) Premium setting

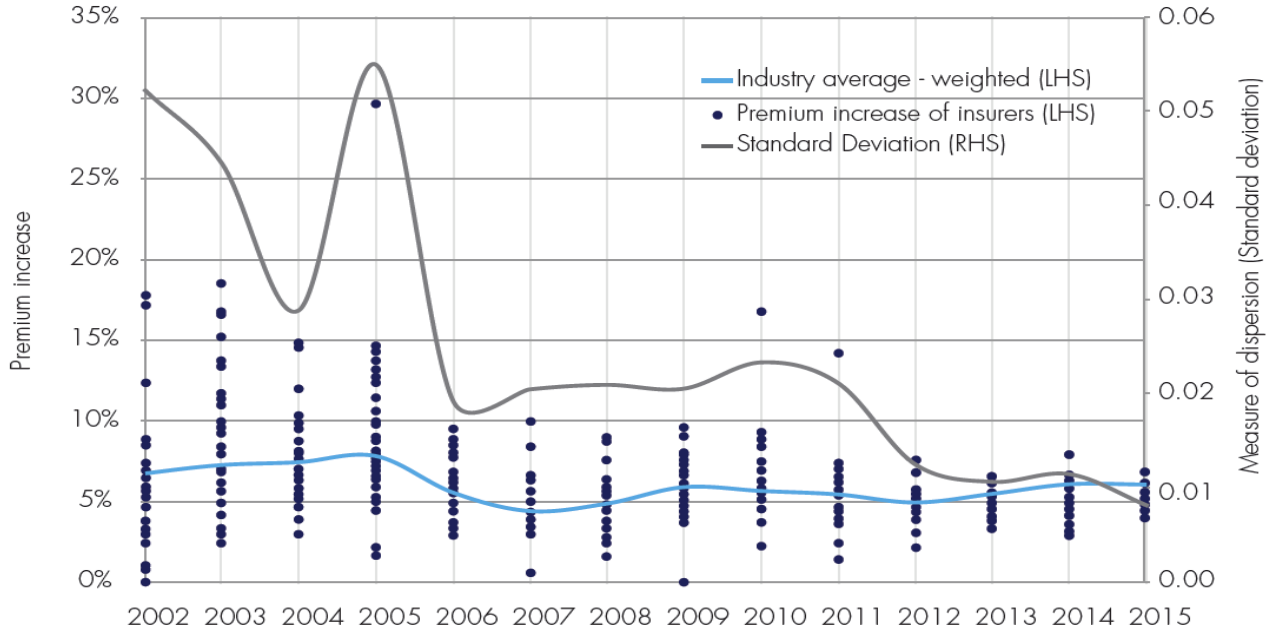
No single topic is more assured to generate heat and disagreement in the Australian PHI sector than the vexed issue of premium-setting.

For many years, the process of setting premiums was largely a matter left to the commercial judgment for the individual funds. That changed however when the Commonwealth began to pay a rebate of 30 per cent to assist contributors to defray the cost of PHI. At that point, the Department of Finance took a significant interest in the premium process with the result that, since the late 1990s there has been a lot more formality.

As noted earlier, the period 2000 to 2002 was a difficult time for the industry, not least because the minister of the day, Dr Michael Wooldridge – seeing the spike in revenue associated with the Lifetime Health Cover policy – decided for two consecutive years that the industry should get an effective 0 per cent increase. The entirely foreseeable result was that the industry experienced a critical drop in capital when the wave of new contributors, having served their waiting periods, began to claim. A crisis in confidence in the premium setting process then ensued, with the process for 2002 being relocated, extraordinarily, into the Prime Minister's Office. Large "catch-up" increases were approved in 2002 to almost universal disapproval.

The rather spectacular gyrations that occurred throughout that period are captured in the following chart (as is the subsequent period of relative stability)

20. Distribution of approved premium increases since 2001



Fortunately, the premium setting process in recent years has not been quite so dramatic, but it has presented its fair share of challenges. The process now is governed by section 66-10 of the *Private Health Insurance Act 2007*, which relevantly states (emphasis added):

> **66-10 Minister's approval of premiums**
>
> (1) A private health insurer that proposes to change the premiums charged under a *complying health insurance product must apply to the Minister for approval of the change:
>
> (a) in the *approved form; and
>
> (b) at least 60 days before […] the change [takes] effect.
>
> (2) […]
>
> (3) The Minister *must*, by written instrument, *approve the proposed changed amount or amounts*, unless the Minister is satisfied that a change that would increase the amount or amounts *would be contrary to the public interest*.
>
> (4) […]

Unsurprisingly, the words in subsection (3) received a great deal of attention when the 2007 law was being drafted. There is little doubt that their purpose was to reflect a *compromise*, namely that insurers could reasonably *expect* that their application would be approved (the Minister "must" approve …) subject only to some quite exceptional event where a decision to approve would actually be "contrary to the public interest".[43]

In practice, however, ministers of both political persuasions continued to regard themselves as primarily responsible for an approval process where intense micro-scrutiny was applied to the applications (often with little transparency) with a view to approving the lowest increase prudentially acceptable.

This approach, which ran from the mid-2000s until 2012, caused significant disquiet in the industry which complained loudly about a process which it said was arbitrary and lacked any clarity as to its over-arching principles. Tellingly, the criticisms continued unabated notwithstanding the changes to the law and the deliberate decision, noted above, to write the legislation in a way which seemed to give rise to an expectation that an application would be approved as submitted.[44]

During this time, PHIAC played an essentially supporting role, providing officials of the Department of Health with a preliminary prudential analysis of the merits of individual applications with the "negotiating" role undertaken by officers of the Department at the behest of the Minister.

This changed in 2012, when PHIAC was given responsibility for preparing the entire advice to the Minister including material on whether, in PHIAC's view, there was anything about an application that raised "public interest" issues. PHIAC's approach, in contrast to earlier approaches, was to be generally supportive of industry applications provided it was satisfied that the insurer in question was subject to adequate competition in the market. In other words, PHIAC promoted the proposition

[43] A Biggs, "Private health insurance premium increases – An overview", *Background Note*, Parliamentary Library, 13 August 2009.

[44] An explanation for this may have been that while the new PHI Act 2007, with its new premium-setting arrangements, was enacted while the Coalition government was in power, the first time the provisions were used was under a Labor Government (with Ms Nicola Roxon as the health minister). Given that the new government had not been party to the earlier discussions regarding the new s66-10 procedure, they may not have felt bound to comply with them in the same way.

that the price for PHI should as far as possible be *set by the market*.[45] This approach was broadly welcomed by the industry as restoring a degree of predictability. Also, PHIAC began sharing all its analysis with the relevant funds so that there was a great deal of transparency about the matter. This openness promoted a much more productive environment for communication with the practice of "ambit claiming" largely dying out. As a result, increases tending to concentrate within a relatively narrow range (see the chart above for the 2015 results).

Following its abolition, important parts of the premium setting process have reverted to the Department of Health with PHIAC's successor, APRA, confining its involvement to mostly prudential matters.

The process continues to evolve, with the process over the last two years involving much more direct contact with the Minister for Health. While details of what occurred have remained private, it is clear that considerable discussion on both occasions has surrounded a proposal by the relevant ministers to secure savings by restructuring the Prosthesis List with an expectation that those savings would be provided to insurers as soon as the revision was completed. Most insurers, appear, however to have baulked at the Minister's offer of a lesser increase in return for what was essentially an IOU. In the event an increase within the normal range of recent experience has been announced in both of the relevant years.

At the time of writing, only relatively minor adjustments have so far been announced to prices set by the Government under the Prosthesis List.[46]

(vi) Member retention

Despite regular references to an "exodus" of members leaving PHI, the retention arrangements in the sector remain broadly satisfactory. As noted earlier, coverage as a percentage of the population has remained quite stable over the last 15 years, notwithstanding events such as the Global Financial Crisis. Policy settings designed to encourage membership and promote retention continue to play a very important role in that context. This is confirmed by the fact that the most important age entry point into the industry continues to be 31 which corresponds with the commencement of the Lifetime Health Cover arrangements. Medicare Levy Surcharge (additional tax liabilities for higher income earners) also play an important role.[47]

The table below reveals that restricted insurers tend to be better at retaining members. This might be because the funds in question tend to be smaller and based around a community of interest (e.g. a profession such as teaching, or an industry, such as defence, or a sector such as transport). Most of the large insurers expend considerable resources to retain members considering leaving their fund.

[45] For more information about PHIAC's approach to preparing advice for the Minister for Health see S Gath, "2014 Premium Round – PHIAC's Role", 6 November 2013 at http://apra.gov.au/PHI/PHIAC-Archive/Documents/2014-Premium-Round-PHIACs-role-pptx.pptx.

[46] This is, of course, a topic with which the Committee is very familiar following its recent enquiry and report: Senate Community Affairs References Committee, *Price regulation associated with the Prostheses List Framework*, May 2017.

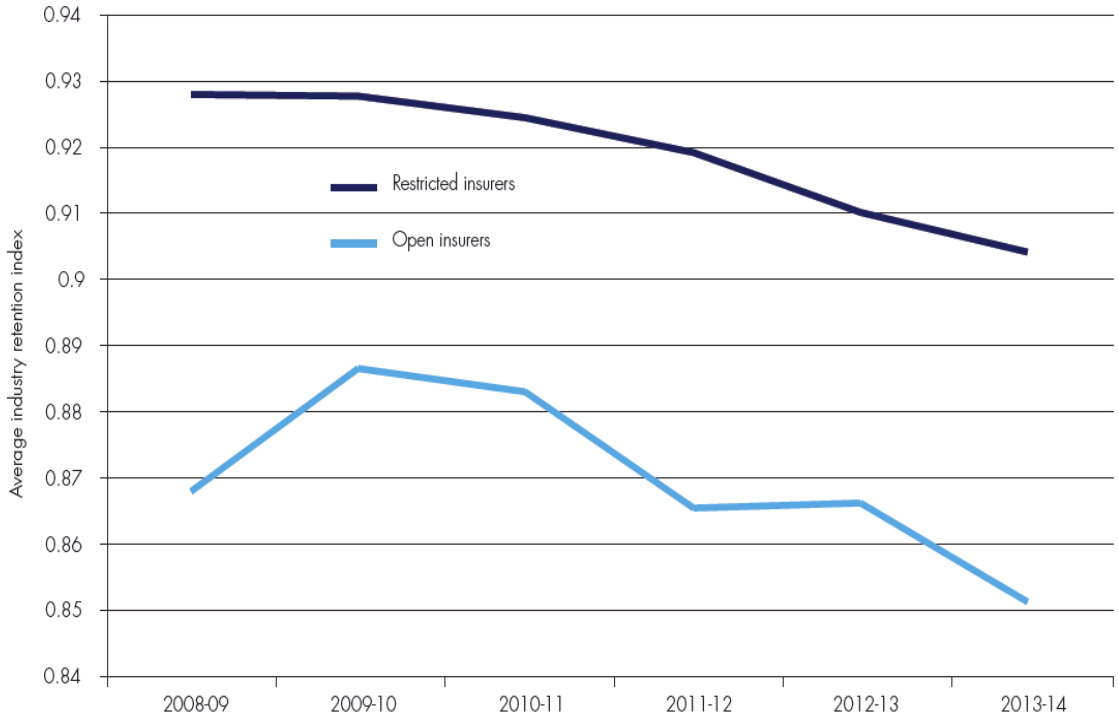
[47] It should be noted that after a period of annual indexation, the thresholds for the operation of that policy have now been frozen, with both political parties agreeing to retention of the "freeze". The effect of this decision will be that, as wages increase with inflation, more people will become subject to the MLS surcharge.

However, where the member has decided to pursue a better offer elsewhere, portability rules exist to encourage and support what, in my view, is fundamentally healthy competitive conduct.[48]

As has been noted several times, the absence of competition in the sector is, however, a continuing problem and misguided disparagement of member value-searching as "churn" – when it is actually a rational act of "shopping around" – is detrimental to improving competition.

As CEO of PHIAC, I rigidly avoided using the word "churn" and discouraged its use by others both in the industry and elsewhere (including, with respect, members of this committee). That continues to be my strong view.[49]

30. Restricted insurers achieve greater member retention



(vii) Contracting and third-party issues

Cost inputs are, in the final analysis, the key driver of private health insurance premiums. The principal costs feeding into hospital products are:

- Hospitalisation service costs (including accommodation, meals, theatre fees, nursing care, medicine, disposables)
- Medical service costs for services provided by authorised medical specialists (surgical, anaesthetic, pathology and related diagnostic)
- Pharmaceutical costs
- Prosthesis costs and
- The insurer's own administration costs including the cost of administering claims.

[48] S Gath, "Private health insurance may be broken, but it can be fixed", *The Australian*, 18 April 2016.

[49] S Gath, "Private health insurance may be broken, but it can be fixed", *The Australian*, 18 April 2016. Cf. E Greenblat, Health insurer Medibank Private hit by customer 'churn rate', *The Australian*, 21 February 2015.

All but the last of these costs (which in the case of PHI run in the range of 8 to 10 per cent of premiums – which is considerably less than other categories of insurance) attracts significant support from the Government through Medicare, but excesses over and above the Medicare payment are a matter of private agreement between an insurer and the relevant provider.

Research undertaken by PHIAC prior to its abolition examined the relative movement in these different cost inputs for typical private hospital admissions over the period between 2003 and 2014.[50] That research found a decline in the relative significance of the "hospital/accommodation" component of costs and an increase in medical and prostheses benefits.

The findings were summarised as follows:

Hospital accommodation, medical and prostheses benefits as a proportion of total hospital treatment benefits

	Hospital accommodation benefits	Medical benefits	Prostheses benefits
2003	73.6%	14.5%	11.9%
2008	70.0%	15.8%	14.2%
2014	69.8%	16.0%	14.1%

Although declining slightly over that period, this data underscores the continuing importance of hospital/accommodation input costs as a component of the overall benefits paid by insurers.

Unsurprisingly, given their significance, hospital costs have been a strong focus for quite aggressive cost management for most insurers over recent years. Indeed, Medibank Private's battles with the hospital groups Ramsey Health Care and the Little Company of Mary and Bupa's contract tussles with Healthscope and others have become the stuff of business page legend.[51]

Apart from providing great theatre, these intense contractual contests appear to have wrought what may be something of a "new normal" as far as hospital costs are concerned. After peaking at over 10 per cent, hospital services cost increases appear to have settled in the 2 to 3 per cent range.[52]

With further rounds in this ongoing "mongoose/cobra" relationship in prospect, it will be interesting to see whether this impression is confirmed. [53]

Medical services, although proportionally smaller, are another issue. These continue to grow at a rate far greater than the CPI with many doctors (particularly in specialties such as urology, orthopaedics, cosmetic surgery and others) largely unwilling to enter into meaningful gap arrangements with the

[50] Trends in Hospital Accommodation, Medical Services and Prostheses, *PHIAC Statistical Bulletin*, June 2015

[51] J Gardner, "Medibank does not understand medicine: AMA President Brian Owler", *Australian Financial Review*, 22 July 2015; Roger Montgomery, "Medibank warms up for the big dances in 2016", *rogermontgomery.com*, 16 July 2015.

[52] M Heffernan, "Medibank, Ramsey end feud over costs", *Sydney Morning Herald*, 29 August 2013.

[53] So-called "Tier 2" arrangements, which guarantee that hospitals that are unable to contract with funds will receive no less than 85 per cent of the amount paid to equivalent hospitals, will also be crucial. The arrangements have been opposed as anti-competitive by the insurers, but are a vital business safety net for many hospitals, particularly smaller and regional hospitals. As an example of an insurer's perspective, Medibank Private's views on the policy are set out in: Medibank Private, *Improving private health for consumers through transparency, affordability and value*, 4 December 2015.

insurers. Unchecked growth in this area has recently been described as the "real villain" in the PHI costs debate, with limited palatable solutions readily at hand.[54]

Terms of Reference

With that context in place, I wish to offer some views on the terms of reference for this inquiry.

(i) private and public hospital costs and the interaction between the private and public hospital systems including private patients in public hospitals and any impact on waiting lists;

This is not an area in which I claim any special expertise since issues like waiting lists in public hospitals were not part of PHIAC's supervisory functions.

A sub-issue within this TOR: "Public hospital only" products

That said, I am aware of the growing sense of frustration on the part of many insurers that what they regard as "cost-shifting" in the public/private domain has grown significantly in recent years.

A considerable part of the responsibility for the emergence of this issue – which is having a toxic impact on both public hospital finances and private health insurance premiums – lies with the current policy which has permitted the marketing and sale of "public hospital only" hospital insurance products.

Although I have considerable reservations about use of the term "junk" in any context,[55] if there is to be a segment of the market which can fairly so described then this is the one.

Such products are, by design, very cheap which makes them attractive to people who are primarily seeking to avoid paying the Medicare Levy Surcharge and/or the impact of Lifetime Health Cover

Beyond that, it is hard to understand the value such a product brings to the market for hospital services. Rather, it seems that the only outcome is the ignition of an unseemly contest between cash-strapped public hospital administrators and insurers aghast that they are, in effect, paying for funding shortfalls in the public hospital system.

Set out below is the Standard Information Statement provided for one such product sold under the brand name "Budget Direct" but in fact underwritten by GMHBA.[56]

The product is available for $160.43 for a couple per month. I have highlighted key components of the cover provided:

[54] S Parnell, "Doctor's Fees the 'real villain' for health insurance funds", *The Australian*, 18 April 2016.
[55] See above at page 13.
[56] Source: Privatehealth.gov.au

Private Health Insurance Standard Information Statement - Hospital Policy

This Statement provides basic information for the purposes of comparison only. For full explanation of this hospital policy please contact the health insurer on 1300 4 GMHBA (46422) or visit http://www.gmhba.com.au.

HEALTH INSURER:	GMHBA Limited	WHO IS COVERED:	Two adults
PRODUCT NAME:	Budget Direct Public Hospital	MONTHLY PREMIUM: #	$160.43 (before any rebate or loading)
AVAILABLE FOR:	Residents of NSW & ACT	MEDICARE LEVY SURCHARGE:	Exempt

You may be entitled to an Australian Government rebate on this premium. Your premium may include a Lifetime Health Cover loading and/or an insurer discount depending on your individual circumstances. Check with your insurer for more details.

WHAT'S COVERED IF I HAVE TO GO TO HOSPITAL?	✓ Hospital treatment, including accommodation as a private patient in a shared room in a public hospital only ✓ Doctors' bills in hospital (see below) ✓ Partial cover for ambulance (see insurer for details) - 0 day waiting period applies
WHAT SERVICES ARE NOT COVERED AT ALL? (Exclusions)	✗ Dialysis for chronic renal failure ✗ Gastric banding and related services ✗ Hospital treatment for which Medicare pays no benefit eg most cosmetic surgery
WHAT SERVICES ARE ONLY COVERED TO A LIMITED EXTENT? (Restrictions, Benefit Limitation Periods)	*No restrictions or benefit limitation periods*
HOW LONG ARE THE WAITING PERIODS FOR NEW AND UPGRADING MEMBERS?	• 2 months for palliative care, rehabilitation and psychiatric treatment • 12 months for treatments relating to other pre-existing ailments • 12 months for obstetric treatments • 2 months for all other treatments
WILL I HAVE TO PAY ANYTHING IF I GO TO HOSPITAL? (Excesses, Co-payments, Medical/Hospital gaps)	EXCESS: You will have to pay an excess of $450 per admission. This is limited to a maximum of $450 per person and $900 per policy per year. EXTRA COST PER DAY (CO-PAYMENTS): No co-payments DOCTORS' AND HOSPITAL BILLS: 7 out of 10 medical services paid for by this health insurer in NSW & ACT have no out-of-pocket expenses. This insurer also has arrangements that may mean lower out-of-pocket expenses on doctors' bills. You may also have to pay other costs depending upon: • the doctor(s) chosen • the treatment you are having • the hospital you go to **Before you go to hospital, you should ask your doctor, hospital and health insurer about any out-of-pocket costs that may apply to you.**
WHAT OTHER FEATURES DOES THIS POLICY HAVE?	Fast online sign-up with no forms, plus a secure online member area where you can lodge claims, change cover and read messages. Budget Direct Health Insurance is brought to you by GMHBA Ltd. Ambulance cover is emergency only. Excludes insulin pumps. Visit health.budgetdirect.com.au for more info.

As can be seen, this product only applies to "accommodation as a private patient in shared room *in a public hospital*". Apart from this, virtually every other kind of cover is excluded.

In my submission, such products – which really do more than cover what Australians already have under Medicare – are a carefully targeted attempt by the PHI sector to generate premium revenue without much claiming risk. Ostensibly this objective is attained by two measures:

The **first** is through careful pricing of the premium by reference to the Medicare Levy Surcharge (**MLS**), as follows:

Minimum couple's income to be subject to MLS x **1 percent**, viz:

$180,000 x 1% = $1,800 per annum or $150 per month

Thus, for a cost of, effectively, $10 a month, a couple on the MLS threshold can insure themselves for a very basic level of health cover when the alternative would be to make a straight tax payment to the government and gain nothing of direct value to themselves.

Where the couple is earning somewhat more (and the rate of MLS increases to 1.25% and even 1.5%), the value of the decision is all the more apparent:

$210,000 x 1.25 = $2,625 per annum or $219 per month

$280,000 x 1.5 = $4,200 per annum or $350 per month.

In these latter examples, the contributor can in effect save a considerable sum of money by comparison to their tax position if they were instead to pay the Medicare Levy Surcharge.

The **second** is by imposing an excess of $450 per admission which is designed to be a disincentive to actual claiming. The rationale here is that, faced with the actual out of pocket cost associated with their admission as private patients, most people will make the economically rational decision to instead seek admission as a public patient, since in virtually every other respect their experience in hospital is likely to the same.

As one fund has pointed out in an FAQ document for its members:[57]

> **Won't I get better treatment though if I am admitted as a Private Patient (i.e. electing to use my Private Health Insurance) in a Public Hospital?**
>
> If you choose to use your private health insurance when admitted to a public hospital, in most cases this will not grant you any better or special medical treatment.
>
> In public hospitals, private rooms are generally allocated to people who medically need them the most. So, while you can request a private room as a private patient, you may not always be allocated one depending on availability. The hospital may also transfer you from a private room to a shared room during your stay if another patient needs the private room more. You also have the option to use your doctor of choice, should you be admitted privately in a public hospital, however depending on your illness or condition and the size of the hospital, this may be the same doctor who would have been allocated to you by the hospital as a public patient.
>
> It should also be noted that should you elect to use your Health insurance in a public hospital, that there may be costs for you to pay (that would have originally been covered for free under Medicare without the use of your Health Insurance) including excess payments, and additional out of pocket charges that your doctor may charge for your treatment.

The problem with this thinking is that it is now apparent that, in many instances at the time of admission, public hospitals are now offering to pay the pay the patient's excess and/or other expenses. Removal of this financial disincentive obviously alters the balance and many privately

[57] Phoenix Health Fund, "Using your Health Insurance in a Public Hospital – Is it worth it?", https://www.phoenixhealthfund.com.au/public_hospital_private_patient/

insured patients are now, it seems, prepared to enter private hospitals as private patients, despite the marginal benefits in so doing.[58]

On the other side of the ledger, having sold such products and pocketed the premium revenue, it rings a bit hollow when insurers complain that their members avail themselves (admittedly usually at the urging of a public hospital admissions officer) of the very product they have purchased in the precisely limited circumstances in which it is intended to be used.[59]

The central truth is, perhaps, that such products are not an edifying experience for anyone participating in this industry.

In my view, in a perfect world, the better option would be to regulate against "public hospital only" products, but it is highly likely that such a decision would come at a cost to other private health insurance contributors, as there would likely need to be a one-off premium adjustment to reflect the altered risk profile of the industry.

The Committee should seek actuarial advice as to the premium consequences of such a regulatory change.

(ii) the effect of co-payments and medical gaps on financial and health outcomes;

As this committee observed in 2014, the size and frequency of out-of-pocket payments have become areas of significant concern for Australian consumers of healthcare. [60]

In the private health insurance setting, these costs can arise in a number of ways including:

- **payments additional to the capped amount payable under ancillary (or general) policies**. These often arise in the context of dental treatment or optical services. In order to control expenses, in these types of policies, insurers impose a cap (whether on a per service, or annual basis) to ensure that costs incurred cannot exceed a predetermined amount. This means that purchases which exceed the insurer's cap – which can be substantial, depending on the extent of cover – must be paid for out of pocket by the consumer.[61]
- some **costs associated with hospitalisation regarded as "additional" to the core service provided**. Such costs may include services such as television, other media, access to Wi-Fi, phone calls etc. These costs are generally not significant but can be the cause of irritation and complaint.[62]
- **some categories of prosthesis** which are classified as "gap-permitted" under the Prostheses List.[63]

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[58] J Medew, "Should you use your private health insurance in a public hospital?", *The Age*, 5 March 2016.

[59] SJ Tasker, "Private health insurance patients failed by public hospitals: survey", *The Australian*, 21 October 2016.

[60] Senate Community Affairs References Committee, *Out-of-pocket costs in Australian healthcare*, August 2014

[61] The topic of dental services and private health insurance has been recently extensively canvassed by the Radio National program, *Background Briefing*. Audio of the program is available at: http://www.abc.net.au/radionational/programs/backgroundbriefing/2017-07-02/8660142.

[62] The topic has been mentioned by the Private Health Insurance Ombudsman in various "State of the Health Funds" reports in recent years. See archive at http://www.ombudsman.gov.au/publications/state-of-the-health-funds-report. See also Consumers Health Forum submission to ACCC Senate Report 2011 at https://www.accc.gov.au/system/files/Consumers%20Health%20Forum%20of%20Australia.pdf and ACCC, *Information and Informed Decision-making*, ACCC Annual Report to the Australian Senate, 2014.

[63] *Private Health Insurance (Prostheses) Rules*.

- **Medical, including surgical, fees** which are in excess of the benefit provided by the insurer.

Of these, without discounting the importance for individual patients of each category described, the most important by far is the issue of out of pocket expenses for medical services. As noted above, BUPA has been active in this area for some time, publishing de-identified data from its claims record showing how much some medical providers are charging for various categories of services.

The full list, which is still available on the BUPA website,[64] is attached at **Appendix A**.

For present purposes, it suffices to note the "top ten" procedures as follows:

			1 Gap=0	2 Gap<=500	3 Gap=501-2000	4 Gap=2001-5000	5 Gap=5001-10000	6 Gap>10000
majSpecialty	majCm	Item Description	% Epsiodes	% Episodes	% Episodes	% Episodes	% Episodes	% Episodes
Orthopaedic Surgery	49519	Knee, Total Replacement Arthroplasty of (bilateral)	37%	13%	2%	39%	8.9%	0.0%
Urological Surgery	37210	Prostatectomy, Radical	17%	11%	8%	35%	28.0%	1.4%
Plastic	45520	Reduction Mammaplasty (Unilateral)	27%	6%	3%	33%	28.7%	1.9%
Orthopaedic Surgery	48424	Osteotomy Or Osteectomy Of Femur Or Pelvic Bone	36%	21%	14%	29%	0.6%	0.0%
Orthopaedic Surgery	48918	Shoulder, Total Replacement Arthroplasty Of,	50%	16%	4%	29%	0.8%	0.0%
Neurosurgery	40301	Intervertebral Disc or discs, descectomy	35%	33%	4%	26%	1.4%	0.1%
Orthopaedic Surgery	49318	Hip, Total Replacement Arthroplasty of	60%	10%	5%	25%	0.3%	0.0%
Orthopaedic Surgery	49542	Knee, Reconstructive Surgery of	56%	11%	8%	24%	0.1%	0.0%
Urological Surgery	37211	Prostatectomy, Radical & pelvic lymphadenectomy	26%	10%	7%	23%	29.7%	3.2%
Orthopaedic Surgery	49518	Knee, Total Replacement Arthroplasty of	63%	10%	6%	20%	0.5%	0.0%

Thus, according to BUPA:

- **48% of knee replacement** procedures attract out of pocket expenses of $2,000 or more (with 9% over $5000)
- **55% of radical prostatectomies** attract out of pocket expenses of $2000 or more (with almost 30 % over $5000)
- **54% of breast reduction** procedures attract out of pocket expenses of $2000 or more (with over 30% over $5000).

And, as can be seen, this experience is repeated for a range of orthopaedic, neurological and plastic reconstructive procedures. Nor is there any reason to believe that this experience of a major insurer is not being repeated across the private health insurance sector.

In my submission, these enormous out of pocket costs are nothing less than a monument to a failed market for the provision of such services. They should in my view, be the subject of direct and specific recommendations by this committee.

[64] https://www.bupa.com.au/staticfiles/BupaP3/AboutBupaAustralia/MediaFiles/PDFs/Providers%20Charges%20by%20MajorSurgical_Nov14-Oct15.xlsx.

In an opinion piece, published in *The Australian* on 18 April 2016 (in the wake of the then most recent premium increases), I addressed this issue and made some suggestions for improvement:

Private health insurance may be broken, but it can be fixed

The three-day moral panic that passes for serious debate around our private health insurance system has come and gone again. Premium increases can do that to you. And obviously getting hit up for an extra 5, 6, or 7 percent is nobody's idea of fun.

Most of the media advice, by design, has a short shelf life. The issue will be back next year and the same games will play all over again.

So, here's a crazy idea… what if we actually did something to try and fix the problem?

But before rushing off, let's at least give PHI its due. It's been a pillar of our health system for over 150 years. Over that time lot of people in real need have been helped.

That remains true today.

So far so good.

Now there's a harder question: Are those services best value for money?

The answer, resoundingly, must be "no".

There are two burning reasons for this. The first is a failure of regulation; the second is a failure of competition.

With regulatory failure, don't be too quick to condemn the government (the current one or its predecessors). Our Constitution is the real villain here. In the 1946 referendum we gave the parliament power to make a range of social security payments, including hospital and medical benefits. But the section also stops the parliament from controlling what doctors charge.

So, one step in that direction and it's off to the High Court…

Competition failure, however, is another story. There's *plenty* of blame to go around. PHI is riddled with failed markets that hurt consumers and damage our economy.

It is no coincidence that ATO statistics show that 6 out of the 10 highest earning groups in Australia are medical proceduralists.

Competition in the referred medicine area is hopelessly weak. Most patients have neither the opportunity nor the inclination to challenge their GP on choice of specialist nor the venue for treatment. And even if they wanted to, the information they need is just not readily available.

So here are some suggestions:

- **Stop labelling compliant PHI products "junk".** Ever since Minister Ley used this term at the Press Club last year, you'd be hard pressed to find a PHI product that someone somewhere hasn't 'junked". This language not only degrades legitimate products, it also corrodes competition. And worst of all, it has opened the door to the medical industry to run a clever displacement strategy proffering their own views on which products are "junk" … judged – no surprises here – by whether doctors get paid enough. Meantime, who is asking the equally pertinent question: "Why are doctors charging so darn much in the first place?".
  If the government believes that insurers are deceiving consumers, then don't just complain, change the rules.

- **Stop referring disparagingly to 'churn' and catastrophizing the consequences of ordinary competition.** Consumers should be allowed to move from one product to another (including downsizing) without that event being the cause of national alarm. Indeed, the portability rules that allow policy holders to change funds without having to re-serve waiting periods are designed to *encourage* that very conduct. It's called competition. It's the activity that actually does put downward pressure on prices. Australia has over thirty insurers that are all very keen to have your business. You should shop around.

  Which brings me to…

- **Publicise and use the one website that is independent and provides reliable whole-of-industry information.** You may have your issues with Tony Abbott, but you should not deny him the role he played in setting up the website privatehealth.gov.au. This website, which is the envy of the world (trust me, I have asked), is an amazing consumer resource. Unlike any other comparison website, it contains information about *all* the products of *all* the funds. If you are prepared to do 30 minutes research, you will likely save a bundle**.** (And a bit of money to promote the site would do wonders too!)

- **Let the PHI funds become involved at an earlier stage in the selection of post-primary medical pathways.** Unlike their members, insurers know a *lot* about doctors and hospitals and can provide great information about where to get good, value for money treatment. Their presence would transform this torpid market.

  At present, however, this is a strict no-go. Medical industry lobbyists have been spooking politicians with the spectre of "managed care" for years. We hear dark comparisons to the "American system" with little regard to the basic differences that exist between the two countries (Medicare anyone?).

  Australians should reject this self-serving nonsense and let some competitive daylight into this crucial area. PHI funds could really help their members and the winners would be individual members … and the long-suffering premium-paying public.

Perhaps we could change next year's headlines. Or have they already been written?

The article makes the point – which remains fundamental to an understanding of this whole area – that the Commonwealth *has limited powers to make laws* controlling doctor's incomes. Indeed, it seems that any provision of that kind would be robustly opposed by the doctors and their lawyers (with, it must be conceded, reasonably good prospects of success).[65]

Because of this, doctors inhabit a very unusual – and constitutionally protected – safe harbour which is not available to any other profession or workforce in the country.

This also means that, where medical services are concerned, Australian consumers are peculiarly dependent upon the operation of *an effective market* to ensure that they obtain access to these crucial services at a fair price.

[65] See T Faunce, "Constitutional Limits on Federal Legislation Practically Compelling Medical Employment", (2009) 17 *Journal of Law and Medicine* 196.

One way to achieve this, I believe, would be to do as proposed in the article quoted above and permit the private health insurers to provide information about the range of potential providers and the fees they charge *before* they commence their journey into secondary and tertiary healthcare.

In this day and age, with modern technology it would relatively simple for a private health insurer, on becoming aware that a contributor was about to embark on a course of treatment – let us say, a breast reduction or removal procedure – for that insurer to provide their member with information about all the surgeons within, say, 20 kilometres of that person's doctor's practice, who provide that service and information about what those surgeons have historically charged and other relevant information such as infection rates. Such information would likely be extraordinarily valuable for the potential patient and could very well guide their decision as to where to seek treatment.

As things stand however, the scenario I have described is illegal because it is against the law for an insurer to be automatically informed that a member of theirs is about to receive treatment (or that it has been recommended). This is, I submit, highly damaging to competition and has led to the situation – as detailed in the BUPA statistics quoted above – where many proceduralists are, in effect, able to charge "what the market will bear' with virtually no competitive accountability for that pricing.

The parliament should change to the law to allow private health insurers to assist their contributors in this way.

(iii) private health insurance product design including product exclusions and benefit levels, including rebate consistency and public disclosure requirements;

Product design is a highly technical areas of private health insurance practice. There are complex and intersecting considerations to be taken into account when changes to products are being contemplated and it is generally unwise to enter this territory without the benefit of detailed actuarial advice.

I am not an actuary, so I will not be venturing into that analysis.

That said, I would offer a number of observations or principles which, in my view, should guide policy development in this area:

- **there are, generally speaking, too many products** many of which individually add little value to the PHI market and only contribute to consumer confusion.
- **products should generally be designed and priced so that they "pay for themselves".** I do not support the widespread practice of cross-subsidising across product groups. This ensures that consumers get for what they are paying for and are in a better position overall to compare "like for like" on the basis that the premium is an accurate reflection of the risk being insured;
- it would be desirable if **products were grouped in a way which assisted consumers to comparison shop** more efficiently. The proposal to introduce the concepts of "gold", "silver" and "bronze" is a worthy attempt in this direction, even if it has been unfortunately

made much harder to achieve than it should have been because of the former minister's unwise comments;[66]

- **I do not *per se* oppose the sale of products with exclusions and/or restrictions of various kinds**. It must be recalled that, because of policy settings such as the MLS and the Lifetime Health Cover, PHI is a "virtually mandatory" purchase for a significant proportion of the population. People who find themselves in this situation should be able to, at least, purchase products which are adapted to their personal circumstances. This means that if they want to buy a product with a large deductible and/or significant exclusions they should be at liberty to do so. The key – as pointed out in my first statement of principle – is that products at all levels should be priced in a way which ensures that the premium charged is a proper reflection of the insurance risk involved.

(iv) the use and sharing of membership and related health data;

The use of medical data or data related to the delivery of medical services is a fraught topic which has been considered at length on many previous occasions. Starting with the Australian Law Reform Commission's seminal reports on privacy,[67] and subsequent examinations of proposals such as the Electronic Personal Health Record, this is ground that has been thoroughly tilled.[68]

The topic continues to draw attention and interest, however, largely due to the challenges posed by changing technology and the internet. Public anxiety about unauthorised release of medical information is never far from the surface and, at the time of writing, has recently been stoked by the troubling news that information about Australian's Medicare cards are available to be purchased on the "dark web".[69]

That said, I have always subscribed to the view that privacy is a value to be promoted and supported *in contest with* equally important – and sometimes incompatible – communal values. It should not be elevated to the position of some absolute, the preservation of which can effectively cripple the pursuit of equally (or more important) social values.

What value is privacy to a person, say, when they are lying unconscious on a gurney in need of critical life-saving treatment and information about their allergies or susceptibilities is available at the click of a button? Should such an intervention be denied merely because the person forgot to fill out a consent form on some previous long-forgotten occasion? These are difficult questions which do not lend themselves to simple "yes" or "no" answers.

In my experience, proposals to increase the informational reach of private health insurers are assured of at least two strong responses:

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[66] See commentary above at page 13.

[67] Australian Law Reform Commission, *Privacy* (Report No 22), 1983; Australian Law Reform Commission, *For your information: Privacy Law and Practice* (Report No 108), 2006; Office of the Australian Information Commissioner, Fact Sheet: Privacy and your health information, 2015; Senate Community Affairs Committee, *Access to Medical Records*, Parliament of Australia, June 1997.

[68] Gath, S, *Electronic Health Records for Australia: Some Legal and Policy Issues*, Australian Government Information Office Discussion Paper 11, Future Challenges for E-government, 2002; Office of the Federal Privacy Commissioner, *Guidelines on Privacy in the Private Health Sector*, 2001; NSW Ministerial Advisory Committee on Privacy and Health Information 2000, Panacea or Placebo?: Linked Electronic Health Records and Improvements in Health Outcomes, Report to the NSW Minister for Health.

[69] ABC News, *Medicare card numbers 'being sold on dark web', Alan Tudge calls for AFP to investigate*, 3 July 2017. *http://www.abc.net.au/news/2017-07-04/tudge-calls-for-afp-to-investigate-medicare-card-numbers-dark-w/8676678*

- The **first is from consumer groups and privacy advocates** who are naturally suspicious of any measures that involve the accumulation of personal information. I have some sympathy for these concerns but, as noted above, I do not adhere to the view that privacy is some kind of *supremus inter omnes* value that cannot be displaced by an equally or more important consideration.
- The **second is from doctors' groups**, such as the Australian Medical Association, who can be relied upon to raise that longstanding professional shibboleth, "managed care". Over many years, doctors' groups have repeatedly opposed attempts to streamline or improved the efficiency of medical services on the ground that to do so would be a step in the direction of "US-style managed care". This is, of course, an absurd statement when it is recalled that Australia has a fully funded national health insurance system (Medicare) which means that our health financing arrangements will never remotely resemble those in operation in the United States. Nevertheless, the spectre of managed care has been an effective way to spook nervous politicians (and their constituents who, in the main, have little real idea what is even meant) so there is no reason to doubt that it will not continue to be employed. [70]

That said, I favour and would support measured proposals that would see membership and health related data being disseminated in ways which:

- enhance consumer understanding of PHI and their products with a view, in particular, to assisting them to switch to better value products when it is apparent that such products exist;
- improve the opportunities for consumers to make informed decisions about the form of cover they need and may need in the future;
- **as a key issue**, assist consumers to make better decisions about which medical service providers and hospitals they will use when they are on the cusp of a post-primary medical event (in particular, elective events).[71]

(v) the take-up rates of private health insurance, including as they relate to the Medicare levy surcharge and Lifetime Health Cover loading;

I have canvassed this issue in some detail above at pages 19 to 20.

There is no doubt, in my view, that both the MLS and the LHC policies have significantly contributed to growing and maintaining current levels of PHI membership in Australia. The little known (and even less-discussed) decision of the Government, announced at the recent budget, to

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[70] For a recent example of this type of rhetoric see Gannon, M, *Release of the Private Health Insurance Report Card*, April 2017 https://ama.com.au/media/release-ama-private-health-insurance-report-card-2017

[71] I note that similar suggestions have been made to – and found favour in – this committee before. For example, in its 2014 report on out of pocket expenses, the Committee quoted a submission from Bupa as follows:

> 5.44 Bupa Australia argued that increased transparency about hospital and specialist charges is fundamental to consumers having greater access to information:
>
> > From our point of view, getting a degree of transparency about how specialists and hospitals charge for things—and making that available to consumers—would be a significant step in the right direction. Given the amount of taxpayer and private health fund money that is tied up in this, we believe that is a completely reasonable ask. Many other organisations are required to divulge these things to the consumer. It would also allow us as an industry to do some of the things that we rightfully have responsibility to do. If transparency were available, we could develop software technology for our members, telling them in advance what the particular products, and the particular doctors they are wanting to see, might mean for them.

The Committee's view on this issue was (my emphasis):

> 5.49 Given that individuals with private health insurance often face large out of pocket costs and informed financial consent is often inadequate, better mechanisms are required to ensure patients are fully informed about treatment costs, *before initial treatment* as well as throughout any follow up treatment.

maintain the "freeze" on indexation of the MLS and LHC threshold levels will likewise continue to draw in members for PHI.[72]

There are various points of view on the future of growth in the PHI sector and it is a favourite topic of conversation amongst analysts now following the two listed PHI stocks, Medibank Private and NIB.

For my own part, I think the industry has now reached (or is very close to) a position of effective "saturation" where it should be regarded as fully mature and with limited growth opportunities in both the hospital and general tables.

While at PHIAC, I was privy to some interesting research on this topic which played a large part in shaping my views on this topic. As I stand now, I no longer have direct access to that research, but would be willing to share its substance with the committee if it is interested.

(vi) the relevance and consistency of standards, including those relating to informed financial consent for medical practitioners, private health insurance providers and private hospitals;

The fundamental problem with many standards in this area is not in their making, but in their enforcement.

Standards relating to the giving of informed financial consent have existed for over two decades,[73] but research continues to show that many medical practitioners either ignore the professional protocols or give them scant attention when dealing with their patients, often outsourcing the "difficult discussion" (such as it is) to their front office staff.[74]

Also, there is the very great pressure that patients feel when in the presence of their doctor to succumb compliantly to, often, very significant out of pocket expenses when – at the very moment they need it most – they have no meaningful information about how the relevant doctor's fees compare to others offering the same services.[75]

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[72] Australian Taxation Office, *Medicare levy surcharge and private health insurance rebate thresholds frozen*, https://www.ato.gov.au/General/New-legislation/In-detail/Direct-taxes/Income-tax-for-individuals/Medicare-levy-surcharge-and-private-health-insurance-rebate-thresholds-frozen/.

[73] Gath, S, "Enhanced Consumer Rights in Private Health Care: Have the 'Lawrence Amendments' Delivered?", *Journal of Law and Medicine*, (1999) Volume 6, 241.

[74] Ipsos – *Health Care and Insurance Australia 2015*, quoted in Private Healthcare Australia, *Submission to ACCC Senate Report on Private Health Insurance*, 2016 file:///C:/Users/shaun.gath/Downloads/Private%20Healthcare%20Australia.pdf. See also ACCC, *Report to the Senate in relation to PHI for the period 2007-08*. p 16-17

[75] The challenges of this situation are exemplified by the advice provided by the PHIO on managing medical fees. In their brochure, *Doctor's Bills*, the PHIO suggests that patient seek answers to the following questions:

- What are the MBS item numbers for the services the doctor is going to perform and what will be the charge for each of these services?
- Does the doctor participate in my health fund's gap cover scheme and will the doctor treat me under this arrangement?
- Will I incur any personal out-of-pocket costs and, if so, how much? (You may need to confirm this with your health fund.)
- Who are the other doctors treating me during the admission and how can I get an estimate of their fees?
- Will the doctor provide me with a written estimate of any costs I'll have to pay so I can consider this when agreeing to the treatment?
- How will the doctor bill me?
- When will I have to pay?

In its pamphlet, *Professions and the ACCC Act*, the ACCC confirms that the misleading conduct provisions of the Act do apply to the behaviour of doctors. It states:[76]

> **Misleading and deceptive conduct**
>
> Misleading and deceptive conduct—whether that conduct actually misleads clients or is merely likely to mislead them—is prohibited. Generally, this type of conduct involves leading someone into error, or being likely to, and includes behaviour such as:
>
> - lying
> - leading someone to a wrong conclusion
> - creating a false impression
> - leaving out (or hiding) important information
> - making false or inaccurate claims.
>
> It is irrelevant whether these are done intentionally or not. A business can break the rules by both deliberate and inadvertent actions.
>
> When advertising goods or services, professionals, like businesses, need to consider the overall impression that the advertisement gives the audience. It should be accurate and contain all essential information. The same applies when negotiating or dealing with clients directly, or in any other way. Any representations made by a professional must be accurate and able to be substantiated.

Arguably, subscribing to a professional code which espouses a significant and structured process of IFC, and then not actually doing anything at all, is a form of misleading conduct because at the least it "creates a false impression". Despite this, and notwithstanding occasional references to broader concerns about IFC,[77] I am not aware of any concerted effort on the part of the ACCC to enforce the law in this area.

Likewise, the Private Health Insurance Ombudsman (which is now part of the Commonwealth Ombudsman), has, over the years, reported "complaints" about this issue at various times, and has undertaken investigations. These have been confined, however, to the area of IFC when provided by a hospital, which now appears to be a diminishing area of concern. The PHIO has no direct supervisory role where private medical practitioners are consulting private patients.

For their part, doctors' professional associations communications in this area regularly return to the proposition that responsibility for raising and resolving these issues lies with substantially with the patient.[78]

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[76] ACCC, Professions and the Competition and Consumer Act, 2010, at p 18. https://www.accc.gov.au/system/files/Professions%20and%20the%20CCA.pdf

[77] ACCC, *Report to the Senate in relation to PHI for the period 2007-08*. p 16-17.

[78] It is interesting to observe the trend in this area. In 2006, the AMA's position statement of IFC included statements which cast a clear onus on doctors to initiate discussion about IFC including this: "The AMA fully supports the principle that patients should be asked to provide IFC prior to any inpatient medical treatment, including any elective and/or pre-planned procedures, wherever this is practicable." and this "The AMA's endorsement of this principle reflects the association's view that providing information to patients in advance of the likely financial implications of proposed treatment is sound ethical, professional and business practice. It indicates respect for individual patients and their rights, avoids negative perceptions of private medical practice, and makes it more likely that patients are willing and able to settle their accounts following treatment". Such statements no longer appear in the latest iteration of the AMA's position statement on IFC see: https://ama.com.au/position-statement/informed-financial-consent-2015. Rather doctors are responsible for ensuring "awareness" about fees and "encouraging discussion" (which may be done, on their behalf, by a staff member). At the same time patients are subject to a long list of potentially daunting shared or personal responsibilities.

(vii) medical services delivery methods, including health care in homes and other models;

[no submission].

(viii) the role and function of:

medical pricing schedules, including the Medicare Benefits Schedule, the Australian Medical Association fee schedule and private health insurers' fee schedules,

[no submission].

the Australian Prudential Regulation Authority (APRA) in regulating private health insurers, and

I do not have anything to say specifically about APRA and the way it is currently discharging its role as the PHI industry prudential regulator.

That said, and without reflecting on the current regulator, I do wish to register my disappointment that a number of the specific attributes which characterised the regulatory relationship between the Private Health Insurance Administration Council (PHIAC).and the industry have now largely been lost. Amongst these I include:

- a regulator governed by **an independent board** of highly qualified (finance, health, governance, law, etc) individuals with close connections to the business community around Australia. This governance structure ensured that PHIAC's important regulatory decisions were always deeply discussed, closely analysed and subjected to intense "real world" scrutiny;
- a **depth of staff expertise** built up over 26 years of regular and specialist interactions with the PHI Sector. Regrettably, now, two years after PHIAC was abolished, only a very few of these staff are still working for the incumbent. For the most part, the PHI sector expertise developed and nourished within PHIAC over those many years has been lost.[79]
- a **sense of "health sector awareness"** derived in significant part from the fact that PHIAC was located in the health portfolio. This meant that the agency reported to the health minister, it was interacted closely with the health department and other health sector agencies, and understood, in a profound way, one of the central truths of PHI, namely that while it might look like a financial product its real and enduring function is as a key pillar in the health sector.

In addition, PHIAC – because it was a specialist regulator – was able to do things that more generalist bodies struggle to do. Such as:

- Issuing a suite of research papers examining specific regulatory and competition issues in the private health insurance sector, these included:[80]
    - *Competition in the Australian Private Health Insurance Market* (RP 1)

[79] Only about three of the original staff of PHIAC are still engaged by APRA.

[80] These papers are available on the PHIAC Archive at http://www.apra.gov.au/PHI/PHIAC-Archive/Pages/Industry-Research.aspx and the National Library Archive at http://pandora.nla.gov.au/pan/146297/20150630-1527/phiac.gov.au/industry/phiacs-industry-research/index.html.

  - *Portability switching and competition in the Australian private health insurance market* (RP 2)
  - *Barriers to entry in the Australian private health insurance market* (RP 3)
  - *Risk sharing in the Australian private health insurance market* (RP 4)
- Redesigning the capital standards for the industry with a focus on what was best for the PHI sector and not necessarily what might be termed a broader "finance sector" cookie cutter.
- Developing a new approach to advising the minister on the annual premium round that reflects both the legislation and the reasonable expectations of stakeholders, including consumers.

I reflected on these issues and others in an address I gave to the Health Insurance Restricted and Regional Membership Association of Australia (HIRMAA), in May 2015 shortly before PHIAC was wound up. That address is attached at **Appendix B**.[81]

the Department of Health and the Private Health Insurance Ombudsman in regulating private health insurers and private hospital operators;

[no submission].

(ix) the current government incentives for private health;

See my commentary above at pages 19 to 20 and 32.

(x) the operation of relevant legislative and regulatory instruments; and

This TOR is far too broad for me to comment in any significant detail, so I will confine myself to a few high-level reflections.

Overall, in my view the legislation governing PHI – although it dates only to 2007 – is much too complex. That is not to deny that there are not complex issues in the sector, but the proliferation of rules and regulations is a lot to absorb, even for people who work full-time in the sector.

Because of this, in my experience, many – if not most– people operating in the PHI sector have a relatively imperfect understanding of the law governing PHI. Part of my role as CEO of PHIAC – particularly with, as I have, a legal background – was to assist in the continuing education of key participants in the PHI sector, in particular, senior executives, directors and those with a distinct, but statutory role to play in the sector notably actuaries and other finance professionals.

Moreover, there is, within the sector something of "disconnect" between the formal word of the law and the practice that has emerged. This, I believe, is because the legislation is rarely litigated or even subjected to legal audit. Two examples of what I mean will suffice:

- First, the premium round has – and continues to be -conducted in a manner which can only be described as a rough approximation of the requirements of section 66 of the PHI Act. This is not a partisan reflection, since the point I am making applies equally to both sides of politics, but there is no doubt that the words of that section were intended to give insurers a sense of assurance that their applications *would be approved*, unless there was something about them that justified an intervention "in the public interest". As I say earlier in this

[81] Also http://pandora.nla.gov.au/pan/146297/20150630-1527/phiac.gov.au/wp-content/uploads/2015/05/PHIAC-CEO-Address-to-HIRMAA-13-May-2015.pdf.

submission, that has – in fact – never been the case with ministers of both persuasions, taking a forensic and detailed interest in all applications. I am aware that legal challenges to this process have been considered on several occasions, but have not proceeded because of broader commercial considerations.

- In the case of the corporatisation of a "not for profit" fund – such as occurred with Medibank Private in 2009 – the regulator is required to go through a complex set of hoops to be satisfied that the circumstances did not give rise to some residual interest in the insurers members as holders of a mutual interest. The Council undertook this process several times, while I was CEO and always sought advice from eminent counsel – including engaging in a round seeking public submissions – notwithstanding that this measure was deeply unpopular with other parties interested in the outcome.

(xi) any other related matter.

In my view, everything that has preceded, merely serves to underscore my only specific recommendation, namely that the PHI sector is desperately in need of a full, well-resourced, and expert examination by the Productivity Commission.

The PHI sector has grown to consume about $23 billion in national resources. 55 percent of Australians are directly impacted as members of either the hospital or general insurance tables. Many more beyond that (doctors, dentists, physiotherapists, private hospital workers, shareholders, employees of the health funds) are also affected.

It is crucial both for the success of our health sector and our broader national well-being that this component of our economy operate as efficiently and successfully as possible.

To that end, my single, but strong, recommendation is as follows:

There should be a full and broad Productivity Commission inquiry into all aspects of the private health insurance sector forthwith. Such inquiry to examine, amongst other things:

- **whether PHI can and should be more integrated into the general health system;**
- **effectiveness and value for money of government rebates and other forms of non-financial support for participants in the industry (e.g. second-tier arrangements for private hospitals, prosthetics pricing and Lifetime Health Cover);**
- **the state of competition within the industry and barriers to better competition;**
- **the needs of consumers at all stages of the PHI cycle including access to reliable and timely information about premiums, preferred provider arrangements and alterations to coverage; and**
- **operation of the portability scheme.**

Shaun Gath
Principal, Narrabundah Partners
Canberra, 13 July 2017

Appendix A – Provider's Charging Pattern Information from BUPA

Providers' charging pattern by Gap Range (episodes discharge between 01/11/14 and 31/10/15)

*Gaps are based on the out-of-pocket for the patient recognising the fee charged minus the Medicare and Bupa contributions. The identified procedures are based on the collection of Commonwealth Medicare Benefits Schedule (CMBS) items that make up the admission where the major CMBS item is identified and stated above.

majSpecialty	majCmbs	Item Description	1 Gap=0 % Episodes	2 Gap<=500 % Episodes	3 Gap=501-2000 % Episodes	4 Gap=2001-5000 % Episodes	5 Gap=5001-10000 % Episodes	6 Gap>10000 % Episodes
Orthopaedic Surgery	49519	Knee, Total Replacement Arthroplasty of (bilateral)	37%	13%	2%	39%	8.9%	0.0%
Urological Surgery	37210	Prostatectomy, Radical	17%	11%	8%	35%	28.0%	1.4%
Plastic Recon/Hand/Amput	45520	Reduction Mammaplasty (Unilateral)	27%	6%	3%	33%	28.7%	1.9%
Orthopaedic Surgery	48424	Osteotomy Or Osteectomy Of Femur Or Pelvic Bone	36%	21%	14%	29%	0.6%	0.0%
Orthopaedic Surgery	48918	Shoulder, Total Replacement Arthroplasty Of,	50%	16%	4%	29%	0.8%	0.0%
Neurosurgery	40301	Intervertebral Disc or discs, descectomy	35%	33%	4%	26%	1.4%	0.1%
Orthopaedic Surgery	49318	Hip, Total Replacement Arthroplasty of	60%	10%	5%	25%	0.3%	0.0%
Orthopaedic Surgery	49542	Knee, Reconstructive Surgery of	56%	11%	8%	24%	0.1%	0.0%

Urological Surgery	37211	Prostatectomy, Radical & pelvic lymphadenectomy	26%	10%	7%	23%	29.7%	3.2%
Orthopaedic Surgery	49518	Knee, Total Replacement Arthroplasty of	63%	10%	6%	20%	0.5%	0.0%
Neurosurgery	40303	Laminecetomy, 1 level	32%	38%	3%	18%	7.2%	1.0%
Neurosurgery	40306	Laminecetomy, >1 level	29%	42%	4%	18%	7.3%	0.3%
Plastic Recon/Hand/Amput	45617	Reduction Of Upper Eyelid	42%	15%	26%	18%	0.4%	0.0%
Orthopaedic Surgery	49321	Hip, Total Replacement Arthroplasty of (bilateral)	60%	22%	4%	14%	0.2%	0.0%
Orthopaedic Surgery	49527	Knee, Total Replacement Arthroplasty of, Revision	66%	17%	2%	13%	0.5%	0.2%
Orthopaedic Surgery	48957	Shoulder, Arthroscopic Stabilisation of	44%	17%	25%	13%	0.3%	0.0%
Orthopaedic Surgery	49709	Ankle, Ligamentous Stabilisation of	31%	40%	16%	13%	0.0%	0.0%
ENT Surgery	41672	Nasal Septum, Reconstruction of	30%	36%	21%	13%	0.1%	0.1%
Orthopaedic Surgery	48960	Shoulder, Reconstruction Or Repair of	44%	17%	27%	12%	0.1%	0.0%
Neurosurgery	39712	Craniotomy For Removal Of Meningioma	37%	42%	2%	12%	6.1%	1.5%
Orthopaedic Surgery	48669	Spinal Fusion	22%	45%	2%	11%	16.2%	3.6%
Orthopaedic Surgery	49521	Knee, Total Replacement Arthroplasty of & major bone grafting	63%	23%	3%	10%	0.1%	0.0%

Gynaecological Surgery	35753	Laparoscopically hysterectomy	34%	36%	20%	10%	0.0%	0.0%
Gynaecological Surgery	35573	Anterior And Posterior Vaginal Compartment repair	41%	35%	14%	10%	0.1%	0.0%
Cardiothoracic Surgery	38503	Coronary Artery Bypass, 2 or more arterial grafts	48%	40%	1%	9%	2.2%	0.2%
Colorectal Surgery	32024	Rectum, Anterior Resection	55%	25%	11%	9%	0.2%	0.0%
Neurosurgery	39709	Craniotomy For Removal Of Glioma	39%	42%	2%	9%	6.6%	0.9%
Cardiothoracic Surgery	38488	Valve Replacement with prosthesis	56%	33%	2%	8%	1.2%	0.3%
Urological Surgery	37207	Prostate, Endoscopic Non-Contact laser abaltion	40%	36%	17%	7%	0.0%	0.0%
Orthopaedic Surgery	48951	Shoulder, Arthroscopic Division of ligament	51%	23%	19%	7%	0.1%	0.0%
Urological Surgery	37203	Prostatectomy, endoscopic	54%	25%	14%	6%	0.1%	0.0%
Orthopaedic Surgery	48651	Spine, Bone Graft to	22%	53%	2%	6%	10.7%	6.7%
Ophthalmic Surgery	42725	Vitrectomy	47%	38%	8%	6%	0.1%	0.0%
Plastic Recon/Hand/Amput	45003	Single Stage Local Myocutaneous Flap Repair	45%	32%	17%	6%	0.0%	0.0%
Plastic Recon/Hand/Amput	45623	Ptosis Of Eyelid (Unilateral), Correction of	53%	24%	17%	6%	0.4%	0.0%
Colorectal Surgery	32003	Large Intestine, Resection Of With Anastomosis	54%	29%	12%	6%	0.1%	0.0%

ENT Surgery	41671	Nasal Septum Resection of	33%	39%	22%	6%	0.1%	0.0%
General Surgery	30336	Lymph Nodes Of Axilla, Excision of	63%	15%	15%	6%	0.8%	0.0%
ENT Surgery	41737	Intranasal operation on sinus	42%	36%	16%	5%	0.1%	0.0%
Cardiothoracic Surgery	38500	Coronary Artery Bypass, 1 arterial graft	58%	35%	1%	5%	1.5%	0.0%
Ophthalmic Surgery	42641	Autoconjunctival Transplant	43%	30%	22%	5%	0.0%	0.0%
Gynaecological Surgery	35638	Complicated Operative Laparoscopy	47%	24%	25%	4%	0.1%	0.0%
Plastic Recon/Hand/Amput	45563	Neurovascular Island Flap,repair	54%	35%	5%	4%	0.9%	0.2%
Vascular Surgery	35309	Transluminal Stent Insertion	19%	68%	10%	3%	0.0%	0.0%
Vascular Surgery	35321	Peripheral Arterial Or Venous Catheterisation	10%	76%	11%	3%	0.0%	0.0%
General Surgery	30300	Sentinel Lymph Node Biopsy	62%	13%	21%	3%	0.8%	0.0%
Urological Surgery	36656	Pyeloscopy, Retrograde	24%	61%	12%	3%	0.0%	0.1%
General Surgery	30405	Ventral or incisional hernia repair requiring transposition	64%	24%	10%	2%	0.0%	0.0%
Cardiothoracic Surgery	38212	Cardiac Electrophysiological Study - 4 or more investigtaions	8%	89%	1%	2%	0.1%	0.1%
Vascular Surgery	35303	Transluminal Balloon Angioplasty Of Aortic Arch	19%	69%	10%	2%	0.0%	0.0%

Orthopaedic Surgery	49562	Knee, Arthroscopic Surgery of, & chondroplasty	60%	18%	21%	2%	0.0%	0.0%
Ophthalmic Surgery	42702	Lens Extraction And Insertion of artificial lens	61%	23%	14%	2%	0.0%	0.0%
Urological Surgery	36809	Ureteroscopy, Of One Ureter	31%	50%	17%	2%	0.0%	0.0%
Vascular Surgery	32508	Varicose Veins, Complete Dissection	44%	38%	16%	2%	0.0%	0.0%
Cardiothoracic Surgery	38306	Stent Insertion	9%	85%	5%	1%	0.0%	0.0%
General Surgery	30445	Laparoscopic Cholecystectomy	62%	25%	12%	1%	0.0%	0.0%
Plastic Recon/Hand/Amput	45442	Free Grafting	54%	38%	7%	1%	0.0%	0.0%
Orthopaedic Surgery	47519	Femur, Treatment of fracture	60%	30%	9%	1%	0.0%	0.0%
Cardiothoracic Surgery	38290	Ablation Of Arrhythmia Circuits Or Foci, 2 chambers	18%	80%	1%	1%	0.3%	0.0%
Gynaecological Surgery	35616	Endometrium, Endoscopic Examination of	49%	30%	21%	1%	0.0%	0.0%
General Surgery	31350	Benign Tumour, removal of	60%	23%	17%	1%	0.0%	0.0%
General Surgery	31512	Breast, Malignant Tumour, excision of	62%	15%	22%	1%	0.0%	0.0%
General Surgery	31000	Micrographically Controlled Serial Excision of skin tumour	51%	43%	6%	1%	0.0%	0.0%

Cardiothoracic Surgery	38246	Coronary Angiography, with catheterisation & followed by further catherters	13%	83%	3%	1%	0.1%	0.0%
Orthopaedic Surgery	49561	Knee, Arthroscopic Surgery of	64%	16%	19%	1%	0.0%	0.0%
ENT Surgery	41793	Romoval of tonsils and/or adenoids, >=12 years old	50%	29%	20%	1%	0.0%	0.0%
ENT Surgery	41789	Romoval of tonsils and/or adenoids, <12 years old	39%	35%	25%	1%	0.0%	0.0%
Plastic Recon/Hand/Amput	45203	Single Stage Local Flap, repair of 1 large defect	59%	29%	12%	1%	0.0%	0.0%
Gynaecological Surgery	35637	Laparoscopy	48%	36%	15%	1%	0.0%	0.0%
Urological Surgery	36845	Cystoscopy, With removal of multiple tumours	60%	31%	9%	1%	0.0%	0.0%
Cardiothoracic Surgery	38240	Coronary Angiography, with catheterisation & injection into graft	15%	82%	3%	0%	0.0%	0.0%
Plastic Recon/Hand/Amput	45206	Single Stage Local Flap, repair of 1 defect (eyelid, nose, lip, ear, etc)	53%	35%	11%	0%	0.0%	0.0%
Plastic Recon/Hand/Amput	45451	Free Full Thickness Graft	50%	37%	12%	0%	0.0%	0.0%
General Surgery	31255	Skin cancer removal, (nose,eyelid,lip,ear,etc) <=10mm	69%	27%	4%	0%	0.0%	0.0%

General Surgery	30609	Femoral Or Inguinal Hernia, Laparoscopic Repair of	39%	42%	19%	0%	0.0%	0.0%
Neurosurgery	39330	Neurolysis By Open Operation	33%	48%	19%	0%	0.0%	0.0%
Neurosurgery	39118	Percutaneous Neurotomy	47%	48%	5%	0%	0.0%	0.0%
Neurosurgery	39331	Carpal Tunnel Release	34%	46%	20%	0%	0.0%	0.0%
Cardiothoracic Surgery	38356	Insertion of dual chamber electrodes	14%	83%	3%	0%	0.0%	0.1%
Gynaecological Surgery	35647	Cervix, Large Loop Excision	58%	36%	5%	0%	0.0%	0.0%
Cardiothoracic Surgery	38287	Ablation Of Arrhythmia Circuit Or Focus, 1 chamber	18%	81%	1%	0%	0.1%	0.0%
Vascular Surgery	34527	Central Vein Catheterisation By Open Technique,	35%	62%	2%	0%	0.0%	0.0%
Obstetrics	16519	Management Of Labour And Delivery	94%	4%	2%	0%	0.0%	0.0%
Obstetrics	16522	Management Of Labour And Delivery (complicated)	63%	35%	1%	0%	0.0%	0.0%
General Surgery	31345	Lipoma, Removal of	70%	25%	5%	0%	0.0%	0.0%
ENT Surgery	41632	Insertion of tube for draiange of middle ear	34%	49%	17%	0%	0.0%	0.0%
General Surgery	30614	Femoral Or Inguinal Hernia, Repair of	53%	39%	8%	0%	0.0%	0.0%
Urological Surgery	36821	Cystoscopy With Dilatation/Insertion/	51%	41%	8%	0%	0.0%	0.0%
Urological Surgery	37219	Prostate Transrectal Needle Biopsy of	23%	58%	19%	0%	0.0%	0.0%

Gynaecological Surgery	35599	Stress Incontinence, Sling Operation for	47%	34%	20%	0%	0.0%	0.0%
General Surgery	30403	Ventral or incisional hernia repair	61%	31%	7%	0%	0.1%	0.0%
General Surgery	30084	Diagnostic Biopsy Of Bone Marrow	15%	83%	3%	0%	0.0%	0.0%
Neurosurgery	39000	Lumbar Puncture	45%	52%	3%	0%	0.0%	0.0%
Plastic Recon/Hand/Amput	45200	Single Stage Local Flap, repair of 1 small defect	56%	36%	7%	0%	0.0%	0.0%
General Surgery	31285	Skin cancer removal (other areas) >10mm	54%	43%	2%	0%	0.0%	0.0%
Vascular Surgery	34528	Central Vein Catheterisation By Percutaneous Technique	23%	73%	4%	0%	0.0%	0.0%
General Surgery	30023	Wound debridement	68%	26%	6%	0%	0.0%	0.0%
Urological Surgery	36833	Cystoscopy With Removal Of Ureteric Stent	74%	25%	0%	0%	0.0%	0.0%
ENT Surgery	41892	Bronchoscopy	66%	34%	0%	0%	0.0%	0.0%
General Surgery	31230	Tumour, surgical excision of (nose, eyelid, lip, ear, etc)	69%	28%	3%	0%	0.0%	0.0%
Neurosurgery	39013	Injection Under Image Intensification	38%	59%	3%	0%	0.0%	0.0%
Urological Surgery	37623	Vasotomy Or Vasectomy	64%	30%	6%	0%	0.0%	0.0%
Gynaecological Surgery	35633	Hysteroscopy With Uterine Adhesiolysis	53%	38%	9%	0%	0.0%	0.0%
General Surgery	30572	Laparoscopic Appendicectomy	72%	21%	7%	0%	0.0%	0.0%

Gynaecological Surgery	35630	Hysteroscopy, With Endometrial Biopsy	69%	28%	3%	0%	0.0%	0.0%
Cardiothoracic Surgery	38218	Coronary Angiography, with catheterisation	14%	85%	2%	0%	0.0%	0.0%
Colorectal Surgery	32090	Colonoscopy, examination beyond hepatic flexure	75%	24%	1%	0%	0.0%	0.0%
Colorectal Surgery	32093	Colonoscpy, plus removal of polyps	72%	26%	2%	0%	0.0%	0.0%
Colorectal Surgery	32084	Colonoscopy	66%	34%	0%	0%	0.0%	0.0%
Colorectal Surgery	32139	Haemorrhoidectomy	59%	30%	11%	0%	0.1%	0.0%
ENT Surgery	41819	Dilatation Of Stricture Of Upper Gastro-tract	64%	35%	1%	0%	0.0%	0.0%
General Surgery	30094	Diagnostic Percutaneous Aspiration Biopsy of deep organ	15%	80%	4%	0%	0.0%	0.0%
General Surgery	30473	Gastroscopy	78%	22%	0%	0%	0.0%	0.0%
General Surgery	30478	Gastroscopy with other minor procedure	76%	24%	1%	0%	0.0%	0.0%
General Surgery	30485	Endoscopic Sphincterotomy	64%	35%	2%	0%	0.0%	0.0%
General Surgery	30621	Umbilical, Epigastric Hernia, >10 years old	75%	16%	9%	0%	0.0%	0.0%
General Surgery	31235	Tumour, surgical excision of, <= 10mm (face, neck, etc)	78%	21%	2%	0%	0.0%	0.0%

General Surgery	31265	Skin cancer removal, (nose,eyelid,lip,ear,etc) >10mm	79%	19%	3%	0%	0.0%	0.0%
General Surgery	31270	Skin cancer removal (face,neck,etc), 10-20mm	61%	34%	5%	0%	0.0%	0.0%
General Surgery	31280	Skin cancer removal (other areas) <=10mm	80%	18%	1%	0%	0.0%	0.0%
Gynaecological Surgery	35643	Evacuation Of The Contents Of The Gravid Uterus by curettage	66%	31%	2%	0%	0.0%	0.0%
Ophthalmic Surgery	42738	Paracentesis Of Anterior Chamber Or Vitreous Cavity	51%	49%	0%	0%	0.0%	0.0%
Ophthalmic Surgery	42739	Paracentesis Ant Chamb Or Vitreous Cavity, requiring anaesthetic	54%	45%	0%	0%	0.0%	0.0%
Plastic Recon/Hand/Amput	46363	Tendon Sheath, Incision of	56%	36%	9%	0%	0.0%	0.0%
Urological Surgery	36812	Cystoscopy With Urethroscopy	53%	45%	2%	0%	0.0%	0.0%
Urological Surgery	36818	Cystoscopy With Imaging	52%	43%	5%	0%	0.0%	0.0%
Urological Surgery	36840	Cystoscopy, With removal of bladder tumour	53%	39%	8%	0%	0.0%	0.0%

Appendix B – Address to HIRMAA, 13 May 2015

Address to the Health Insurance Restricted and Regional Membership Association of Australia (hirmaa)

Shaun Gath, CEO, Private Health Insurance Administration Council
Realm Hotel, Canberra
13 May 2015

Valedictory(?) contemplations of an industry regulator

Good afternoon colleagues

Today I am going to diverge slightly from my usual practice at such events and deliver a more "prepared" address.

By my very rough reckoning, this is around the 23rd occasion that I have stood at this podium. It is entirely possible (although not assured) that this will be the last time I will speak to you in this capacity.

In so saying, I will admit that the passage of legislation through the current parliament is not a thing to be taken for granted, but it would, for me at least, be a shame if this important occasion were to pass without an attempt on my part to share with you some of the reflections – nay *contemplations* – I have garnered in discharging my current role.

I should say, at the outset, it has been an enormous privilege to be associated with the private health insurance industry these last seven years and, in particular, to occupy the very special position in that industry afforded to the CEO of PHIAC.

Did you know, in a fact little acknowledged but telling in its own way, that during PHIAC's, hitherto, 26 years of existence only three people have had that opportunity? Some of the old stagers (my apologies, if that description offends you!) will recall the first CEO, Mr Tony Coates, who was the Director of PHIAC from its inception in 1989 until 1996; many of you will of course remember my colourful and dynamic predecessor, Gayle Ginnane, who was CEO from 1996 until 2008; and then there is my time in the role, which as I have noted is just about to notch up seven years.

For a public sector agency that is, I think, a remarkable record of stability. I won't indulge in the obvious points of comparison, but they will be apparent to you.

Why is it, then, that people would choose to undertake this role and then, having assumed the mantle, stay on for such periods of time?

I think the answer is both obvious and complex.

The obvious answer is: because it is a worthwhile and important job.

I can speak for myself (and I strongly suspect my predecessors) when I say, never once in the last seven years did I wake up in the morning and feel that I was off to do "another day in the salt mine". Quite the contrary, I have greatly enjoyed the opportunity this position has afforded me:

- to work in a constantly evolving and ever-challenging environment (how often do we tell ourselves, PHI is many things, but it is never dull?);
- to get to know you all and many others who are not in this room today (at least a little and in many cases quite well);
- to understand and play a role in shaping the growth and development of an industry which is of central importance to the 11 million Australians who pay hard-earned cash every fortnight to secure the benefits they need and which you provide, and
- above all, to work with gifted and passionate people, my colleagues at PHIAC, who share my commitment to making the "PHI part" of our national health system work in the interests of all Australians.

In short, it has been a fantastic job which I have found very satisfying in many ways.

That would be enough you would think, but let me also reflect a little bit more on the "complex" side of things, which I mentioned a moment ago. When I think about this element, I believe it comes back to one essential distinguishing feature about PHIAC: it is a specialist *industry* regulator.

That regulatory model is obviously a little bit out of favour these days and let me be the first to say, I can readily understand the reasons why that might be so.

- First, there is the ever present risk of "capture". The risk that we might get too close to the entities we regulate and lose our dispassionate, objective capacity to "take the tough decisions" that regulating sometimes requires. A kind of regulatory "Stockholm syndrome" if you like … or wait, aren't we the jailers?
- Second, there is a legitimate concern that by being narrow-cast, a regulator might suffer the shortcomings of limited resources, limited staff and isolation so that they lose contact with best regulatory practice; and
- Third, there is a concern about cost. Single issue regulators require "all that administrative and corporate infrastructure" which adds indefensibly, in the eyes of some, to the cost burden born by the regulated.

You would expect to me to say, - and I won't disappoint you - that I feel that PHIAC has managed those risks well over the period of its operation. With perhaps one exception (pricing advice), I don't think we are objectively regarded as a "soft touch" even though, we have worked hard to build a regulatory stance based upon effective working relationships where problems are normally solved at two ends of a telephone rather than by a lawyer's letter. (And I will be coming back to the pricing issue in a minute or two). Nor do I think we have suffered meaningfully from being relatively small. On the contrary, PHIAC has recruited and retained some exceptional people who have committed deeply to knowing the industry and your individual businesses, while retaining broader connections to the wider regulatory world. Finally, where cost is concerned, PHIAC's administrative costs add about 60cents per person to the cost of an average $3, $4, or $5,000 premium. That ain't a lot to ensure that people are protected. Full stop on that issue.

On the other hand there are the advantages:

First and foremost, over the last 26 years we have come to know you and understand the industry deeply and intimately. As we all know, the Australian version of PHI is a highly idiosyncratic beast

with curiosities such as community rating, risk equalisation, taxation surcharges, rebates and membership incentives all interacting to form a cauldron of regulatory and commercial complexity. Like you, PHIAC navigates this shifting and challenging world on a daily basis to ensure that we understand your businesses, your strategies and your objectives in a very detailed way.

Second, like you and your own staff, our gaze is always fixed on the interests of your customers and those who will, at some time, become your customers. PHI is a mystery for many Australians – they really don't have the capacity or time to deeply understand the product yet they know the day will likely come when they will depend on it. And of course, very often that day is a day full of other stresses as well — illness, injury, psychiatric disturbance, the list goes on. That is the day when it is imperative that their PHI arrangements work seamlessly and effectively, meeting their needs and expectations without adding to their distress. I know you take that responsibility seriously. So do we.

Third, with our knowledge of the industry and the backing of our independent board, PHIAC has cultivated a regulatory attitude where we have largely eschewed the "cookie cutter" answer to regulatory issues and, instead, posed the more difficult question: what is the right regulatory response for *this* industry?

There have been many examples over the years, but the two instances that stand out in recent times are the approaches we have taken to industry capital and premium setting.

- In the case of the former, as you know, we have all been on a journey over the last three years as we have explored the meaning of risk and what it requires by way of capital provision *in the private health insurance sector*. We have, in so doing, actively invited you and your boards to think deeply about this issue, to discuss it and, ultimately, to own it. It has been a highly collaborative process: while we have provided the guidelines, you have provided the answers and, also, accepted the accountability for those outcomes within your own businesses. It has been a challenging, beguiling but ultimately rewarding process. And in the doing, a lazy $1.5billion in capital has been liberated from the box previously marked "Do not touch: statutory capital". Let me say it out loud, because sometimes we forget: that is a very large amount of money which is now available to you and your members (and, in some cases, shareholders) to use in ways which generate benefit for all of us. I am happy to be proved wrong, but I'm not sure another regulatory model would have produced that outcome.
- With the latter (premiums), in 2012 we inherited a process which captains of the industry were decrying as broken, lacking transparency and incompatible with proper commercial processes. When we were asked to do so, we accepted the task of being the minister's primary advisor with enthusiasm. In our view, that task matched up exactly with our broader statutory mandate: protecting consumers by promoting competition and ensuring the financial security of the industry. Since that first year we have completed the task two more times, and on each occasion without the need for anybody to go through the dreaded "resubmission" process! We have promoted an approach that stands squarely on the (I would have thought uncontroversial) proposition that prices are best set in markets, not by public servants. So the key and fundamental questions must be: is there a viable market for these products? Do consumers have a good range of price and choice? Do providers feel market pressure to adjust products and prices? Our answers to those questions were set

out in our 2013 paper *Competition in the Australian PHI Market*. That research provided us, and the Minister, with an evidence base and a benchmark which has enabled us to develop a significantly deregulated model of premium-setting. Of course, in a process which last year increased premium revenue by around $1.3 billion (with taxpayers contributing significantly through the PHI rebate), we still look at the drivers of cost to ensure that benefit growth projections are credible and defensible. That component is rigorous, as it should be. But we have seen a remarkable turnaround which has liberated the conversation between government and industry and largely removed the frustration and "positioning" behaviours that previously surrounded the premium process. And let us also recall, PHIAC's steady and independent hand played a key role in addressing the perceived sovereign risk associated with price setting which was an early concern of analysts leading up to last year's very successful Medibank Private IPO. The very tangible benefits of that are now being counted in the Treasury. Again, those outcomes have, I would suggest, the hallmarks of a regulator which not only understands the prudential rules, but knows and understands the industry it is dealing with.

In concluding, I acknowledge that I have, perhaps, tooted my trumpet a little too loudly to suit everybody's ears. If so, I apologise, but I hope you will indulge me this time in this important industry forum. There may not be too many further occasions on which to do this.

PHIAC's legacy over 26 years will be, I think, an important reference point for the new generation of regulation and I sincerely wish Keith Chapman, Ian Laughlin and their APRA colleagues the best as they take up the baton. I know they will enjoy, as I have, the challenge and the experience of working with this very important industry.

Thank you

Shaun Gath
Canberra
14 May 2015

Appendix C

Narrabundah Partners

Consultants and Advisers

Shaun Gath
Principal

SHAUN GATH is the Principal of Narrabundah Partners, a consultancy specializing in the financial and regulatory aspects of private health insurance and the broader Australian health sector. NP's clients include merchant banks, hedge funds, investment houses and private equity firms.

Prior to NP, Shaun spent seven years as the CEO of PHIAC, the Australian government agency responsible for prudential regulation of the private health insurance industry. In that capacity he oversaw the financial soundness of a $22 billion industry. PHIAC operated for 26 years but was closed in 2015 following machinery of government changes made by the Coalition Government.

Shaun also has extensive experience as a senior lawyer working both as a partner in a major Australian law firm and as in-house general counsel in a large government enterprise. His time as a lawyer took him around Australia and the world and included work for the World Bank assisting in the legal redesign of health systems in post-communist economies. In his earlier career, Shaun worked as an adviser to an Australian government minister where he was involved in key changes to Australian consumer, privacy and corporations laws which continue in force today.

In his spare time, Shaun enjoys endurance cycling, swimming, and travelling to new and exotic places as often as circumstances allow. He lives in Australia's capital city Canberra with his wife and two children.

Education:
University of California, Berkley: Global Health Leadership Program
Massachusetts Institute of Technology: Sloan School Executive Management Program
Australian National University: Master of Laws
Australian National University: Bachelor of Laws (Honours)
Australian National University: Bachelor of Arts (Honours)

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