Bupa submission to the Productivity Commission's Productivity Inquiry

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Executive Summary

The Productivity Commission's (the Commission) review into Australia's productivity performance provides a timely opportunity to examine how high value and sustainable health care can be delivered to Australians by enhancing the contribution of private health insurance (PHI).

A report by the Evaluate economics consultancy for Bupa has found PHI contributes $61 billion each year to Australia's economic activity and contributes further to economic wellbeing by helping people remain healthy and productive. Critically, participation in private health care takes pressure off our increasingly under-pressure public health sector, so its resources can be directed to caring for those in most need.

Evaluate has identified a number of barriers that hamper the ability of PHIs to maximise productivity and the economic benefits that accrue, which are outlined further in this submission.

Bupa believes the consumer must be at the centre of reforms to make private health care more *simple, relevant and affordable*. Such reforms will deliver a more productive private health care sector that maximises overall public welfare.

Private health care journeys should be *simple*, addressing information asymmetries and empowering consumers to better navigate, understand and control their own health care through improved reporting, transparency and data sharing.

Greater *relevance* will be driven by enabling PHIs to cover more preventative and out of hospital care that reflects modern care delivery and the increase in chronic illness.

Affordability can be achieved through addressing waste and inefficiencies that drive unnecessary costs, dealing with out of pocket costs, and reforming price setting.

The COVID-19 pandemic has exposed significant structural flaws in Australia's health care system. The ageing of our population, together with increases in chronic illness and advances in technology will only exacerbate these pressures. A detailed examination of these matters by the Productivity Commission and part of its Productivity Inquiry can quantify the economic and community benefits of reform and provide policy makers with the imprimatur to progress it.

Introduction

In the first report on Australia's productivity performance, *Shifting the Dial* published in 2017, the first substantive chapter outlined the significant opportunities for improving productivity in our health system.

The challenges and opportunities identified are still relevant today with the COVID-19 pandemic acting like a spotlight, making the structural flaws in our system more obvious and more urgent to address. Reform is needed to meet Australia's changing health needs and the challenges posed by our ageing population, increasing chronic and complex disease and advances in clinical care.

Bupa recommends the Commission examine the role of PHI in the wider health care system and the interaction between the private and public sectors of the health care system as part of this inquiry. This area is ripe for productivity enhancing reforms that will boost economic growth as well as improve the health, wellbeing and living standards of Australians.

Indeed, the Commission recognised this and related issues such as the role of consumer choice across all of the health system in a section of *Shifting the Dial* titled 'Dollars on the pavement we have not yet picked up'.

Bupa commissioned Evaluate to examine the value of private health insurance, its contribution to keeping Australians healthy and gather data to better understand the factors affecting its productivity in Australia. The major findings of the Evaluate report will be covered in the following sections and we have included a full copy of the report in Appendix 1.

Private health is a major part of our health system and economy, contributing to better health outcomes

PHI contributes $61 billion to the Australian economy each year, which equates to 3.11% of our GDP, and adds to economic wellbeing by helping people remain healthy and productive. [1]

The Evaluate report notes that because the contribution of PHI to economic growth results from productivity effects not fiscal activity, the same or higher economic benefits are available at lower prices via a broader membership base or by removing waste and inefficiency.[2]

As well as supporting the health and wellbeing of insured people, PHI also benefits those without insurance through the reduction of public hospital waiting lists and minimising demand pressures on the public health system.

There are substantial opportunities to enhance these economic benefits owing to three distinct and unique attributes of PHI:

1. As single payors we have inherent financial incentives to keep our members as healthy as possible for as long as possible. By contrast, in our present system neither primary care providers nor acute care hospitals benefit financially from avoided hospitalisations.

[1] Evaluate 2021, A sustainable private health sector: an economic study, pages 28-29
[2] Evaluate 2021, page 29

2. We are the only part of the health system with members. Many members are long standing and develop an active relationship with their health funds. This allows a greater level of more relevant, proactive communication, support and services to be offered, fostering greater health literacy and active self-management.
3. PHIs can productively channel and leverage the financial contributions of those who are willing and able to invest in their own health and wellbeing, in ways that enhance the positive spill over benefits to the whole system.

Reform is urgently needed to sustainably meet Australia's health needs, with reform of PHI a critical component

While Australia's mixed public-private universal health system has long been considered one of the best in the world, its limitations have been well documented by the Commission and many others and been further exposed by the COVID-19 pandemic.

Our health system is built on regulatory and funding structures that encourage hospitalisation, discourage community-based care, and active self-management, fail to incentivise prevention, discourage collaboration and stifle innovation. It is also siloed, fragmented and passive, waiting for sick people to present to it, rather than proactively anticipating and preventing medical conditions, informing and then meeting consumer needs.

Australia lags much of the developed world in utilising new technologies, sharing information and providing tools for communities to manage their own care. The OECD has characterised Australia as relatively poor in its capacity to collect and link health data.

In the public system there are real limits on the ability of hospital networks to fund primary health care which would reduce hospitalisation and in the private system, the ability of PHIs to fund out of hospital services where a Medicare benefit is payable is also restricted.

In the wake of COVID-19, there is less capacity for waste and poor regulation, and our public health system is under severe strain. The AMA says our public hospitals are in crisis,[3] with increased wait times for surgery, and hospital overcrowding impacting on access to emergency care.

Even a moderate drift away from PHI will put untenable pressure on public hospital systems. For example, a 10% drop in PHI membership would mean 1.5 million additional people becoming fully dependent on the public hospital system, having a significant impact on both waiting times and government spending. Waiting lists would increase by over 90% and taxpayers would need to pay for an extra 3,600 hospital beds - equivalent to Australia's four largest hospitals.[4]

By 2057, the number of Australians aged 65 and above will double. If PHI becomes increasingly dominated by older and sicker Australians, the health outcome and productivity benefit it is currently

[3] AMA, Public Hospitals: Cycle of Crisis, 2022 https://www.ama.com.au/sites/default/files/2022-03/Public%20hospitals%20-%20cycle%20of%20crisis.pdf

[4] Private Healthcare Australia Budget Submission 2019, available at www.pha.org.au

providing will decrease, in turn reducing Australia's economic growth while more people remain on ever-increasing public waiting lists.

Government and industry must heed the lessons of COVID-19 and address these issues now, so that private health care can continue to play its important role, become more productive and sustainable for consumers and importantly, help create a healthier Australia.

PHI is central to maintaining the world-class health system that underpins Australia's health and productivity. Reform is key to driving participation and taking pressure off our under-pressure public health sector, so it can care for those in most need.

The ideal state for private health

PHI needs to enable the delivery of person-centred care; namely the 'right care', in the 'right place', at the 'right time' within a private health system that facilitates new technologies and models of care that increase convenience and quality for consumers while lowering costs and producing optimum health outcomes.

Among other things, this will be enabled by a shift to the funding of outcomes-based and value-based funding models that reward the health outcomes that matter most to patients and communities. It will also need a regulatory environment that:

- supports integrated solutions and funding across both hospital and non-hospital provided services
- promotes hospital avoidance and out of hospital care across the continuum
- recognises there is a diversity of locations and facilities, and funding should be tied to the most efficient benchmark, regardless of setting, while allowing for patient complexity
- empowers insurers and providers to negotiate fair, sustainable financial agreements and other beneficial contractual arrangements for example quality assurance, evaluation, and data sharing requirements.

Improving the productivity of Private Health Insurance

Evaluate's report notes that there are multiple ways PHI "could become more productive and more sustainable … more value could be achieved from the same or lower expenditure – a desirable outcome for consumers, the health sector, governments and the economy more broadly".[5]

At a high level these include reforms to increase and broaden PHI membership, as well as solutions that substantially reduce the mean cost of PHI while still delivering high value care.

The report found that in considering how to maximise the productivity of PHI and the role it can play within the entire health system it is important to distinguish between:

- The rules and structures that are necessary or desirable for maximising overall public welfare and to correct market failures, particularly those caused by information asymmetry.

[5] Evaluate 2021, page 6

- Those introduced to address specific problems, but which have had unintended consequences, or are now causing more harm than they are solving.
- Gaps in the rules which are driving inefficiency, such as when one party to a contract is constrained and the other is not.[6]

Health care reform must have the customer (consumer / patient) at its core. With this in mind, Bupa has identified pathways to achieving a more productive private health care sector that maximises overall public welfare by being *simple, relevant, and affordable* for consumers.

Simple

- Empowering consumers to better navigate, understand and control their own health care through improved reporting, transparency and data sharing (addressing information asymmetries).

Relevant

- Reducing red tape so that PHIs can fund more preventative and out of hospital care that reflect modern care delivery and the increase in chronic illness (market completion).

Affordable

- Removing waste and inefficiencies that drive unnecessary cost for consumers
- Dealing with out of pocket (OOP) costs
- Improve the premium pricing process.

If the customer's interests are prioritised, rather sectoral interests – which has been a hallmark of past reform efforts – genuine improvements to productivity can be achieved to provide better health outcomes, affordably, and which ensure benefits are maximised for those using both the private and public health sectors.

We also note that while policy changes and studies have been undertaken in some areas, these often fall short of genuine reform. As the Commission has stated previously "*be very wary of the seductive claim that something is well under way already in the areas to which we devote most attention. The Commission's analysis…is that the headline is often not supported by reality; or has not yet achieved the cooperation of all the necessary participants".*[7]

Some of the matters that could be further investigated by the Commission are outlined below. We would be happy to provide further information and data in support of these recommendations should the Commission determine to include these matters in the scope of the Inquiry.

[6] Evaluate 2021, page 5
[7] Productivity Commission, Shifting the Dial (2018), Foreword https://www.pc.gov.au/inquiries/completed/productivity-review/report/foreword

Simple

Empowering consumers and promoting transparency

The Evaluate report outlines Kenneth Arrow's proposition that health care is a good that suffers from exceptional levels of information asymmetry.[8] While the report goes into some detail, it is sufficient to note that this asymmetry means individuals cannot value potential care or its cost. In theory, PHIs should provide some bridge through this gap though mis-aligned financial incentives, regulatory impediments, and asymmetries in market power between PHIs and certain suppliers mitigate against this.

Bupa supports consumers being more empowered to better manage their own health and care, underpinned by a system that is easier to navigate and more relevant to individual circumstances. As stated earlier, PHIs are currently the only part of the health system with members and incentivised to keep these members well and out of hospital. Many members are long standing and develop an active relationship with their health funds. This allows a greater level of more relevant, proactive communication, support and services to be offered, fostering greater health literacy and active self-management.

Standardised reporting for all hospitals

One way in which this information asymmetry may be address is by providing Australian consumers access to consistent, readily accessible national public reporting of quality healthcare and patient safety outcomes across the hospital sector.

In 2011, the Australian government introduced the MyHospitals website, the only nationally consistent and comparable public reporting system for public and private providers. Reporting to the MyHospitals website is mandatory for public hospitals, but voluntary for private hospitals and comparison of data is only available between public hospitals. Owing to methodological challenges and lack of data, just seven of the 17 proposed indicators are reported, and only two of the seven are safety and quality indicators.

A single set of safety and quality indicators with compulsory reporting obligations for all public and private hospitals must be implemented as soon as possible. Standardised reporting across all hospitals in Australia, regardless of sector, will enable better understanding of performance and better enable improvements in productivity.

Relevant

Allowing market completion

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

Bupa wants to support our customers in their efforts to maintain their health and wellbeing. When they require more acute support, we want them to have a seamless journey through the health system. We want the ability to offer care choices that align to their needs and preferences. These

[8] Evaluate 2021, pages 9-10

aspirations are particularly relevant to younger cohorts who are looking for greater relevance and value in private health insurance.

Innovation and improvements across a wide variety of major diagnostic categories (MDCs) mean that many surgical, medical and diagnostic procedures and services that once required a hospital stay with expensive built infrastructure and staffing needs, can now be safely performed in a variety of non-admitted, community-based settings.

The definitions of hospital treatment and hospital-substitute treatment, as they apply to PHI, have not kept pace with this reality. Both the *Private Health Insurance Act 2007* (The Act) and the *Private Health Insurance (Complying Product) Rules 2015*, and the *Private Health Insurance (Health Insurance Business) Rules 2018* (the Rules) place strict definitions on the type of care that may be covered by private health insurance. They are out of date, stifling innovation and more preventative approaches across many areas of care, including mental health care.

Funding services in a community setting rather than in hospital will reduce the incentives to medicalise treatment which do not inherently require a hospital setting, for example drug and alcohol counselling, and can be carefully considered on a case-by-case basis.[9] A productivity benefit could also arise from capital being made available which would otherwise be invested in the potentially unnecessary expansion of hospital accommodation.

'Gaming' is also a risk in non-tertiary settings, and so offering these services as a substitute to hospital treatment should be on a discretionary basis. [10]

Consumer attitudes are also changing to support this direction of reform. The experience of COVID-19 has changed the way we think about our healthcare and accelerated trends towards consumers wanting to receive care in a time and place that suits them, whether that be via telehealth or at-home treatment. In 2020 we saw a 54% jump in members choosing to have their chemotherapy, rehabilitation or palliative care treatments at home. Having this option has been critical for many of our customers with underlying illnesses and vulnerabilities which made it even more challenging for them to leave home during the COVID-19 pandemic. Most members who receive haemodialysis treatment spend up to six hours in hospital three times a week. Our Dialysis Choices pilot program allows those members to have their treatments at home.

Reducing the red tape binding PHI can both reduce costs (and thus premiums) as discussed in the next section or allow more treatment to be offered for the same cost. It also offers more options for innovation competition and differentiation of specific PHI products. This would have significant benefits in areas such as chronic disease management and prevention, supporting healthy behaviours across the lifespan.

Benefits for chronic disease management

The approach to helping people manage chronic conditions must be as holistic as possible, with both medical treatment and behavioural elements. By their nature, chronic and complex diseases will often require hospital treatments. They also require ancillary care that can be provided out-of-

[9] See Evaluate 2021, page 22
[10] Evaluate 2021, page 35

hospital, and preventive action on contributing behaviours such as poor diet, low exercise, lack of mediation compliance, alcohol consumption and smoking.

There is significant scope for healthcare providers, public and private funders, and the broader community to work more closely and collaboratively on the prevention, early treatment, inpatient and out-of-hospital care of these conditions. Both international and Australian research supports the case for holistic care programs for people living with chronic or complex diseases, improving quality of life and reducing the demand for hospital admissions.

Attracting young people and supporting health across the lifespan

The participation of young and healthy customers in insurance is key to the sustainability of the community rating principle. But increasing costs and regulatory restrictions have made PHI less relevant and less affordable for them, as in general, younger cohorts do not extract the same value from hospital cover as their older counterparts even though they attribute great importance to their mental and physical health.

Bupa's research demonstrates that millennials (those aged 18 to 34) are actively engaged in looking after their health and wellbeing: 85% are actively managing their health and wellbeing; 69% say they look after their health so that they will have a better quality of life; 70% are eating well (including following a dedicated diet plan to maintain a healthy weight); 63% are exercising regularly or occasionally; and another 33% wish to exercise more regularly. Though price sensitive, millennials will spend money on things that matter to them.

Relaxing the rules and enabling health insurers to fund wellness and lifestyle products that are relevant to younger peoples' desire to invest in their health and wellbeing, would increase the value proposition of health insurance for this cohort, and potentially expand the pool of PHI customers, improving its sustainability for all participants.

Encouraging young people to invest in their own health and wellbeing will help address disease burdens as people age, which will have a material impact on future health care costs. Obesity is one such area that is having an increasingly significant impact on health care costs. This is evidenced by surgeries for hip and knee replacements and major procedures in obesity being among Bupa's top 10 most expensive claim items.

Affordable

Supply-side asymmetries

Under the current regulatory framework PHIs have limited capacity to control input costs or ensure efficiency and value for money. PHI premiums are regulated, however there is no similar regulation of the costs of covered procedures and medical items, including on Out of Pocket costs, resulting in both PHI funds and insured consumers being price takers.[11]

A combination of regulatory and financial impediments creates unwarranted distortions that benefit in-patient providers. They limit the capacity of insurers to ensure service quality and value, inhibit

[11] See Evaluate 2021, page 19

innovation and efficiency and stifle the creation of community-based care options as investment predictably favours the sector where there is a known and guaranteed floor price.

For example, many of the services currently provided in a hospital setting could be provided in alternative community settings. However, section 121-5(1)(c) of the *Private Health Insurance Act 2007* (The Act) only allows Hospital policies to cover elements of an episode of hospital care outside the physical boundary of a hospital (for example hospital-in-the home) as long as a hospital is involved in the delivery of the services (treatment is provided, or arranged, with the direct involvement of a hospital). This stifles innovation and healthy competition in the development and delivery of alternative models of care in the community delivered by non-hospital providers.

Minimum and default benefits

Regulatory settings should support people's access to the most efficient form of care. It should be easier for PHIs to pay for better alternatives to inpatient care, where they can deliver the same clinical outcomes but at a lower cost. These are genuine productivity improvements. Key policy reforms in this area should include leveling the playing field between PHIs and providers as well as between care settings, by removing or reducing minimum and default benefits.

Amending the *Private Health Insurance (Benefit Requirements) Rules 2011* to remove minimum benefits from services that can be provided in community-based or non-hospital settings will promote cost effective, provider agnostic care.

Second tier default benefits play an important role in providing rural and regional consumers with access to health care, which must be maintained. However, adjustments should be made to address the perverse incentive that has been created through these benefits to establish hospital beds in locations that are already well serviced, or where care may be better delivered in the community, and this must be addressed. Restoring the second-tier default benefit to this original intent to protect smaller rural and regional hospitals would save $200 million annually.

Consumers could be protected from rising out-of-pockets charged by uncontracted hospitals if hospitals falling out of contract with health funds were not permitted to charge the patient more than 100% of the average charge for the equivalent episode of hospital treatment.

Alternative funding models that incentivise and reward the most efficient, cost-effective, high-quality care delivery and discourage low value care share should be recognised and supported. For example, the creation of bundled case payments based on optimal care pathways and pay for performance models.

Medical devices

Australia's private patients pay the highest prices in the world for medical devices. They also pay more than Australia's public patients for comparable medical devices with no evidence this differential is driven by clinical outcomes[12]. A recent MoU between the Minister for Health and Aged Care and the Medical Technology Association of Australia proposed to reduce the price of

[12] https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/nationalarrangements-clinical-quality-registries

medical devices subject to a "floor" of 7% differential[13]. There is no clinical reason private patients should pay a premium for the same medical device. It is a wealth transfer away from Australian consumers and erodes the value and productivity of private health care.

Incentivising best practice, value based care

As pressures mount on household and government budgets, it is critical our spending on health care is directed to care that offers genuine improvements in the health outcomes of those receiving it. Further, to make a real impact on people's lives, we must shift from just measuring what is delivered – such as the number of campaigns or programs delivered – and instead focus on what is achieved at the individual, service or population level. Much stronger collaboration between public and private payors, focused on outcomes and how to measure them is needed.

Independent estimates are that 30% of care delivered in our health system is wasteful and does not improve health, while 10% causes harm. The Evaluate report found that addressing this 'low value care' is probably the most productive option to reduce PHI premiums over time.'[14]

There are changes afoot — such as the Australian Atlas of Clinical Variations and initiatives like the ACI's Stroke Clinical Audit Process (SCAP), an exemplar of what data collection, analysis and learning at the site level can do. But we need to accelerate implementation of strategies for increased interoperability of health data.

To improve service planning and outcomes it is essential that more data of higher quality is made available across both the public and private systems. Its use by all payors to interrogate whether spending is effective, efficient and informed by evidence, and assesses whether people's needs are being met needs to be legitimised and encouraged.

Patient level data should be routinely collected at the hospital level and be used to provide continuous feedback to hospitals so they can improve practices (decision support systems). Better integration of the public and private sectors would give rise to better opportunities to collect and share data that would, in turn, drive more effective and targeted health policies.

There are institutions that are well equipped to provide this sort of analysis and advice across both sectors — such as the ACSQHC and Choosing Wisely, and research agencies that develop tools for better health care, such as the Centre for Health Informatics.

PHIs can also contribute to these efforts using our expertise in pattern-based identification of appropriate expenditure. Currently, this is principally used to monitor and identify fraud, but it could also be utilised as an early warning system for inappropriate medical practice, in collaboration with the institutions mentioned above.

To improve health care delivery models, PHIs need access to meaningful outcome data collections such as Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) and others, linked to care settings and claims or cost data, that can be used

[13] See Memorandum of Understanding for the policy parameters of the Prostheses list reforms | Australian Government Department of Health

[14] Evaluate, page 35

to measure the impact of different patient pathways to 'test and learn' what works best for people and contribute to a learning health system.

Dealing with out-of-pocket costs

In the March 2021 quarter, more than 97% of medical services covered by private health insurance had no gap (89.9%) or a known gap (7.7%).[15] The Grattan Institute has pointed out that just 7% of medical services account for 89% of medical gaps.[16]

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

There is very little data available on the practice on splitting billing between patients, health funds and government. This is not surprising given the nature of the practice is to deceive. The IPSOS survey noted that just under one in twenty (4%) of respondents indicated a fee for a single service was split across two or more invoices for one person/organisation. [17] This may be an indication of a provider seeking to avoid disclosure of the full fee.

The survey by IPSOS in 2018 suggested booking and administration fees are charged in about 11% of hospital admissions and other 'hidden' fees in about 5% of admissions.[18] Just fewer than one in ten (8%) of those who had claimed against their private hospital insurance said they had been charged a booking fee. Of those, 13% claim to be charged multiple booking, admission or other types of administration charges. [19] Common types of booking, admission or other administration charges as detailed by respondents included:

- Hospital admission fees/charges, hospital stays, and hospital services and consumables
- Emergency hospital administration charges
- Booking fees/hospital booking fees, and/or
- fees to confirm the surgeon or room. [20]

Seven percent (7%) of respondents reported that they were charged a 'deposit' to lock in their surgery on their most recent hospital admission. [21]

The Consumers' Health Forum undertook a self-selected survey in 2018, which found, "An unexpected and highly concerning finding was that some surgeons are asking consumers to pay upfront before surgery. Consumers described experiences of being told that they would not be able to proceed with their appointment or with surgery unless they were able to pay up front."[22]

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[15] Australian Prudential Regulatory Authority 2021, *Quarterly Private Health Insurance Statistics*, March 2021, Available at https://www.apra.gov.au/sites/default/files/2021-05/Quarterly%20private%20health%20insurance%20statistics%20March%
[16] Duckett S, Nemet K 2019. *Saving private health 1: reining in hospital costs and specialist bills*. Grattan Institute. Available at https://grattan.edu.au/wp-content/uploads/2019/11/925-Saving-private-health-1.pdf.
[17] IPSOS 2019. *Medical out of pocket: final report*. March.
[18] Ministerial Committee on Out-of-pocket Costs 2018. Report. Canberra, November. Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/3A14048A458101B0CA258231007767FB/%24File/Report%20-%20Ministerial%20Advory%20Committee%20on%20Out-of-Pocket%20Costs.pdf.
[19] IPSOS 2019. *Medical out of pocket: final report*. March.
[20] IPSOS 2019. *Medical out of pocket: final report*. March.
[21] IPSOS 2019. *Medical out of pocket: final report*. March.
[22] Consumers' Health Forum 2018, Out of pocket pain: research report. Canberra. Available at https://chf.org.au/sites/default/files/20180404_oop_report.pdf.

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

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

Pricing reform

The annual premium round process for PHI funds to increase prices, legislated under the *Private Health Insurance Act* 2007, limits the ability of health funds to compete on price in the interest of customers.

Since 2017, health insurance premiums have been rising slower than health inflation, driven by the ability of consumers to switch, downgrade or drop their health insurance altogether in the face of increasing premiums.

Evaluate has found:

> While there is an argument – stemming from the non-marketability of health risk – that competition will be limited in offering consumers reasonable prices, other non-fixed and highly asymmetric markets suggest that the competition between a reasonable number of large funds will be effective in driving down prices.[23]

The existence of a substantial number of large health insurance funds in the Australian market, in addition to aggregators and the information contained in privatehealth.gov.au, necessarily drives competition on both price and product.

Competition is stifled, though, by the legislative framework that requires a process of a single, annual premium increase for health funds approved by the Minister for Health. This limits flexibility in adjusting price throughout the year, both in response to consumer demand and competition. Furthermore, the single annual increase requires funds to hold additional capital to account for changes in market conditions that, in other sectors, would be addressed by adjusting price. This additional capital could otherwise flow through to consumers in the form of lower premiums.

There should also be greater scope for insurers to provide discounts to customers, including the amount of discount that can be applies and the reasons for such a discount, for example to incentivise good health choices. Mindful of preserving community rating principles, greater pricing flexibility would enable innovative funds to compete to gain members, or to retain existing members.

[23] Evaluate 2021, page 17