



**Submission to
Senate Inquiry**
*Value and affordability of
private health insurance and
out-of-pocket medical costs*

August 2017

About National Seniors Australia

National Seniors Australia is a not-for-profit organisation that gives voice to issues that affect people aged 50 years and over. It is the largest membership organisation of its type in Australia.

We give our members a voice – we listen and represent our members' views to governments, business and the community on the issues of concern to the over-50s.

We keep our members informed – by providing news and information to our members through our Australia-wide branch network, comprehensive website, forums and meetings, bi-monthly lifestyle magazine and weekly e-newsletter.

We provide a world of opportunity – we offer members the chance to use their expertise, skills and life experience to make a difference by volunteering and making a difference to the lives of others.

We help our members save – we offer member rewards with discounts from thousands of businesses across Australia. We also offer exclusive travel discounts and tours designed for the over-50s and provide our members with affordable, quality insurance to suit their needs.

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Overview

- National Seniors appreciates opportunity to provide input to the Senate Inquiry into value and affordability of private health insurance and out-of-pocket medical costs. Our submission focuses on the priority areas of concern for older consumers – affordability of maintaining cover, diminishing benefit value and product complexity that is compromising health literacy and informed decision making.
- Higher than inflation premium increases and erosion of the private health insurance rebate means older people are allocating an increasing share of their limited budgets on maintaining private health cover. Older consumers are responding to the issue of affordability by downgrading their products or dropping their cover entirely, forgoing access to timely medical services when it is needed most. Changes to the Age Pension means testing arrangements, which took effect January 2017 has intensified this trend.
- In addition to private insurance being expensive, older consumers highlight limited value in their cover with a proliferation of product exclusions. Out-of-pocket expenses are difficult to estimate and consumer understanding of what medical services are covered is often only established when making a claim.
- Consumer driven competition is undermined by current product complexity from varied level of benefit across health funds and issues with excess and gap payments. Simplification and consolidation of offerings may ease comparison, but will only lead to improved outcomes if it results in product selection that is of value and appropriate to the needs of older consumers.
- More clarity is needed on the role of private health insurance in Health Care Homes. National Seniors supports continued innovation in out of hospital medical service delivery models provided there is equity of access. Older people, with or without private health insurance, should benefit from improved access to innovative models of care.
- National Seniors recognises there are benefits in increased data use and technology solutions. We remain concerned about privacy and risks to the system of community rating, which is necessary to safeguard older patients from unfairly pricing.
- We acknowledge ongoing work of the Private Health Ministerial Advisory Committee in considering these issues and advising the Federal Government on reforms. Reform should encourage a competitive private health insurance market that offers affordable and effective coverage for older people relevant to their needs.
- Changes to regulatory and policy settings must not undermine the continuity of cover for older consumers or impose additional financial strain. The contributions already made into health funds as a legitimate investment by older Australians to support their own health care costs.

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

National Seniors believes consumers should have the choice of using their private health insurance in public or private hospitals. However, we are concerned about the growing incidence of private patients in public hospitals and suggestions of preferential treatment of insured patients.

The median waiting time for elective surgery for public patients in a public hospital was 42 days, while it was 20 days for patients who used private health insurance to fund all or part of their admission.¹ There may be valid reason for this gap, including differences in clinical diagnosis or lack of private services in rural and regional areas. Further information is needed to better understand how private insurance is being used in public hospitals and impacts on waiting times in public hospitals as well as private hospital investment decisions.

Hospital funding arrangements are clearly at play. Research suggests the public hospital drive to increase the number of private patients is a direct result of the capped Commonwealth and State funding arrangements.² Practices encouraging patients in public hospitals to elect to use their private health insurance have been identified and suggests health funding policy parameters are contributing to the recent trend of increased privately funded public hospital separations.³

Insured consumers are becoming more aware of exposure to out-of-pocket expenses, which may be contributing to them opting for public hospitals instead of private hospitals. As the fees and charges for admitting private patients in public hospitals are typically lower than in private hospitals, there could also be benefits in lower costs across the whole health system.⁴

While private patients in public hospitals may well be a driver of competition and help alleviate funding pressures, our interest is ensuring older patients are protected and supported in accessing the medical services they need. We are cognisant of information asymmetry between doctors and patients and issues with informed financial consent, where there is risk of older people being misled when they are sick and vulnerable. The desire to help the public health system is a key factor for some patients in electing to use their private health insurance.⁵

Procedures in public hospitals in obtaining informed consent is critical to ensuring older patients understand the out-of-pocket costs in electing to use their private health insurance. We know from experiences of our members that older people, especially those with early onset of cognitive decline, need additional assistance in making decisions at the point in time of accessing health services.

¹ Australian Institute of Health and Welfare 2017. *Admitted patient care 2015–16: Australian hospital statistics*. Health services series no.75. Cat. no. HSE 185. Canberra: AIHW.

² King, D., 2013. *Private Patients in Public Hospitals*. Sponsored by Australian Health Services Alliance and Australian Centre for Health Research.

³ Independent Hospital Pricing Authority 2017. Private Patient Public Hospital Service Utilisation.

⁴ Sivey, P., and Cheng, T. 2017. *Are private patients in public hospitals a problem?* <https://theconversation.com/are-private-patients-in-public-hospitals-a-problem-79910>

⁵ Catholic Health Australia 2017. *Upsetting the balance: how the growth of private patients in public hospitals is impacting Australia's Health System*.

National Seniors believes the dual public private system creates tension for government funding and the issue of affordability of private health insurance is exacerbating these conflicts.

Research by the National Seniors Productive Ageing Centre shows older Australians purchase private health insurance for peace of mind, choice of doctor, treatment as a private patient in hospital and skipping public hospital waiting list.⁶ The main reason for older Australians not purchasing health insurance was affordability.

Feedback from our members confirms increasing financial stress in retaining private health insurance. Retirees are allocating an increasing proportion of their limited, fixed incomes on private health insurance premiums. Changes to the Age Pension asset test from 1 January 2017 has adversely impacted around 330,000 part-pensioners many of whom are now struggling to maintain their private health insurance.

In our view, older consumers are becoming more price sensitive and concerns about the affordability of health insurance as well as awareness of gap costs may be contributing to public hospital waiting lists.

There needs to be a thorough assessment of the value of tax payer funded support for private health insurance, but this needs to consider implications of additional resources for the public system. Changes to the private hospital system will have substantial impacts on the public hospital system that have not yet been thoroughly evaluated.

National Seniors believes the Federal Government should outline its view of the desired future role for private health insurance in the broader health care system and in particular, ensuring the system's sustainability. Reform must be comprehensive and consider the public-private interface, consumer responsiveness to price change as well as rising expectations of health care to improve affordability and equity of access to health services, especially for older consumers with higher care needs.

The effect of co-payments and medical gaps on financial and health outcomes

Feedback from National Seniors members indicates older cohorts have preference for retaining their private health insurance because they consider it necessary to avoid lengthy waiting lists and have the doctor of their choice. This is reflected in high health insurance participation rates amongst older people and is consistent with recent survey findings which show older Australians (56+) were far more likely to leave their cover level unchanged (61 per cent).⁷

However, affordability is becoming an increasing concern. Older people who can no longer afford higher premiums are downgrading their level of cover with products that have higher excesses, co-payments and more exclusions to avoid lapses in health insurance. Pensioners and retirees on modest incomes have limited capacity to increase their earnings to cover increased costs of accessing health services. This means they face increased premium costs as well as higher out-of-pocket expenses at a time when their health needs are the greatest.

⁶ Temple, J., and Adair, T. *A carrot and a big stick: understanding private health insurance and older Australians*, NSPAC Research Monograph no. 1, National Seniors Productive Ageing Centre.

⁷ Choice 2017. *Making Private Health Insurance Simpler: Results from Choice's national survey*.

Medical gap payments are causing substantial levels of financial burden for those who suffer from complex and chronic illness, requiring ongoing care and more frequent admissions. This burden falls disproportionately on older people, with 93 per cent of those aged over 75 having at least one chronic condition, while for those aged 50-64 there are 77 per cent with at least one chronic condition.⁸

The average out-of-pocket payment for a hospital episode was \$318 per episode in the March 2017 quarter and was in addition to any excess or co-payment amounts relating to hospital accommodation.⁹ The actual out-of-pocket expenses can vary substantially depending on the level of hospital cover, the choice of doctor and hospital and whether there is an agreement with the health fund. Our members have indicated out of pocket expenses range from a couple of hundred dollars to around \$25,000 dollars.

In response to gap payments, some are opting to rely on the public health system, which can result in deterioration of their function and health status. Waiting periods for elective surgery can be a determining factor for an older person's wellbeing. Older patients requiring total knee replacement experience pain and restricted mobility, yet the median public hospital wait time for the procedure is 188 days (as at 2015-16)¹⁰. Some are deferring treatments and not filling medication scripts, which can lead to increased presentation to emergency departments, which comes at a greater expense than primary health care.

National Seniors acknowledges moves by the Federal Government to review the prostheses list framework. Some of our members have shared statements of their hospital expense statements, which reveal the extent of prostheses costs – in one case \$56,880 for a defibrillator. Health insurers often pay twice as much for medical devices delivered through the private system rather than public. If the same prices for medical devices in public hospitals were applied in the private setting during 2014-15, consumers would benefit by around \$130 per hospital policy premium. With the difference expected to approach \$1 billion dollars by 2017-18, premiums could be reduced by as much as \$180 per hospital policy.¹¹

Cost escalation across the health sector needs to be closely investigated, including the reasonableness of charges for services in private hospitals and the financial performance of private health funds. The difference between health insurance business premium revenue and total fund benefits paid was \$3.3 billion and after-tax profit was \$1.35 billion for the 12 months to March 2017.¹² National Seniors questions the appropriateness of such margins given these are taxpayer subsidised businesses.

Government must also seek to address the over-utilisation of costly medical services and wide variation in surgical interventions. There appears to be unwarranted variation in healthcare use across Australia, which means some people are missing out on the care they need or not getting appropriate care. For surgical procedures with uncertain benefits outside a small patient population, substantial variation raises the likelihood that rates are too high in some areas.¹³

⁸ National Seniors Productive Ageing Centre 2012. *The Health of Senior Australians and the Out-of-Pocket Healthcare Costs They Face*.

⁹ APRA 2017. Private Health Insurance Quarterly Statistics March 2017.

¹⁰ Australian Institute of Health and Welfare 2016. *Elective surgery waiting times 2015-16: Australian hospital statistics*. Health services series no. 73. Cat. no. HSE 183. Canberra: AIHW.

¹¹ Hirmaa 2017. New data highlights the failure of prostheses pricing at <https://www.hirmaa.com.au/2017/05/01/qq/>

¹² APRA 2017. Private Health Insurance Quarterly Statistics March 2017.

¹³ Australian Commission on Safety and Quality in Health Care and National Health Performance Authority 2017. *Australian Atlas of Healthcare Variation*.

National Seniors is supportive of the ongoing work of the MBS Review Taskforce to ensure the MBS covers only those procedures where there is clinical evidence of patient benefit. We also consider there is merit in examining the feasibility of introducing a maximum limit on out-of-pocket costs based on efficiency benchmarks for categories of procedures. Innovative approaches are needed to address excessive provider fees which are putting at risk the viability of private health.

Government needs to tighten regulation of fees, including rigorous evaluation of what is an appropriate surgeon fee for a procedure. We acknowledge the difficulty of fee regulation given complications that may arise in procedures and the use of technology which can add to costs. However, the AMA recommended fee can be more than double the MBS fee and schedule fee observance appears low. In the year to March 2017, only 13.8 per cent of anaesthetic services were charged at the schedule fee and less than half (47.7 per cent) of total operations observed the schedule fee.¹⁴

National Seniors supports moves for greater pricing transparency, including potential for publishing fees, to ensure consumers are more informed about hospital accommodation and treatment costs and how these are determined.

Private health insurance product design including product exclusions and benefit levels, including rebate consistency and public disclosure requirements

National Seniors recognises that product design flexibility is largely a response to the community rating and risk equalisation policy settings. However, this has resulted in the proliferation of product exclusions, which diminish the benefit of health cover for older people.

ACCC's latest report shows people are shifting towards lower-cost policies with lower benefits.¹⁵ This aligns with feedback from our members. Common areas where health cover benefits are being reduced include restricting cover to treatment in public hospitals only, removal of treatments most relevant to older people (e.g. joint replacement) from policies, no longer covering accommodation in individual rooms, and variations to ambulance cover that excludes transport between hospitals. Our members have also highlighted increased conditions linked to preferred provider arrangements that is adding to unexpected costs.

The number of exclusionary policies has steadily increased, accounting for nearly 40 per cent of hospital insurance policies as at June 2016.¹⁶ This is in addition to policies with excesses and co-payments, which have also grown steadily over time.¹⁷

With 34 private health insurers offering more than 45,000 policies,¹⁸ comparing health insurance products is difficult and stressful. Older consumers are overwhelmed by too much choice and there is poor understanding of product features because the exclusions and definitions of restrictions on certain treatments vary between funds. Inconsistent naming of top, medium and basic products,

¹⁴ Quarterly Medicare Statistics, March 2017.

¹⁵ ACCC 2017. Private Health Insurance Report 2015-16.

¹⁶ APRA 2017. Private Health Insurance Membership and Benefits March 2017.

¹⁷ Private Health Insurance Administration Council 2015. Competition in the Australian Private Health Insurance Market: Research Paper 1. http://www.apra.gov.au/PHI/PHIAC-Archive/Documents/Competition-in-the-Australian-PHI-market_June-2015.pdf

¹⁸ Department of Health 2015. Private Health Insurance Consumer Fact Sheet at <http://www.health.gov.au/internet/main/publishing.nsf/content/phi-consumer-factsheet> m

varied rates of benefit and premium prices further undermines health literacy. This is adversely affecting consumer confidence and trust in private health.

Product rule changes are not effectively communicated by health funds and consumer understanding of exclusions is often only tested when the time comes to make a claim. This is reflected in complaints to the Private Health Insurance Ombudsman, with the main issue of consumer concern relating to benefits for hospital policies with unexpected exclusions and restrictions.¹⁹

Third party intermediaries offering comparison platforms have not addressed the information barriers for older consumers. There is also a lack of transparency around the commission arrangements with health funds and whether operators of such comparison platforms are bias toward particular products.

Older Australians require substantial improvement in information to better understand what is covered under their private health insurance policy and compare different health funds in a meaningful way.

Regulatory responses are needed so health funds extend the scope of eligible coverage and limit use of 'no gap' and 'known gap' schemes that can be misleading and fail to protect consumers against large expenses. We suggest government consider amending regulatory requirements for minimum policy coverage to address the escalation of exclusions and restrictions.

Estimates of likely gap payments are needed before consumers receive initial treatment. This can be difficult in cases where the treatment is complex and involves estimating service fees from multiple providers over and extend period. However, we believe there can be protocols in place to establish informed financial consent at key intervals.

The current Standard Information Statements (SIS) are of little use because there is insufficient information about policy exclusions, waiting periods and actual benefit limits. Consumers have to read the SIS together with other disclosure documents relating to fund rules and policies to attain a complete picture. Government must simplify and improve the SIS so critical information about the cover and exclusions is obvious to consumers and definition of terms are consistent across health funds.

National Seniors is aware of the Bronze, Silver and Gold categorization proposal being progressed by the Private Health Ministerial Advisory Committee. This may help improve comparability of products, but it is important the older consumers are not disadvantaged from such developments. The exclusion of services in the Bronze category may have unintended consequences of adversely impacting the health outcomes people with chronic illness.

National Seniors acknowledges recent efforts by the Private Health Insurance Ombudsman (PHIO) to assist consumers through its online comparison tool, fact sheets and general information. We consider there is scope to further develop the PHIO consumer website to provide more advanced comparisons of health policies using price and non-price factors, as well as enabling searches for policies based on specific health conditions.

¹⁹ ACCC 2017. Private Health Insurance Report 2015-16.

Older consumers need more than online options and prefer to seek oral advice. Yet, advice provided by health fund staff appears to be inadequate in helping consumers understand product benefits and select a level of cover that is suited to their needs. The PHIO continues to report instances where health fund sales staff continue to sell policies which are shortly to become eliminated or to undergo major detrimental changes.²⁰

National Seniors considers the current rules relating to notification of policy changes is ambiguous and does not safeguard consumers from unexpected costs. The notification requirements, including method and timing of communicating policy rule changes, need to be strengthened so consumers have opportunity to maintain continuity of cover and consider any gap cover arrangements. Improved communication of preferred provider arrangements is also vital given this often leads to unexpected, higher out-of-pocket costs for patients.

Use and sharing of membership and related health data

National Seniors considers the use and sharing of membership and related health data to be inevitable as funds seek to better understand their members and manage risk.

We are supportive of greater use of technology solutions that can help address affordability of private health as well as improve health outcomes for all consumers. For example, there may be opportunity to improve sharing of membership and related health data which can identify and address the issue of fraud and in turn, minimise related pressure on premiums. The sharing of membership and related health data also has potential to increasing efficiencies through better understanding of how private health insurance is being used, which may help drive down health costs.

We remain concerned about increased use and sharing of membership and health data driving a means of maneuvering around the community rating foundation of premium setting. Health funds with increased information about the lifestyle and health choices of their policy holders may indirectly risk selection, which would adversely affect older people. There is a balancing act between rewarding those who respond to wellness initiatives and ‘penalising’ those who do not participate and being considered higher risk.

Greater use of big data analysis is expected to flatten out the spread of insurance premiums. This may reduce insurance premiums for many, but there will be more consumers falling into the higher risk category, ultimately reaching the ‘unaffordable’ levels of insurance premiums.²¹

National Seniors believes community rating should be preserved so that everyone pays the same premium for the same health insurance policy. Many older Australians would fall into the higher risk category, yet have paid premiums for many years prior to becoming seniors with health funds benefiting during that time from lower claims. Differentiating premiums on the basis of risk would price seniors out of the market and is inequitable. Under a risk rated model, people aged over 60 would pay three times as much for premiums and there would be a 43 per cent drop in participation.²²

²⁰ Private Health Insurance Ombudsman 2017. *State of the Health Funds Report 2016*.

²¹ Actuaries Institute 2016. *The Impact of Big Data on the Future of Insurance*, at <https://actuaries.asn.au/Library/Opinion/2016/BIGDATAGPWEB.pdf>

²² Finity Consulting Pty Ltd. 2013. Community rating – more trouble than its worth? Presented to the Actuaries Institute for the 2013 Actuaries Summit.

We are also concerned about privacy, especially for older people who may not understand the implications of data sharing and the potential for cross-matching with other information such as social welfare. The Productivity Commission Chairman recently observed that the willingness of consumers to supply data depends on trust. Best practice data use is assuring people their data is not just safe, but also showing them how they can share in benefiting from its use so community-wide trust is maintained.²³

National Seniors is supportive of enabling technology solutions that can make better use of member data and improve health outcomes. For older people, we see potential benefits where technology solutions can help deliver more effective chronic disease management and support independent living (e.g. through in home monitoring devices and increasing use of wearables).²⁴

Strict regulatory oversight is needed to ensure data used by health funds to gain insights into healthy behaviours does not impose additional costs on existing members, especially older cohorts. Existing private health insurance policy holders must not be impacted and their existing level of benefit preserved.

Any move to introduce incentives or adjust benefits on the basis of lifestyle-related factors must explicitly recognise that older people may not be able to control their health risks. Ageing is a natural occurrence and not a choice.

Medical services delivery methods, including health care in homes and other models

National Seniors considers there is merit in government exploring partnership arrangements with private health funds that would improve the efficiency and integration of medical services, encourage greater use of preventative initiatives and facilitate better data collection on clinical outcomes. The current fragmented delivery of care is contributing to avoidable hospital admissions.

In this context, we support the trial of Health Care Homes from October 2017, where GPs will be funded to deliver a coordinated care package for patients with complex and chronic conditions. This includes coordinating access to allied health professionals, specialists, diagnostic and imaging services, medication management and to government and community social service programs.

However, the role of private health insurers needs to be clarified under the Health Care Homes trial or any other integrated model of care. We understand health funds can help with the costs of non-Medicare funded services outside the hospital setting, including dental, optical and physiotherapy services. However, the contributions of private insurers should not indirectly impact funding of Medicare services for the general population or those who have chronic disease already.

We believe universal accessibility should be paramount in developing innovative medical service delivery methods. Any role for health funds should be limited and well-defined to support coordination of primary care for those with chronic illness. There is a risk that extending private health

²³ Harris, P., 2017. *Data – The Thing that Ties it All Together*. Speech to the Committee for Economic Development of Australia (CEDA) on 22 March 2017 in Melbourne, at <http://www.pc.gov.au/news-media/speeches/data/20170322-data.pdf>

²⁴ For example, Medibank's CareInsight Program trial involved members over the age of 75 who had been hospitalized as a result of a fall. By installing sensors in a member's home to monitor movement and temperature in the house and check on the member's health and wellbeing to keep them out of hospital. Data collected was used to inform family and friends of changes in a person's routine.

insurance into primary care delivery methods would drive up costs and ultimately premiums, which would compromise equity of access.

We believe effectiveness of the Health Care Home trial should be independently evaluated to determine if these trials improve patient outcomes relative to the status quo. It will need to carefully assess the appropriate role for health insurers and utilisation of existing services by health funds relating to chronic disease prevention and management.

Current government incentives for private health

The three major government incentives in place – the private health insurance rebate, the Medicare Levy Surcharge and Lifetime Health Cover loading – have contributed to the current 47 per cent coverage rate, which is high relative to other OECD countries.

Though the cost-effectiveness of these measures is questionable, the majority of National Seniors members believe the private health insurance rebate should be retained. This is not surprising given the cost pressures from rising premiums and preference amongst older cohorts to retain coverage.

We recognise there is opportunity to improve the effectiveness of the rebate with Federal Government expenditure on the rebate expected to reach \$6.8 billion in 2020-21.²⁵ However, growth in rebate outlays will continue to slow with means testing and changes to indexation.

The value of the rebate (currently 25.9 per cent for those under 65 and 34.5 per cent for those aged 70 and over) is eroding. Since April 2014, an index factor is applied to the rebate which is the difference between the CPI and the industry weighted average increase in premiums. With premium increases (averaging between 4 and 6 percent over the past decade) increasing around three times the rate of inflation, the value of the rebate is declining as a percentage of the premium. The private health industry suggests if health inflation continues at the current rate, the value of the rebate at the highest tier will be 16 per cent of the premium by 2026.²⁶

Recent speculation about the rebate being abolished is worrying older consumers. National Seniors is concerned that reducing or abolishing the rebate would result in a spike in premiums and force many older Australians, with limited fixed income, to abandon private health insurance. The lapsing of health cover means older consumers would forgo any benefit despite making contributions via premiums over many years. This would be a devastating outcome for older people when their health care needs are the greatest and timely access to health care may not be possible given the prevalence of extended waiting periods in the public system.

Rather than abolishing the rebate altogether, National Seniors suggests exploring options to better target and improve the value of the rebate to consumers. This may include considering the feasibility of restricting the rebate to hospital cover only for new members, so any policies relating to general treatment or extras cover would not receive the subsidy and/or tightening eligibility for new members so the rebate only applies to those private health policies that cover private hospital treatments.

²⁵ Federal Budget 2017-18. Budget Paper No. 1

²⁶ Private Healthcare Australia – Pre-Budget Submission 2017-18.

Importantly, the impacts and potential savings from such options would need to be carefully assessed as well as grandfathering arrangements for those with existing policies. National Seniors also suggests the Federal Government examine the interaction between the rebate and other existing incentives, including the lifetime health cover loading and Medicare levy surcharge, before making any changes.

Operation of relevant legislative and regulatory instruments

National Seniors believes the regulated annual premium process is ineffective at addressing the issue of affordability for older consumers. This is because the public interest test remains undefined in the legislation and the Ministerial consideration has tended to focus more on ensuring the viability of the health funds. The current regulated process provides no incentive for health funds to minimise costs because any savings leads to approval of a lower premium increase. Further, the detailed information required as part of the annual premium setting process adds to health fund administrative costs and these costs are ultimately borne by consumers.

We suggest clarifying the public interest test in legislation so the annual premium setting process better balances considerations of health fund viability against consumer affordability and sustaining participation in the private health insurance sector. Any move to introduce efficiencies through less regulation and a system of price monitoring should be part of a longer-term goal of improving competitiveness of the sector.

Premium regulation must also address the underlying cost factors in the private health insurance sector and improve pricing transparency.

Given health insurance premiums largely reflect benefit payments, the Federal Government should explore all options to improve affordability of premiums, including through regulatory oversight of pricing arrangements between health funds and providers. There is potential to apply the efficiency benchmarks established by the Independent Hospital Pricing Authority (IPHA) for public hospital services to assess the reasonableness of private hospital costs. This would improve the cost-effectiveness of patient care and help curb unsustainable premium increases.