

# The case for greater data sharing in health


**Submission to Productivity Commission**

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## The case for greater data sharing in health

Medibank is pleased to submit to the Productivity Commission's Inquiry into data availability and use. Improving the ability of consumers and business to access data will enhance choice and competition, improve healthcare delivery and outcomes, boost innovation and create new efficiencies and opportunities within the Australian economy.

Medibank's submission is focused on the health sector. Over 25 years after much of the Australian economy was opened to greater levels of competition and the productivity benefits this produced, competition in the health sector remains muted. Largely this is due to the difficulties in developing well informed and functioning markets, a failure that Medibank contends can be addressed at least in part by improving access to data and information.

The health sector is very good at generating and storing data. It is less effective at translating this data into useful information. It is poor at linking and sharing information between health professionals, where it could be used to improve health outcomes and system efficiency. Worst of all is the health sector's ability and willingness to share data and information with consumers, whom it fundamentally mistrusts to be able to use health data in a way system actors deem appropriate.

This is unfortunate. The potential benefits from linking and sharing health data are substantial:

- At the consumer level, if health performance and cost data were made available individuals could make better informed decisions when choosing providers and care options. In doing so they would be acting not only in their own interest as they do in non-healthcare markets, but aggregated together consumer self-interest would create incentives for service and cost improvements that are presently lacking.
- At the provider level, access to more and better connected health information would help healthcare professionals optimise care decisions based on a more complete picture of the patient's health needs, and to collaborate more efficiently and effectively. This would improve outcomes and reduce waste in the system, while also reducing risk for providers.
- At the system level, health system administrators and researchers would be able to reach more informed conclusions and make better decisions, and to cooperate to reduce negative outcomes associated with the fragmented nature of Australia's healthcare system.

Ultimately the benefits of better data linking and sharing would accrue to the users and ultimate primary of the system, being consumers and taxpayers.

Focusing on the health insurance viewpoint, if insurers could access personal health data, with consent from the consumer, they could offer targeted prevention, early intervention and pathway management to their members resulting in lower cost of delivery and better health outcomes.

Medibank is of the view that a key reform necessary to tackle the effects of system fragmentation and make the system more efficient is affirmative action on data and information sharing. Because system actors appear unlikely to do this voluntarily, we urge the Productivity Commission to give special consideration to measures that would encourage greater health system data availability, sharing and use.

### **About Medibank**

At Medibank, we stand For Better Health.

These three simple words sit at the heart of everything we do. They define why we exist and what we stand for. For Better Health means seeing every interaction with our members as an opportunity to build a relationship. It means we promise three things:

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- Better Choices – we help members make positive health decisions and feel in control of their health.
- Better Confidence – we ensure members feel confident about their health and offer genuine peace-of-mind.
- Better Outcomes – we advocate for an improved health system that produces quality health outcomes at a sustainable cost.

We provide health insurance under two brands: Medibank and ahm. Our Medibank brand delivers a premium, full-service offering, giving Medibank members better access to health services and advice. Our ahm brand is focussed on giving members maximum value. Altogether we cover 3.8 million private health insurance members Australia wide.

To better meet their needs, today and into the future, we are pioneering a range of innovative healthcare initiatives. Our approach to optimising health is guided by the “Triple Aim of Healthcare”, developed by the Institute of Healthcare Improvement, and focuses on the following elements:



We further extend our health expertise to other populations. This is most clearly seen in our management of the national, integrated healthcare system for the Australian Defence Force. This system provides seamless access to quality healthcare for over 80,000 ADF personnel – from point of injury or illness to recovery. We are proud of the role we play in delivering care to this important group and the position of trust we have established.

Medibank is also one of the largest telehealth providers in Australia, delivering a range of publically available healthcare services via phone, online and video, including nurse triage, health coaching and mental health counselling services.

### The macro organisation of healthcare in Australia

From an economic perspective, the human capacity to engage in work and produce economic value, often termed “human capital”, is amongst the most important factors of production and so essential to the creation of a prosperous society. Creation of human capital is dynamic and relies on many inputs, but there can be no doubting that amongst the most important of these, at both an individual and macro level, is health. As such, the relationship between an efficient and effective healthcare system and economic wellbeing is of fundamental importance to Australia.

Australians are fortunate to enjoy access to one of world’s most advanced healthcare systems, one which sees the nation consistently ranking highly on global healthcare indices. Generous levels of government funding mean that all healthcare consumers can access publically funded healthcare services including public hospitals, subsidised primary, specialist and diagnostic services and subsidised pharmaceuticals. Frequently these services present as “free” to the user at the time of use, often leading to demand exceeding supply and resulting in health service rationing in the form of queuing.

Consumers also have the option to access “private” healthcare services delivered outside of the public system. While all health services available in the public system tend to also be available privately (and some exclusively so<sup>1</sup>), the services most commonly associated with the private sector are private hospitals, privately billing doctors and privately billing allied health services.

Consumers who choose to use the private system will generally avoid the rationing in the public system, but may incur a financial expense in doing so. To help manage such expenses many people choose to purchase private health insurance and today over half of Australians have some form of private health insurance.

In practice funding is often contrivuted from multiples sources. For example the costs of medical services delivered in a private hospital are shared amongst Medicare, private health insurers and individuals, while some general practitioner and most specialist outpatient consultations are funded by both Medicare and individuals.

This mixed nature of the Australian health system produces both positives and negatives for consumers. On the positive side, the public system ensures a high minimum standard of care is available for all Australians, while the private system grants consumers greater levels of choice and control over their healthcare than the public system, including no or only short delays to access care.

However a clear negative aspect of the design of the system is the fragmentation between the public and private health care sectors, a blurring of the lines between regulator and funder and a lack of competition among healthcare providers, which mutes incentives for innovation and efficiency. It also has negative implications for data generation and information sharing, with the system and actors within it unable or reluctant to share data and information.

Addressing these fundamental system design flaws would improve the efficiency and consumer centricity of the Australian health system. However, partly due to flaws being rooted in the design of the Australian federation and partly due to the inherently slow nature of health reform, the chances of fundamental system change appear modest. Medibank therefore recommends taking a microeconomic approach to reforming our healthcare system, with data sharing being a central and essential feature.

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<sup>1</sup> For example, some allied health consultations and products, non-PBS pharmaceutical items and some health devices and appliances are not funded in the public system.

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### ***The healthcare system exhibits market failure***

Leaving aside macro system design issues, at a microeconomic level the health sector demonstrates several characteristics consistent with market failure. Understanding and addressing these failures would improve markets resulting in efficiency improvements and consumer benefits.

The technical nature of healthcare has allowed the market to suffer extensively from information asymmetry. Compared with their provider or supplier, healthcare consumers are usually less informed about their health status, treatment options and likely outcomes and costs. While the internet has improved the situation, authoritative sources of information for consumers to help make an informed choice are few, particularly in relation to alternative treatment pathways, outcomes and cost.

Often the only signal available to consumers is the price associated with a service. With little other information available, consumers generally do not know whether the price represents good value or not and this can lead consumers to associate expensive care with quality, when in fact no such relationship may exist.

Obtaining price information on healthcare services can be difficult and often involves its own transaction costs. Unlike many markets, it is generally not possible for consumers to accurately research the cost of healthcare services in advance without paying for the information<sup>2</sup>. These transaction costs act as barriers to consumers seeking alternative treatment options or quotes (i.e. via a second opinion) as they are likely to be incurred again.

Even after incurring a transaction cost, the information obtained may still be imperfect. For example, additional expenses in a private hospital admission such as diagnostic costs and post-treatment outpatient costs may not be known until after the service has been provided.

The technical nature of healthcare also gives rise to a challenging principal-agent relationship between providers and consumers. Typically consumers do not have the access to information that would allow them to critically compare the price and likely outcomes of alternative treatments on offer. As a result consumers may relinquish responsibility for making decisions about their treatment to their provider. Previous work by the Productivity Commission suggests the extent of delegation by consumers to their provider is probably more marked in the healthcare market than other markets, and that this may lead to the phenomenon of supplier induced demand<sup>3</sup>.

### ***Impact of market failure***

One consequence of these market failures is that healthcare is expensive in Australia compared to other countries. Domestic price levels for medical procedures were over twice the level of most European countries for hospital services in 2011. Similarly, an international comparison of six comparable countries in 2013 found total physician and hospital costs for hip replacements and bypass surgery in Australia were second only to the United States. In this analysis, the cost of hip

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<sup>2</sup> For example, a consumer is unlikely to find out about the treatment options and prices of a surgical procedure until they attend a paid consultation with their specialist or surgeon, at which point they may have already sunk other financial and time costs they may be reluctant to pay again.

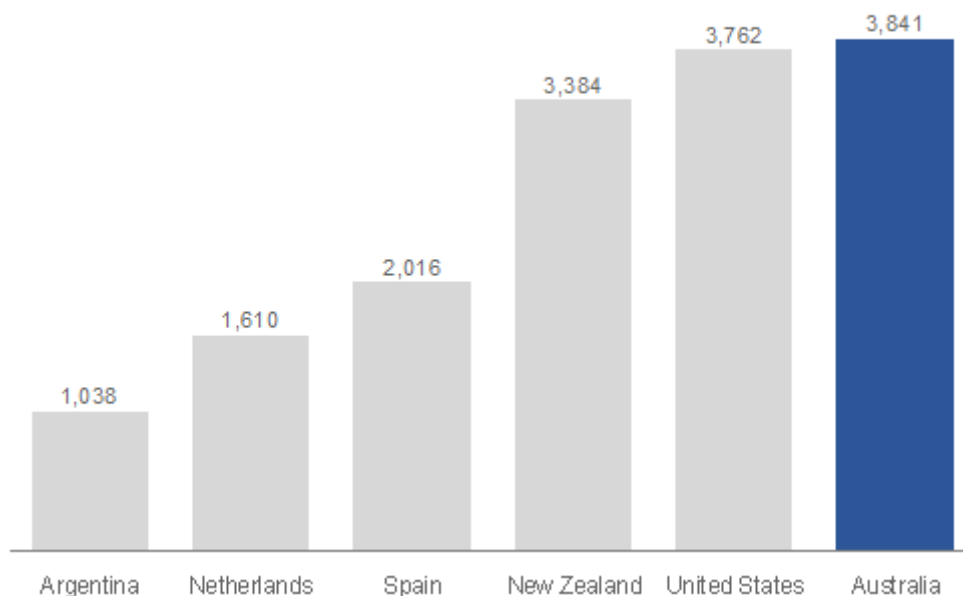
<sup>3</sup> Supplier-induced demand refers to the concept that because providers are in the position of both advising patients on their need for medical care and supplying health services, providers can influence patient demand for medical services to create additional demand. This may not occur out of self-interest, but can arise as part of the provider's attempt to promote the well-being of their patient. See Bickerdyke, I., Dolamore, R., Monday, I. and Preston, R. 2002, *Supplier-Induced Demand for Medical Services*, Productivity Commission Staff Working Paper, Canberra, November.

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replacements in Australia was 38 percent higher than New Zealand, and more than double the cost in the Netherlands<sup>4</sup>.

The increase in prices cannot be explained by increasing complexity of procedures alone: the cost of the same procedure in Australia is more expensive than in other countries. For instance, the chart below shows the average invoice cost for cataract surgery in Australia was greater than that for other comparable healthcare systems, including the United States and New Zealand.

Average invoice cost, US\$, 2013



Source: International Federation of Health Plans 2013, Comparative Price Report: Variation in Medical and Hospital Prices by Country.

## The benefits of greater health system data availability and sharing

Creating or improving the function of healthcare markets would address some of the failings associated with the fragmented nature of the Australian health system. In the absence of larger, system level reforms, Medibank contends the functionality of markets would be improved by addressing the information deficiencies and asynchronies that currently exist.

Greater sharing of health data could produce benefits at multiple levels with the Australian healthcare system:

- At the consumer level, if health performance and cost data were made available individuals could make better informed decisions when choosing providers and care options. In doing so they would be acting not only in their own interest as they do in non-healthcare markets, but aggregated together consumer self-interest would create incentives for service and cost improvements that are presently lacking.
- At the provider level, access to more and better connected health information would help healthcare professionals optimise care decisions based on a more complete picture of the

<sup>4</sup> International Federation of Health Plans 2013, *Comparative Price Report: Variation in Medical and Hospital Prices by Country*

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patient's health needs, and to collaborate more efficiently and effectively. This would improve outcomes and reduce waste in the system, while also reducing risk for providers.

- At the system level, health system administrators and researchers would be able to reach more informed conclusions and make better decisions, and to cooperate to reduce negative outcomes associated with the fragmented nature of Australia's healthcare system.

Each of these is analysed in more detail below.

### ***Consumer level benefits***

The current private health system contains too many unknowns for consumers, including unexpected costs. Across the health system patients often face unexpected medical gap charges which arise without forewarning or clear understanding on the patient's behalf. Immediate consumer welfare gains are obtainable if provider cost and quality information were shared with consumers and their agents<sup>5</sup> to make informed, value-based choices.

An example of the consumer impact felt by this issue is variation in out-of-pocket costs charged by medical specialists. Medibank's medical billing data indicates many medical specialists are billing more in out-of-pocket expenses than they are paid in Medicare and private health insurance benefits, with this billing behaviour highly correlated with the socioeconomic status of patient pools. In some cases, provider charging appears truly extreme: Medibank claim records show one medical specialist charged \$678,000 in out of pocket expenses over the period of a year, for just 180 billed services, in addition to claiming Medicare and private health insurance benefits.

If it were possible to link specialist billing behaviour with health outcomes then, arguably, variation in charging practices could be justified. Unfortunately while such data undoubtedly exists it is unavailable to consumers, leaving them with little information to make informed decisions on medical specialists – a classic example of market failure.

Current restrictions on how data is shared and used means consumers do not have access to the informational tools needed. Medibank recommends the development of an expanded range of standardised healthcare information including price and quality measures for hospitals and health services providers. Such information should then be made available by a centralised database of clinical providers and hospitals that allows greater consumer level transparency on price and quality of care metrics.

Medibank acknowledges private health insurers have a role to play in improving consumer understanding of their healthcare. Many Australians have encountered difficulties understanding their cover and it is important insurers help minimise such issues by providing clear, digestible information about cover to consumers. Medibank has called for greater transparency and simplification of insurance to achieve this goal and is working with the Australian Government to achieve it.

However, regardless of how well insurance products can be structured and communicated, without supporting changes in data sharing insurers will continue to lack access to essential health information about their members that could improve outcomes and value-for-money. Insurers have no visibility of healthcare provided outside of claimed hospital admissions or claimed allied healthcare treatment.

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<sup>5</sup> An agent in this sense could conceivably be a patient's coordinating GP, a government agency or even their private health insurer – whomever the consumer trusts to help them make an informed decision.



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The absence of data related to care provided in the primary care sector, the absence of pharmaceutical data and the incomplete nature of data relating to public hospital admissions is a significant issue hampering insurer's ability to help members achieve better health outcomes. Were it possible for insurers to link a person's insurer held hospital and medical claims data with their Australian Government held Medicare primary and secondary health data and Pharmaceutical Benefits Scheme prescribing data, the result would be an enhanced insurer understanding of the incidence and impact of chronic disease.

Such an understanding would greatly improve the predictive accuracy of early-intervention programmes. Early intervention directly benefits individual's health status, while reducing the downstream health costs that accrue across the entire health system.

The easiest way of achieving this would be by allowing Australians to choose to link their insurer with their My Health Record personal e-health record. My Health Record is a critical investment in long term efficiency and effectiveness of the health sector, but there are opportunities to further increase the value of My Health Record to patients and the health system that supports them, including by allowing record holders to consent to private health insurers having access to their individual My Health Record.

Access by private health insurers to My Health Record would permit insurers to identify patients that would benefit from any beneficial programs the insurer might make available. For example if via access to My Health Record an insurer were able to identify a person with chronic disease or chronic disease risk factors prior to a hospitalisation, it could proactively offer that person access to a disease management or health coaching program. These programs would benefit the individual member by offering the chance to better manage their health and wellness before their condition deteriorated to the point that a hospital admission was required.

If the current New South Wales and Queensland based trials to create a My Health Record on an "opt-out" basis are successful and expanded nationally, Medibank recommends that serious consideration also be given to allowing record holders to choose to share the data with their insurer.

### **Provider level**

The benefits for providers of having greater visibility of the health information at an individual patient level are well established and underpin the policy rationale to introduce the My Health Record electronic health record system in Australia. Information such as medical history, medication records, allergies and hospital discharge summaries help clinicians make better decisions, spend less time chasing clinical information and help patients better manage their own health.

However there remain opportunities to better connect clinicians with other sources of information that will support clinical decision making. Clinicians make decisions with and for their patients every day. Generally these decisions are technical in nature and well informed on the basis of scientific evidence and the provider's own training and experience. For example a GP is well equipped to diagnose and treat a wide range of acute and chronic illnesses and to provide generalised healthcare to patients.

Unfortunately however uncertainty starts to slip in when a patient's condition is such that it requires care and management by a medical specialist. The transition from GP to specialist care is termed a referral and is initiated by the GP based on their understanding of the patient and the medical condition. In doing so, the GP either choose's the specialist for the patient, or sometimes offers the patient a limited range of choices.



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A referral is a critical step in a patient's diagnosis and treatment journey, marking an inflection point that will define the future care pathway of the patient. This is because specialist doctors are each unique in the way they diagnose, treat and charge patients, with differing practices in respect of each and variable levels of proficiency.

The basis for GP's choice or range of choices of specialist is poorly understood, but at least some research suggests that it is more heavily weighted towards the GP's relationship with the specialist, including the level of satisfaction with their own experience in working with the specialist, rather than an objective understanding of the specialist's clinical appropriateness for the patient, their proficiency or the costs the patient may go on to incur with the specialist<sup>6</sup>.

In part this is no surprise as there are presently no tools to enable GP's to view or compare variations in care or costs (including out of pocket costs) between different specialists. For example a key leading indicator of the successful outcome of surgery is the volume of particular surgeries a surgeon performs. Were even this level of information available to GPs and their patients in a useful way it is likely to affect patient referral choice.

Medibank has taken steps to bring the variability of specialist practice to light via its partnership with the Royal Australasian College of Surgeons (RACS). Using data collected as part of its hospital and medical claims processing function, Medibank and RACS have co-published reports showing the variations in cost, hospital length of stay in and readmissions on a de-identified surgeon by surgeon basis<sup>7</sup>. The intent is to encourage specialists to critically analyse their own clinical practice and so reduce unwarranted variation.

### **System and public policy level**

Providing health system administrators with richer data in respect of health system performance would permit the implementation of more sophisticated funding models. For example introducing Value Based Purchasing frameworks that reward hospitals based on the achievement and improvement of specific performance targets, rather than on simple patient volumes, would create incentives for clinical improvements and economic efficiency. However achieving such a goal requires the development of guidelines, benchmarks and measures which are based on having administrator access to the required underpinning data sets.

Unfortunately access to such data is inconsistent. By way of example, Medibank is able to access detailed data relating to individual private hospital separations and refine this data to inform its understanding of hospital performance and quality. In contrast the data Medibank receives from a public hospital when policy holders attend as a private patient is often limited to an invoice specifying the dates of the admission and the amount owing.

Aggregated data could also be used by researchers to test and validate clinical decision making and funding models, and to hypothesise future changes. Such an approach would permit a continuous improvement model in healthcare system design and operation which would allow for ongoing, incremental improvement in the system.

System level data sharing would also permit system administrators, be they public or private, to address system level waste such as duplication and improper payments. In respect of the latter, improper payments occur when a funder makes a payment that should not have been made. This

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<sup>6</sup> Hespe, C, "How do urban GPs make decisions about referrals?", *O&G Magazine*, Vol 12 No 1 Autumn 2010, viewed 25/0716, [https://www.ranzcog.edu.au/editions/doc\\_view/361-31-how-do-urban-gps-make-decisions-about-referrals.html](https://www.ranzcog.edu.au/editions/doc_view/361-31-how-do-urban-gps-make-decisions-about-referrals.html),

<sup>7</sup> The most recent reports can be accessed on the RACS website at <https://www.surgeons.org/policies-publications/publications/surgical-variance-reports/>

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can occur for a range of reasons, ranging from administrative error to outright fraud. Through analysing allied health claiming data Medibank has successfully been able to reduce the rate of improper payment within its own allied health payments ecosystem, but the additional benefits that could be achieved through sharing data with other health insurers, or with the Commonwealth, remain out of reach at the moment.

At the broader public policy level, the sharing of provider level health data and, with consent, individual level health data would allow intermediaries such as insurers, Primary Health Networks or Local Health Districts, to identify patients with high risk and chronic conditions such as heart disease and diabetes well before the patient presents in hospital.

In turn this would make possible the provision chronic disease management and preventative health programs that keep the patient healthier and reduce the number of avoidable emergency department presentations and hospital admissions. In an environment of growing demand for expensive hospital services but limited room for health budget growth, well targeted and clinically effective preventive health programs are of key importance and aligned with the public interest.

## International comparisons

International examples suggest there is much to be gained by publishing user-friendly cost and quality information to help consumers select providers and navigate the health system. For instance, the US Center for Medicare and Medicaid Services (CMS) released data for \$77 billion in payments to over 880,000 providers and 4,000 hospitals from 26 million beneficiaries, empowering consumers to 'shop around' more effectively based on health outcomes and price<sup>8</sup>. The US Veteran's Administration created electronic access for patients and saw bed days reduced by 25 percent.<sup>9</sup>

Germany published risk-adjusted mortality indicators and saw a 29 percent decline in mortality for heart failure, and 28 percent in mortality for aortic aneurysm. The NHS North West London used public reporting to target mortality processes and outcomes, reporting 255 lives saved, and a drop from 84 to 71 in the hospital standardised mortality ratio<sup>10</sup>.

The health industry could also benefit from learnings in international parallel industries that publish user-friendly cost data. For instance, a US power company observed sending personalised bills to consumers that compared their energy use with that of their neighbours reduced energy use<sup>11</sup>. A similar innovation is Green Button, which provides utility customers with easy and secure access to their energy usage information, thus empowering consumers to manage energy use and save on their bills<sup>12</sup>.

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<sup>8</sup> Pennic F 2014, 'New Public Health Mobile App Uses CMS Medicare Data to Empower Consumers', HIT Consultant, viewed 3 December 2015, <http://hitconsultant.net/2014/06/03/public-health-mobile-app-uses-cms-medicare-data/>

<sup>9</sup> Kerr EA & Fleming B 2007, 'Making Performance Indicators Work', *British Medical Journal*, No. 335, pp. 971-3.

<sup>10</sup> Kelsey T 2011, 'Open data works! Making the information revolution a reality in public services', presentation given to Cabinet Office of the United Kingdom, viewed 3 December 2015, <http://www.ucl.ac.uk/constitution-unit/events/tim-kelsey-presentation>

<sup>11</sup> Cameron D 2010, 'The Next Age of Government - Feb 2010', TED talk presented in London United Kingdom, transcript viewed 3 December 2015, [https://www.ted.com/talks/david\\_cameron/transcript?language=en](https://www.ted.com/talks/david_cameron/transcript?language=en)

<sup>12</sup> McKinsey and Company, 2011, *Transparency - The most powerful driver of healthcare improvement*.

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Despite ongoing advocacy from organisations such as the Australian Commission on Safety and Quality in Health Care for greater performance transparency, providing consumers with transparency on clinical performance and cost has been difficult to achieve in Australia. There are only four publicly available metrics on nation-wide hospital performance, compared to 150 in the United Kingdom and 119 in the United States<sup>13,14</sup>. In contrast, in Australia, ECLIPSE only collects a limited set of cost, treatment volumes, and quality metrics for private providers. Tools such as myhealth.gov provide incomplete information to consumers; furthermore, doctors frequently charge fees directly to patients, who are not always aware of these costs until after the event.

International experience also suggests that opening up public-sector data enables better disease management and early intervention. For instance, Dr Foster International, a private infomediary that gathers and links information online for companies and consumers, analysed public data and found that a hospital in Stafford, England, had unusually high mortality rates. Investigation revealed this was caused by poor clinical practices – creating the impetus to improve<sup>15</sup>.

## Which data sets should be shared?

High value data that would enhance health system outcomes and efficiency is contained within the Medicare claims dataset and the Pharmaceutical Benefits Scheme (PBS) dataset. These are Australian Government owned datasets that contain extensive, standardised information on private individuals, either patients or Medicare eligible clinicians. While it is already possible to access aggregated data from the datasets, the benefits described above can only be achieved if access is made available at least at the provider level, with access at the identifiable patient level able to be accessed with the individual's consent.

Access to Medicare claims and payments records is the key data set. Public access to high fidelity Medicare data would permit a consumer's GPs to better understand the performance and costs associated with providers. To facilitate this publically available data should include claims level data containing provider registration details, the Medicare item number claimed, service location, the date of service, the charge amount and the benefit amount.

Data that identifies the patient should not be included in publicly accessible data sets, however could be shared with specifically nominated third parties for defined purposes with the consent of the individual patient. This consent should extend to individual patient PBS data as well.

The sharing of individual patient Medicare and PBS data would permit authorised third party intermediaries, including but not limited to health insurers, to better target at risk people with preventative and chronic disease management health programs.

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<sup>13</sup> 2015 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report 2015, Centers for Medicare & Medicaid Services, viewed 3 December 2015, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/QualityMeasures/QualityMeasurementImpactReports.html>

<sup>14</sup> 2015 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report 2015, Centers for Medicare & Medicaid Services, viewed 3 December 2015, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/QualityMeasures/QualityMeasurementImpactReports.html>

<sup>15</sup> Dr Foster, 'Is 'Special Measures' Working?' 2015, viewed 3 December 2015, <http://www.drfooster.com/wp-content/uploads/2015/02/Dr-Foster-Special-Measures-report.pdf>

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### ***Current impediments to data sharing***

Individual patient level health information is, quite correctly, regarded as one of the most sensitive types of personal information and for this reason, the *Privacy Act 1988* (Cth) provides specific protections around its collection and handling. Health information is collected by clinicians as part of their diagnosis and treatment and is generally only shared with other trusted medical professionals or used for the purposes of Medicare or private health insurance claims billing and processing. It is reasonable that such sensitive personal information is not shared with any third party without the individual's consent.

As already noted above, health information that is created outside of privately billed hospital admissions, such as GP services, is not shared with health insurers and as a result there are missed opportunities in respect of the ability of insurers to provide consumers with value added health services. Medibank identifies My Health Record as an avenue for individuals to consent to the sharing of out of hospital health information with their health insurer.

Presently the ability to consent to this such sharing is not incorporated into the design of the My Health Record system and this impedes data sharing. It is also unclear whether the *Personally Controlled Electronic Health Records Act 2012* (Cth) or the *Healthcare Identifiers Act 2010* (Cth) permits record holders to consent to sharing the data with insurers. Medibank recommends the Australian Government provide both clarity on the consent issue and the facility for individuals to to consent to sharing with their insurer. In doing so Medibank notes that insurers are already trusted to maintain large stores of sensitive personal health information on their members and have done so for many decades.

A matter for separate consideration is making available to third parties Medicare claims data that contains sufficient provider details as to enable their identification. Presently claims data that permits the identification of the provider is characterised as sensitive private information, similar to an individual patient's health information, and attracts the same protection under the Privacy Act. This means that, under current privacy laws, in order for this information to be published the express permission of the provider is required.

Medibank considers information relating to a provider's professional service delivery such as the volumes, intervention rates and charging practices as being of a fundamentally different nature to personal health information and that a distinction between the two should be made. In particular a ruling would be required to clarify the application of *National Privacy Principle 2*, which governs the use and disclosure of personal information. A favourable determination that information collected by Medicare for the purposes of claims processing and benefit payment can be used to aid consumers and other clinicians in their decision making would permit the development of innovative new health support tools.

Medibank recognises some clinicians and their representative associations are reluctant to allow professional information shared in the manner depicted in this submission and that this reluctance represents an impediment to sharing of health information within the health system and with consumers. A possible response to this would be to permit clinicians, be they GPs, specialist doctors, surgeons or allied health professionals, to opt out of having their professional data included in any centralised database or disclosed to third parties. Clinicians would then need to balance their desire for performance and cost related data to remain confidential against their desire to be visible to consumers and referring GP's and the commercial advantages this may bring.

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### ***Public interest considerations***

Medibank considers that the need to create functioning markets in healthcare and the potential consumer welfare and overall cost-efficiency benefits such markets may bring as being a key consideration in making health information more available. This is particularly the case given demographic and consumer trends that together lead to projections of ongoing high rates of health service utilisation growth, but far lower capacity to sustainably fund this demand. In this environment there is an overriding national interest argument for each dollar spent on healthcare to deliver maximum value.

There is also a public interest argument on the basis that individual patients bear the costs associated with healthcare services which are higher than they would be if information relating to provider costs and performance were more widely known.

This is particularly the case in the private system where some doctors charge large out of pocket expenses that are a frequent source of dissatisfaction with private health insurance. Combined with other affordability issues, left unaddressed the cumulative effect could be that private health insurance ceases to perform its role as a way to release demand in the public health system, placing the public system under even greater pressure.

### **Conclusion**

In the absence of a fundamental health system redesign, the sustainability of Australia's health system depends on it becoming more efficient and patient centric. Obtaining this goal will require micro-economic reform and Medibank contends that a central element of such reform is the development of better functioning healthcare markets.

The failure of existing markets is extensively a result of inadequate and asymmetric access to information by consumers and their agents. Consumers and their agents are unable to act in a way which maximises their interests and creates incentives for efficiency, quality and innovation. Addressing this cause of market failure is likely to enhance health system productivity, to the benefit of all Australians.

The information required to produce functioning markets exists, but is trapped in the system and inaccessible to consumers and others who could make use of it. Making datasets such as the Medicare claims database and the PBS prescription database publically available with higher fidelity than at present, and allowing consumers to consent to sharing their health information more widely than is presently permitted, is an essential first step towards improving healthcare delivery and outcomes, boosting innovation and creating new efficiencies and opportunities that would benefit all Australians.