HEALTHY OPTIONS

Opportunities to uplift key patient and provider experiences

KPMG

Commonwealth Bank

Foreword

CommBank Health, commissioned KPMG to undertake qualitative and quantitative research using surveys and interviews to identify potential areas of friction in the healthcare customer experience and inefficiency in healthcare providers' administrative processes.

Healthcare providers are set to take on a new era of capability with digital solutions driving greater productivity, enhanced insights and most importantly better patient experiences.

The KPMG *Healthy Options* report, commissioned by CommBank Health uncovers exciting opportunities for how digital transformation could improve connectivity across the entire healthcare ecosystem and bring better outcomes for all stakeholders.

The Australian healthcare system is recognised as world-leading, when it comes to access and affordability. The direct experiences of patients, providers and private health insurers outlined in the *Healthy Options* report provide valuable insights into how we can maintain these high standards, while rising to the challenges of escalating healthcare costs and the changing expectations of patients for simpler and more transparent service delivery.

The research in this report reveals how digital technology can transform healthcare processes, including by eliminating the direct and indirect costs arising from manual booking systems.

Digitisation and automation has the power to dramatically reduce time, costs and labour spent on administration and the manual processing of claims and payments – especially in primary healthcare and referred medical services.

Consumers agree that fully digital processes make it easier and faster for them to book, claim and pay for appointments. Many say they would consider changing providers if they offered better service and these sentiments could stimulate greater uptake of digital solutions by healthcare providers.

The integration and sharing of data could underpin more connected and personalised experiences while empowering patients with greater control and visibility over their health information. Practitioners meanwhile could devote more of their scarce resources towards the administration of clinical care and less towards dealing with paperwork.

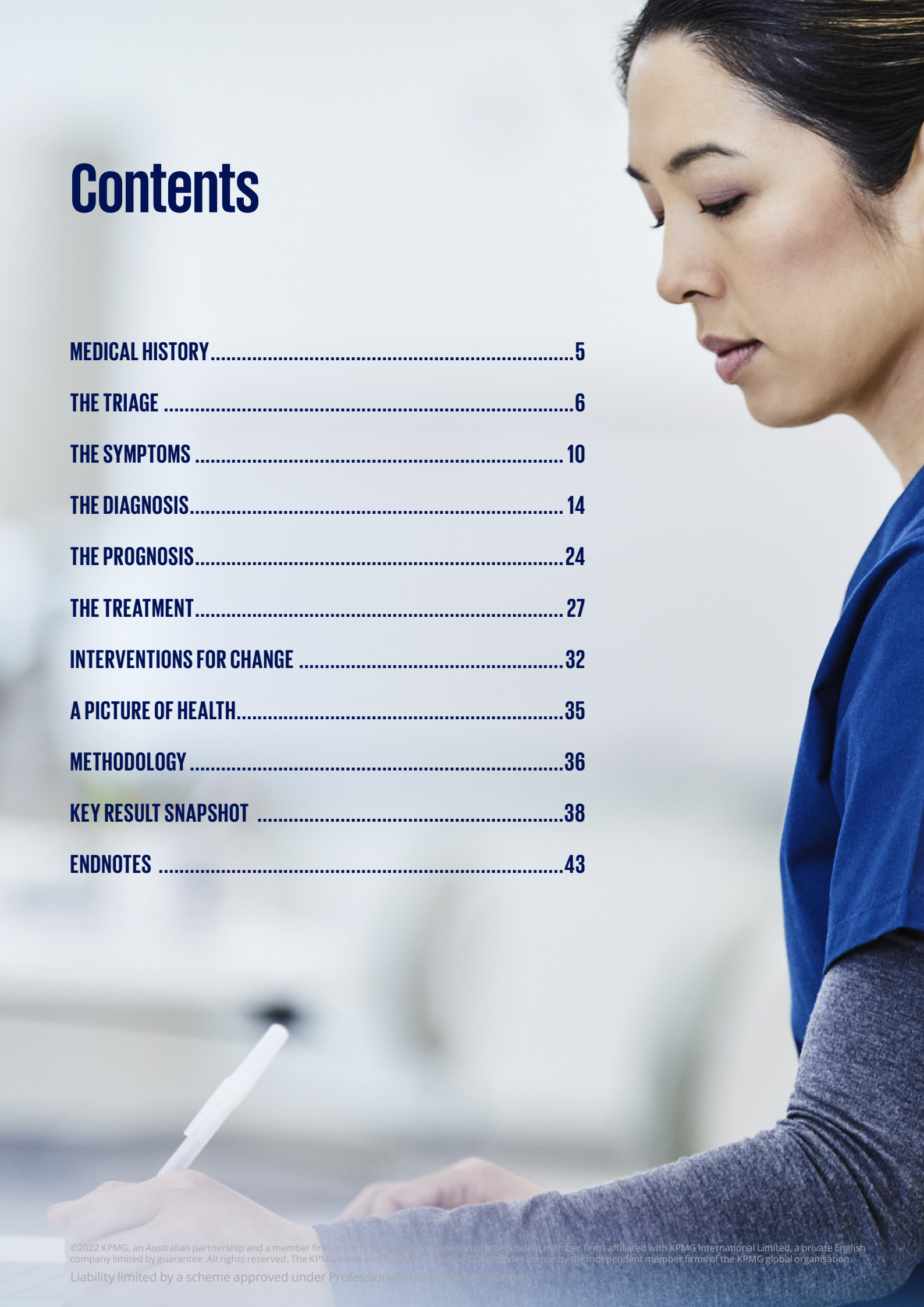
Building trust with patients through better-informed and more transparent processes, and making access to healthcare services easier are benefits that flow through to governments and private health insurers. Similarly the major payers in the healthcare system have an opportunity to develop policies and build new products to further improve the system and manage increasing community needs for quality services.

At CommBank Health, we are focused on helping providers, patients, insurers and governments work together to optimise outcomes. Smart Health is the future of healthcare and the way to create a truly connected journey for everyone.

The end goal is better access to quality care for Australians and more time for healthcare professionals to deliver it.

Albert Naffah
CEO, CommBank Health

Contents



Medical history

How has our health been to date?

As maligned as it sometimes feels, the Australian healthcare system is actually a national treasure.

We lead the world in many social, medical, and technological innovations – including the NDIS and digitised claims. Australia ranks highly when compared to other developed nations with an enviable system of universal healthcare supplemented by privatised healthcare.

The facts show that Australian healthcare is among the most accessible and affordable in the world. For example, a simple comparison with the USA, Switzerland, and the United Kingdom sees patients receive a good balance between spend and health outcomes in Australia.[1]

That said, we can still do better.

Right now, Australia has an opportunity to modernise the consumer experience, while simultaneously lowering administrative costs for healthcare providers, leading to greater satisfaction all round. This report focuses on experiences for patients in ambulatory settings, often with private health insurance coverage.

This could be a win-win felt by everyone – but we must do it together.

WHO IS THE CONSUMER?

For the purpose of our research, and for this report, the healthcare consumer is defined as the person who receives care, in any form, from the healthcare provider, and then pays for that service. They are typically the patient.

100%

of Australians covered by Medicare[2]

55%

of Australians also covered by private health insurance[3]

#1

Australia's ranking among comparable OECD countries for healthcare outcomes[4]

#10

Australia's ranking among comparable OECD countries for health expenditure as proportion of GDP[5]

The triage

Tell us where it hurts

As it stands, most Australians are satisfied with the existing healthcare system – 83% of us are satisfied with the availability of quality healthcare.[6] There are, however, factors lurking to undermine patient satisfaction:

COSTS ARE RISING

Australia's aging population is expected to increase demand for services, which will continue to drive up costs.

CONSUMER EXPECTATIONS ARE CHANGING

Our collective idea of true convenience is being shaped by world-class interactions with other organisations in other contexts – like Uber's embedded, easy payment system.

These two factors are starting to impact (private) healthcare delivery now. Which is why now is the ideal time to explore opportunities to re-frame key experiential elements of the Australian healthcare system.

Patients value different things, that contribute to their overall experience. Important amongst those are administrative elements, which this report focuses on. By improving things like bookings, admissions, claims processing and payments we can provide a better patient experience, while simultaneously reducing costs for providers.

The assessment

The first, crucial step we need to take is to look at healthcare delivery as an end-to-end journey, not a series of isolated steps. That way we can identify multiple points of friction that are experience gaps for consumers. Fixing these pain points leads to efficiency gains for everyone.

Frontline healthcare providers often deal with the consequences of sub-optimal consumer experiences resulting from systemic inefficiencies – including consumer dissatisfaction and the direct costs of the inefficiencies themselves.

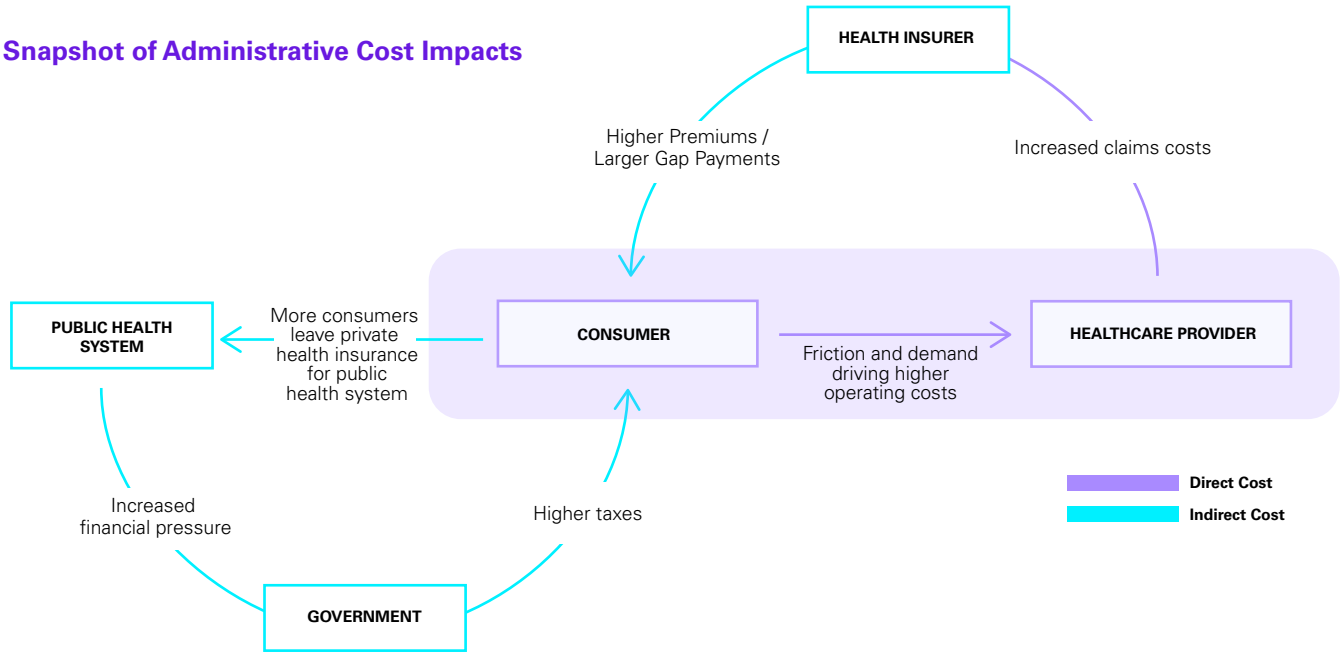
The impact of these inefficiencies can also be felt less directly – by other stakeholders like Private Health Insurers (PHI) and multiple levels of Government.

Of course, the main affected group are the consumers. They are the reason we need a healthcare system. They're also making a material contribution financially through gap payments. Ultimately, poor service changes their perception of value for money of private healthcare.

It is therefore in everyone's interest to find ways to improve efficiency in healthcare delivery.

The research conducted for the 'Healthy Options' report suggests that incremental improvements in provider efficiency and consumer experience have the potential to lead to better outcomes for healthcare stakeholders.

Snapshot of Administrative Cost Impacts



Source: KPMG

What happens next?

In the pages that follow, you will see detailed results of in-depth discussions with healthcare consumers, providers, and healthcare insurance executives. The insights gained from these interactions have helped identify opportunities to improve Australia's already remarkable healthcare system.

KPMG and CommBank Health have partnered to explore options for industry leaders to return greater value to all Australians.

We've laid out how a more connected and more efficient healthcare system will result in a better health journey for consumers as well as providers.

That will be better for everyone.

"When consumers search for a healthcare provider, they not only look at whether they can provide the required treatment, but also evaluate the overall customer experience, including the expertise of provider, how close-by is the provider, and what are the expected out-of-pocket costs."

Chief Officer, Major Australian Health Insurer

The symptoms

Where is the spending in the system?

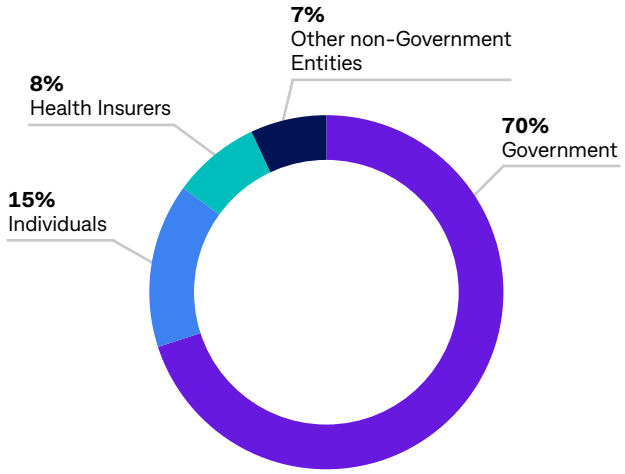
Healthcare spending on primary healthcare (e.g., GPs) and referred medical services (e.g., specialists) in FY2019-20 was $87.1B – a significant component of the Australian economy. Plus, it's both diverse and growing.

While government is the largest funder of healthcare, a function of Australia's social security, a significant 23% is funded by the consumer, either directly through out-of-pocket expense or through private health insurance premiums.[7]

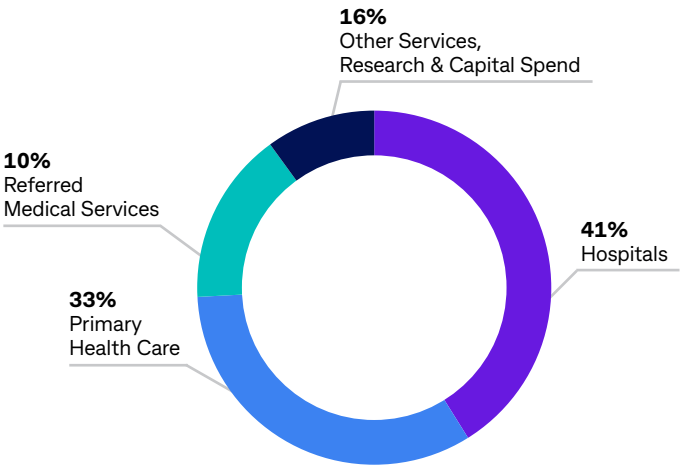
And what is this funding being spent on? Out of a total of $202.5B, a combined 43% (or $87.1B) is for primary healthcare and referred medical services that are delivered on an everyday basis through practices in our communities.[8]

Health spending has grown faster than the rest of the economy. In 2000-01 the ratio of healthcare spending to GDP was 8.3%. It's now 10.2%. Importantly, as spending has grown, so too has the number and diversity of health practitioners – Australia now has 292,890 service providers, up from 225,468 just 5 years ago.[10]

Funding by source



Spending by area



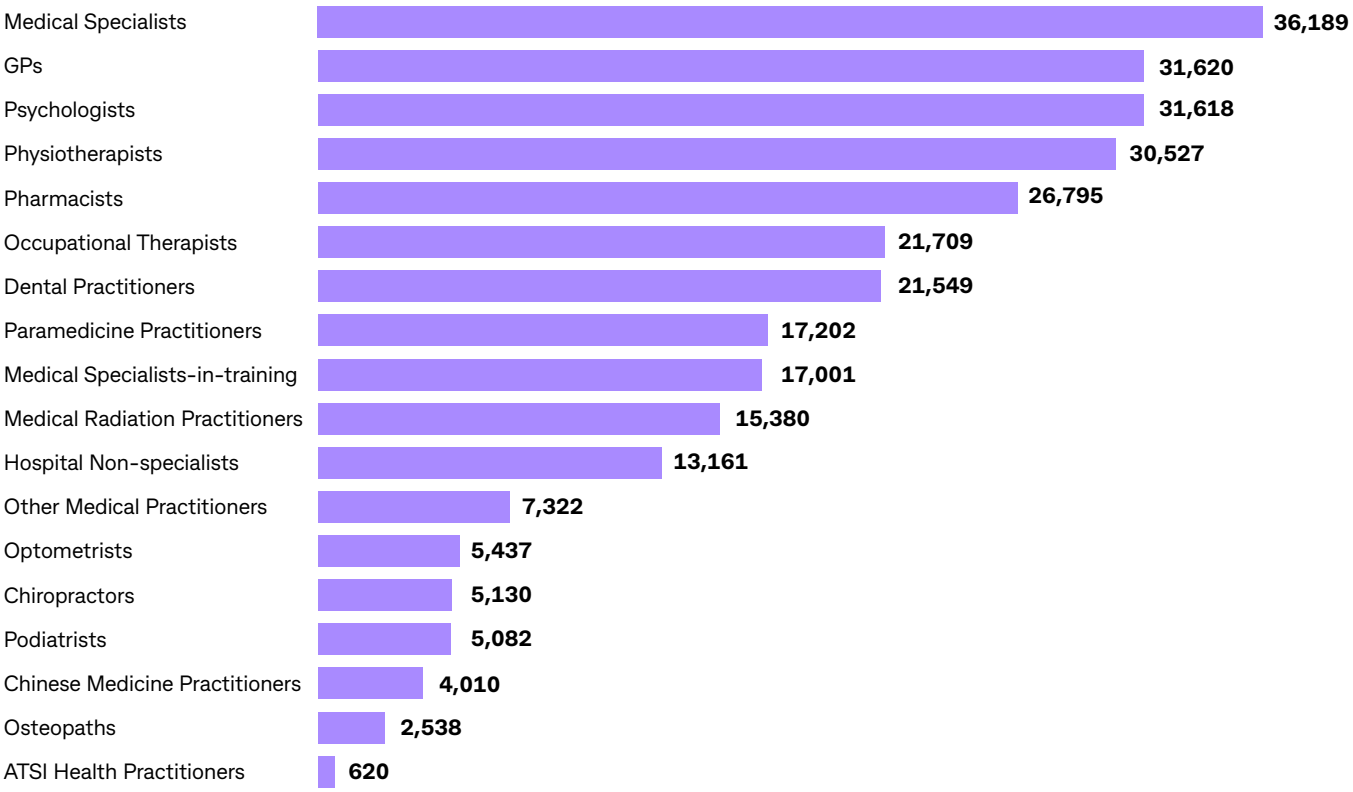
The services that we focus on in particular are:

- **Primary healthcare services** – a range of services delivered outside the hospital that generally do not need a referral, like GP, dental, pharmaceutical, community, public and other health services.
- **Referred medical services** – where a consumer needs to be referred by a GP or medical specialist, including diagnostic pathology, medical imaging or other allied health services.

It is important for healthcare providers to deliver a frictionless, high-quality and cost-effective end-to-end consumer experience.

Particularly if they want to be the preferred provider for consumers.

Number of medical and allied health practitioners by segment



"A key challenge for society and insurers is how to collectively fund high-cost, customised therapies, such as robotic surgery, chemotherapy drugs, and other treatments not covered by PBS, [that will be expected to be accessible] for the mass population."

Chief Officer, Major Australian Health Insurer

How is healthcare set to shape-up in the near future?

On average, OECD countries have seen a steady growth of health expenditure as a share of GDP – from 7.8% in 2005 to 8.9% in 2019 before a sharp rise to 9.9% in 2020, coinciding with the COVID-19 pandemic.[11]

Australia currently sees healthcare expenditure at 10.2% of GDP and is ranked #16 among the 38 OECD economies.[12]

However, in the same study, Australia ranked #8 highest by price of healthcare goods and services – a higher rank means higher prices, leading to less affordability. Australia was just behind the United States (#7), but well ahead of the United Kingdom (#14), Canada (#16) and New Zealand (#23).[13]

This correlates with rising costs of medical technology – some of which can be 30% higher in Australia than in the countries listed.[14]

Australia's aging population will also add upward pressure. The proportion of Australians aged 65 and older has grown from 12% in 1995, to 16% now, and is expected to grow to 22% by 2066.[15]

Interestingly, there has been some short-term impacts from COVID-19 on the historical trends. Private health coverage increased during the pandemic and people delayed or avoided seeing a GP (9.8% of people) or a dental professional (12.2% of people) due to COVID-19.[16]

However, these effects have been short lived and the general upward pressure is expected to return to the cost of healthcare. This will set the scene for even greater focus on effectiveness and efficiency in healthcare delivery.

The diagnosis

How the end-to-end consumer experience is felt by everyone

Consumer experience has a major impact on efficiency in healthcare.

Last year, Australia was the world leader for healthcare satisfaction, but in 2021 it has fallen to #3, behind Singapore (#1) and Switzerland (#2).[17] When probing deeper into consumers' and providers' satisfaction levels, KPMG and CommBank Health identified clear areas for improvement. In isolation, the issues identified may not appear significant. However, when considered in totality they add up to significant drag on both consumer experience and provider efficiency.

In summary, in focusing on primary healthcare and referred medical services four themes emerged from the research as opportunities for improvement in customer and provider outcomes through administrative uplifts:

How do we close the knowledge gaps for consumers?

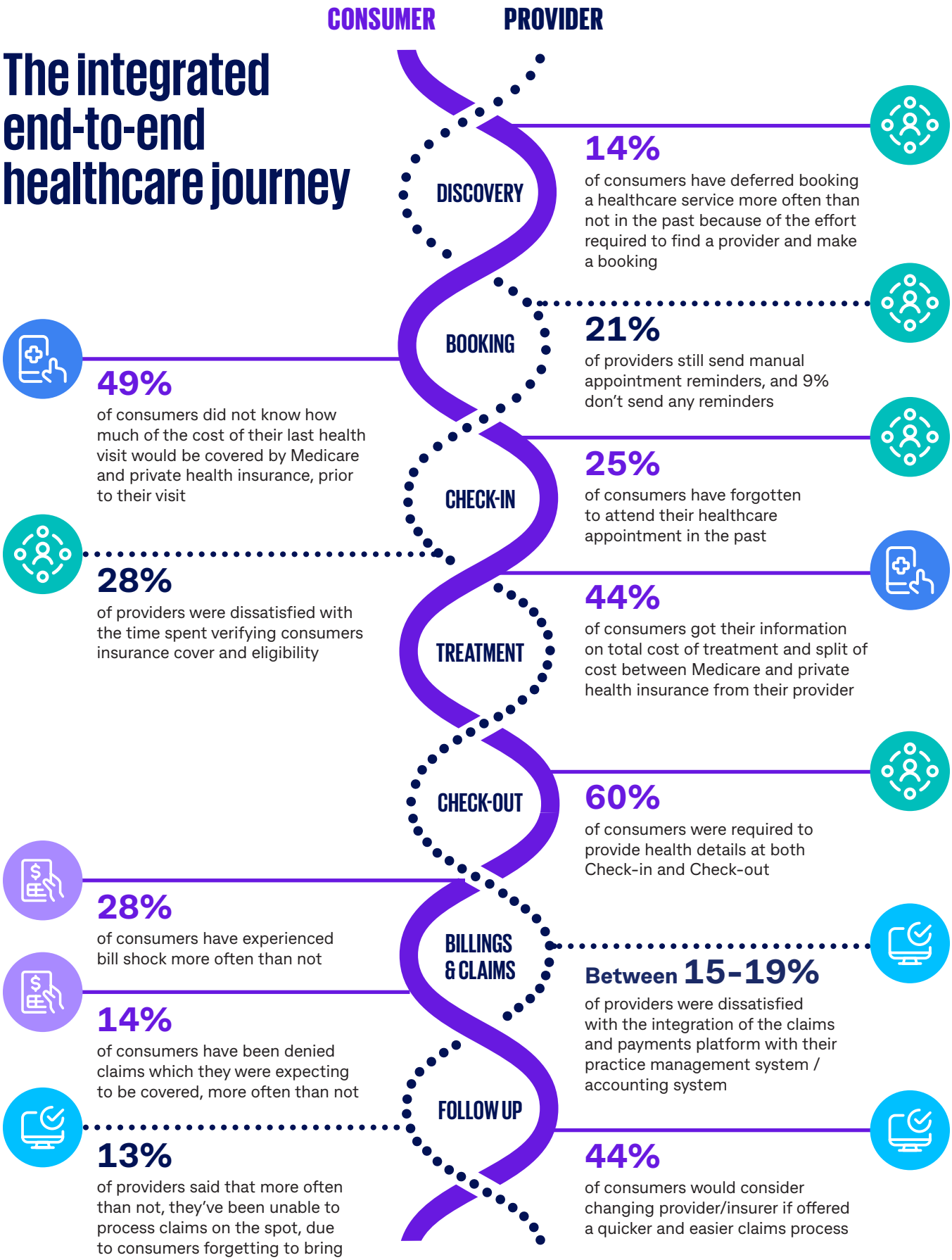
How do we improve the process for bookings and consumer administration?

How do we make claiming consistent, regardless of infrastructure?

How do we limit 'bill shock'?

Each of these were used as a catalyst for further exploration.

The integrated end-to-end healthcare journey



Note: 'More often than not' refers to respondents answering 'always' or 'most of the time.'

How do we close the knowledge gaps for consumers?

While around three-quarters of private policyholders surveyed said they understood their cover, over half said they never, or only occasionally, checked their health cover before booking an appointment. That's despite more than three-quarters confirming they know where to find the information.

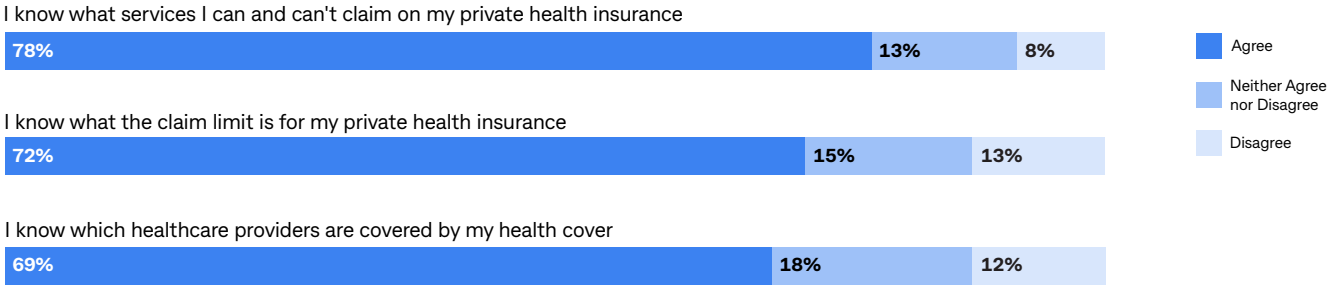
Plus, nearly half of respondents said, prior to their last healthcare visit, they didn't know, how much of the cost would be covered by Medicare and how much by their private insurer.

Consequently, providers are being asked to help consumers close their knowledge gap. Providers are having to become insurance experts – well-versed in topics like insurance coverage and unused benefit. This simply adds to their day-to-day workload.

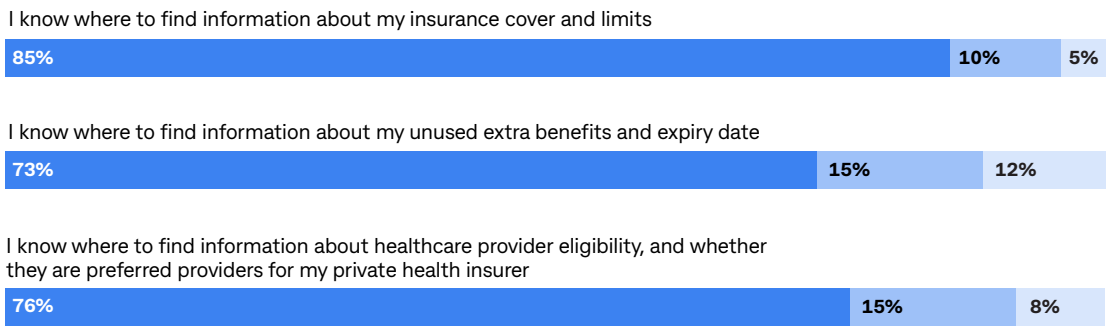
This is backed up by providers responding to our survey question about *"… the main difficulties [faced] when processing insurance claims"* referring to patients who either don't know their cover eligibility or are surprised by their benefits at the point of payment.

This is having a negative impact on frontline staff at primary and referred providers, with close to one in four saying they were dissatisfied with the time spent on verifying cover and eligibility queries from consumers.

Consumers' self-assessed health cover knowledge



Consumers' confidence in finding health cover information



Consumers checking health cover before booking healthcare service

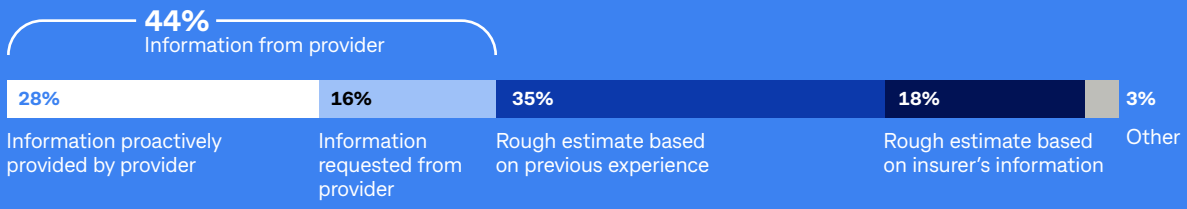
Before you book a healthcare service, how often do you check how much is covered by your health insurance and what is the out-of-pocket expense

Before booking a healthcare service, how often do you check your level of unused extra benefits

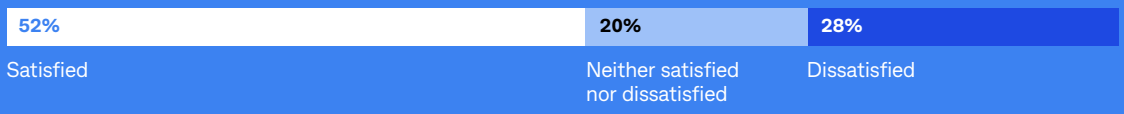
Consumers' knowledge of coverage prior to their last healthcare visit

Before visiting your last healthcare provider, did you know how much of the cost would be covered by Medicare and/or private health insurance?

Consumers' source of total treatment cost and cost split information



Providers' satisfaction regarding time verifying consumers' eligibility and cover



How do we improve the process for bookings and consumer administration?

It's no surprise that consumers want to book accurately and make changes easily – bookings rated as the second most asked area of questions by consumers of primary and referred providers. So, improving this process can have a significant impact on the operational efficiency for providers.

However, this is not an easy fix as nearly three-quarters of bookings were conducted either over the phone or in-person. In our survey, most providers indicated they have the capabilities to modernise booking and administration, but some have been hesitant in operationalising them.

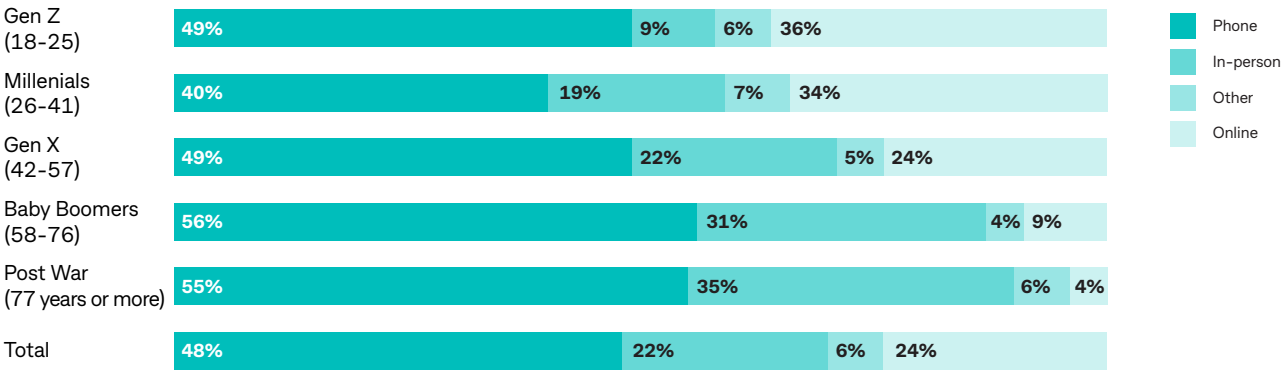
Predictably, booking preferences are age-related. Online bookings are most popular with Gen Z and Millennials. However, their popularity gradually declines with increasing consumer age – ultimately only 4% of those aged 77 or older using online bookings.

For providers, avoiding costly appointment 'no-shows' is a key concern. Interestingly, although 70% of providers are using an automated reminder system, 21% send reminders manually and 9% don't send reminders at all. This means up to 30% of providers are prone to higher rates of 'no-shows'. That's particularly concerning given the high rates of forgetfulness among consumers – 25% have forgotten an appointment, including 9% that forget more often than not.

In addition, providers are also tasked with administrating each consumer's information. This demands significant overheads and the process can detract from the consumer experience. Our survey identified a friction point at both check-in and check-out – where a large number of consumers said they had to provide details at both stages.

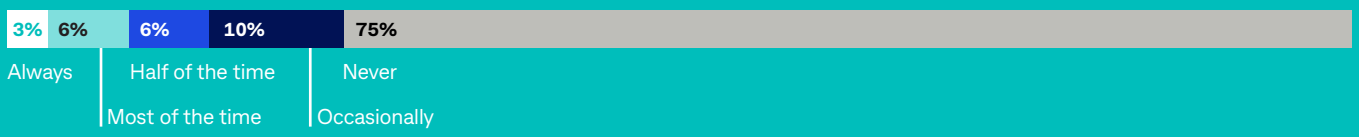
This double-handling is both costly for providers and frustrating for consumers.

Booking method used by consumers by age

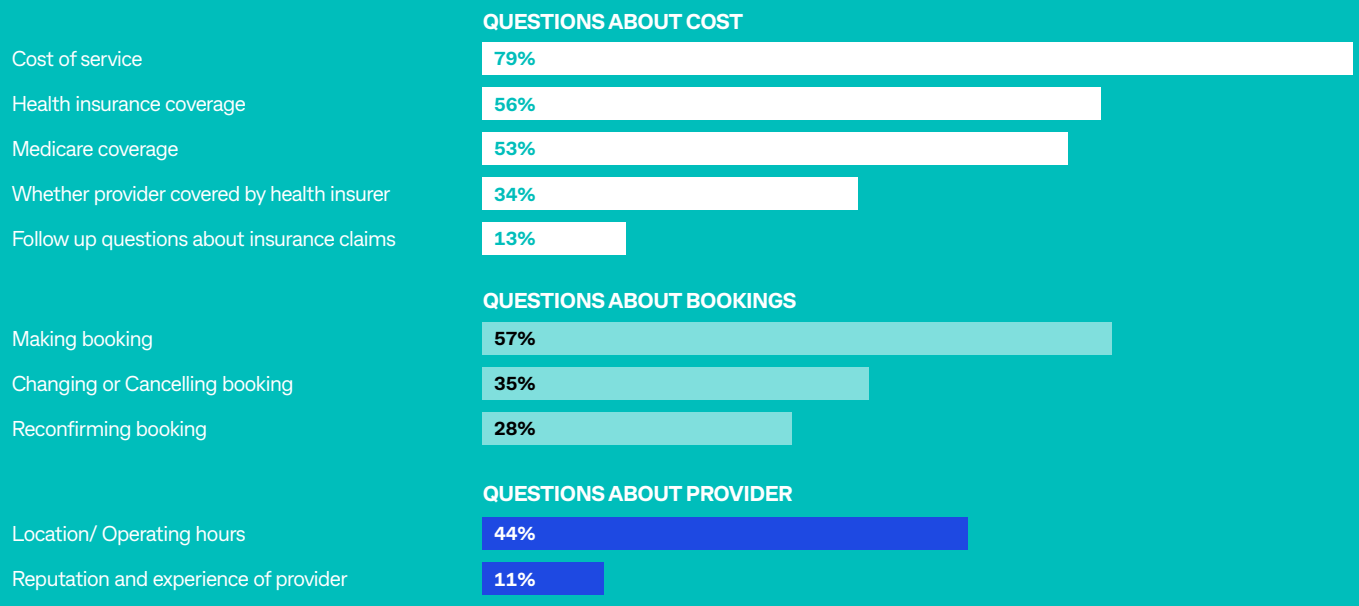


Booking reminder system used by providers

Frequency of consumers forgetting to attend their appointment



Most common questions raised by consumers



When did consumers supply their details to the provider

How do we make claiming consistent, regardless of infrastructure?

Claims processing and payment is a key link in healthcare delivery. The good news is that 87% of consumers said they were satisfied with the payment and claims process at their last healthcare visit.

In stark contrast, when issues do occur, provider staff are forced to focus on the remedy, thereby delivering a less-than-ideal experience to consumers. Inevitably these issues are driven by technology issues (e.g., technology infrastructure failure), unforeseen circumstances (e.g., consumer has forgotten their PHI card), or a lack of access to infrastructure (e.g., providers without electronic processing of claims at the point-of-sale).

Importantly, these technology issues are heightened in regional areas. There, providers often have less access to technologies and therefore rely more on manual processing. Clearly this impacts affordability for individuals and families – waiting for a manual claim to be processed can put pressure on already tight cashflow.

Plus, with over a third of consumers forgetting to bring their Medicare and/or private cover details to a visit, the impact is also significant on providers. 13% of healthcare providers said that, more often than not, they have been unable to process claims due to consumers failing to bring correct information. That leads to claims having to be reprocessed – adding additional strain on staff and resources.

So why are some providers not operating more up-to-date systems

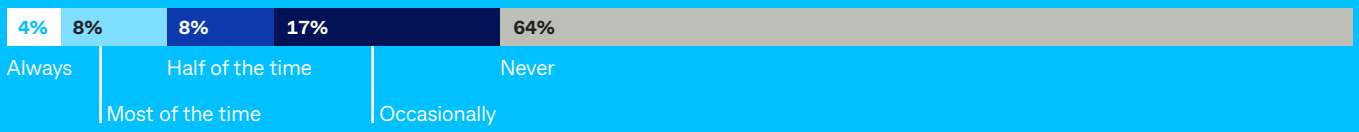
Currently, the cost of implementing new claims processing and payments platforms is a material hurdle – one fifth of providers surveyed say they are dissatisfied with the cost of the technology.

Importantly, the implementation quality of the technology is also a significant issue for providers – 19% of respondents cited dissatisfaction with the integration of the claims and payments solutions with their accounting software and 15% were concerned about integration with their practice management systems. An additional 15% indicated that internet connectivity and system outages were also a significant hindrance.

Common contributors to manual claims processing

Regional providers with limited/no infrastructure	**Specialist providers with limited/no infrastructure**	**Patient forget to bring PHI card/details**	**Internet Connectivity Issues**	**System Outages**

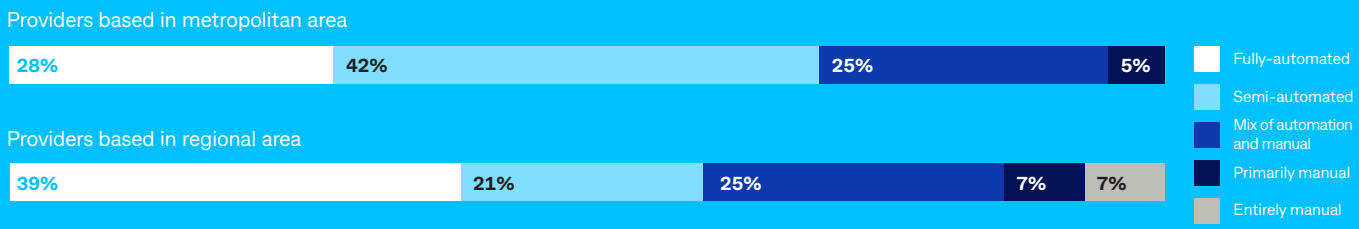
Frequency of consumers forgetting their Medicare and/or Private Health Insurance details



Frequency of being unable to process claims on the spot

Providers' satisfaction with their claims and payment platform

Provider's level of automation by region



Frequency of errors in processing causing reprocessing

How do we limit 'bill shock'?

'Bill shock' presents in several forms. For some consumers it's that their out-of-pocket expenses are higher than expected. For others, their claim may be denied entirely – 14% of policyholders said they have been denied claims, which they were expecting to be covered by their health cover, more often than not.

Often, consumers are creatures of habit. In our survey, 35% said they estimated the cost of a healthcare visit based on previous experience. A further 21% estimated based on information from insurer or other sources. Only 44% got estimates from the provider directly.

Therefore, it shouldn't be surprising that nearly half said their gap payment was higher than expected – half or more of the time. An additional 38% said they had occasionally experienced higher than expected gap payment.

Clearly, this 'bill shock' is a poor consumer experience. Just as importantly, it's also a poor provider experience. Administration staff feel they have to explain the situation to a potentially unhappy consumer – therefore they need to be fluent in the wide variety of private health fund issues. All of which is putting pressure on an already stretched workforce.

Consumers' experience of bill shock and claim denial

When it is time to pay, how often is the total out of pocket expense (i.e. GAP payment) higher than you expected

How often have you been denied claims which you were expecting to be covered by your health insurance

Frequency of consumers deferring or avoiding healthcare services

Defer booking a healthcare service because of the effort required to find a provider and make a booking

Defer or avoid booking a healthcare service because it isn't covered by your private health insurance

Claiming behaviour of consumers currently covered by have private health insurance

Claimed in the past 12 months

Have not claimed in the past 12 months

"There is a whole-of-ecosystem opportunity for Australia's healthcare system. Health insurance isn't just about hospital and extras cover, but also about health services, rewarding lifestyle empowerment, flexibility of treatment, prevention and well-being, discounts, and partners."

Chief Officer, Major Australian Health Insurer

The prognosis

Efficiency helps insurers, Government, and 'future' consumers alike

Although consumers and providers are the most directly impacted by the issues identified in our survey, the interconnected nature of healthcare means there are flow-on effects for everyone – see 'The integrated end-to-end healthcare journey' on page 15.

In FY2019-20 Australia spent $87.1B on healthcare with primary and referred medical services providers.[18] If even a modest 1% efficiency improvement was achieved, that could amount to a $871M savings.

Conversely, tolerating the cost of this inefficiency short-term may ultimately inflate the impact of other, long-term environmental factors – like Australia's ageing population. Private insurers would need to decide whether to absorb all, part, or none of the rising costs. The result of which would be rising premiums or limiting benefits. And the Governments' increasing spending on healthcare ultimately will have an impact on taxpayers.

Rising costs today also have unexpected detrimental effects on demand. In our survey, 53% of consumers with private cover indicated they occasionally or more frequently avoided booking a healthcare appointment not covered by insurance.

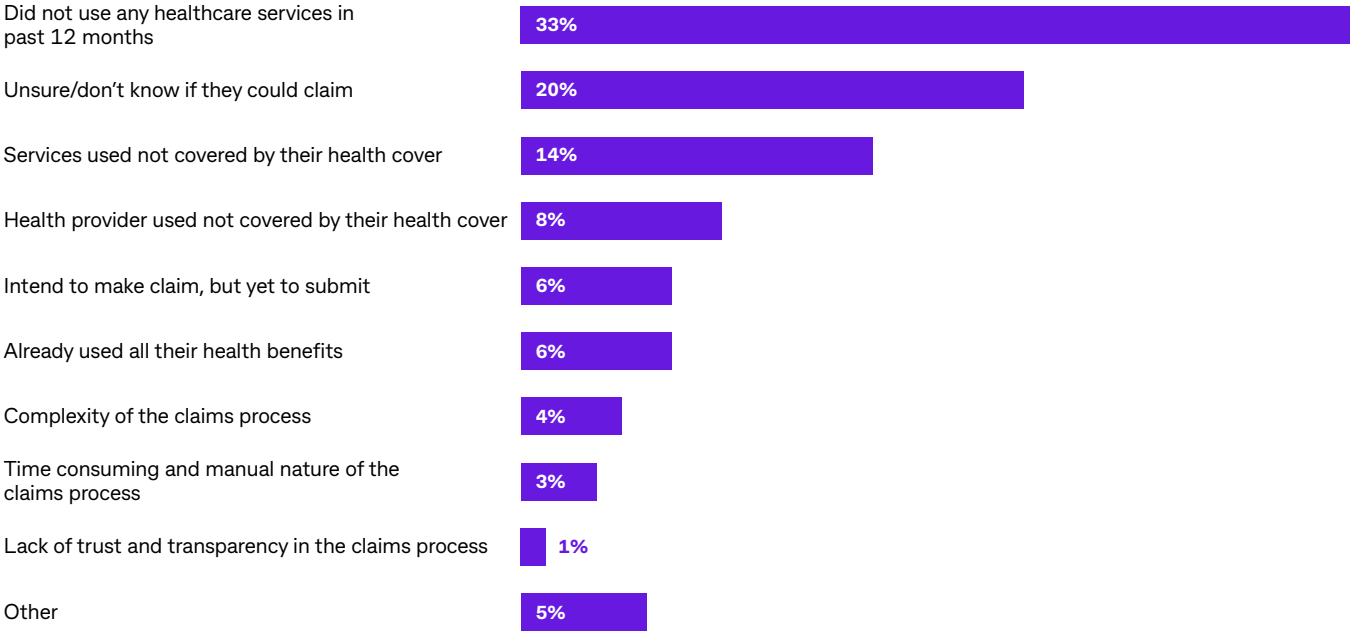
So, in fact, consumers are already not seeking care because of cost sensitivities. Should future cover not match rising costs then more consumers could opt out of healthcare treatment – potentially presenting with more acute conditions in the future.

This could then add to the proportion of consumers using private health cover tactically. They take cover to address lifestyle or stage of life risks rather than making a whole-of-life choice. This may work in the short term, but it can mean consumers are not exposed to the preventative care programs that could otherwise lead to a reduced risk for the consumer's 'future me'.

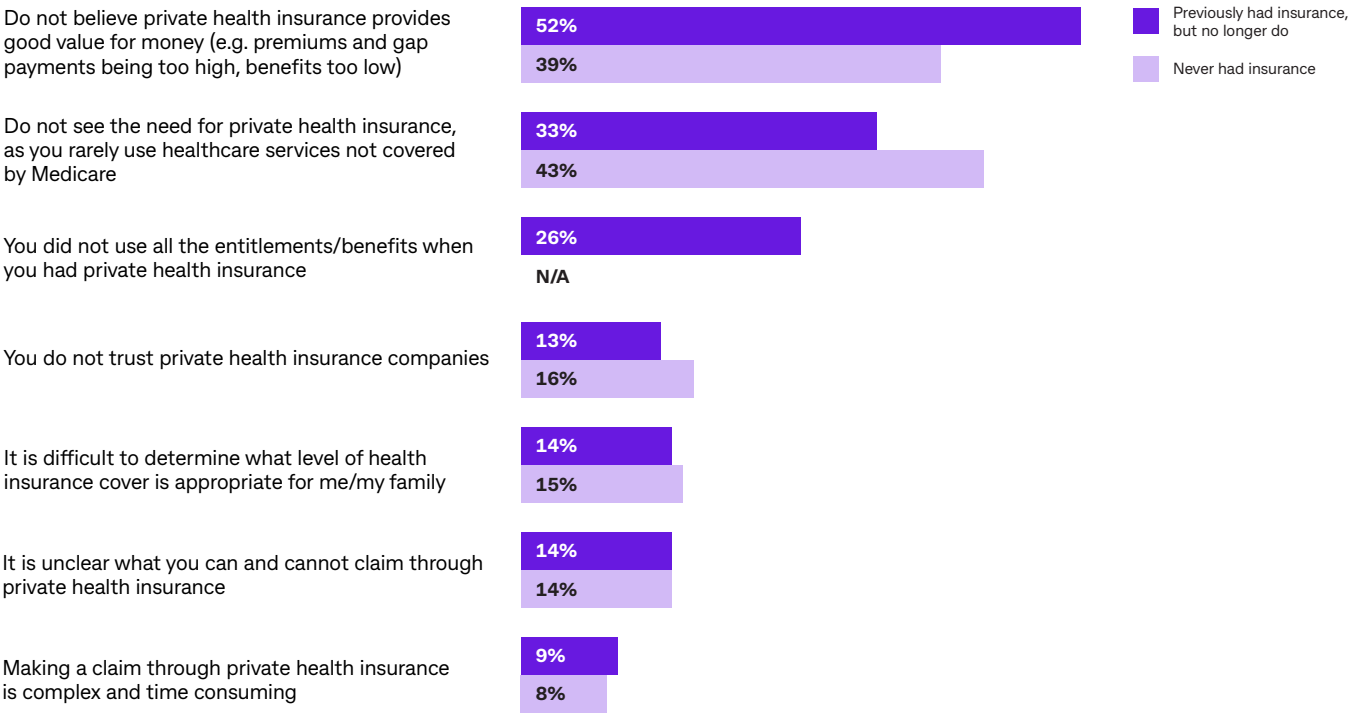
Finally, 20% of consumers holding a policy said they had not made any claims in 12 months. Within this group, 20% said this was because they simply did not know whether the treatment they received was covered.

Ultimately this lack of information means consumers are simply not getting full value.

Reasons why consumers with private health insurance have not lodged claim in past 12 months



Consumers' top reasons for not having health insurance (multiple answers allowed)



"There is a shift towards empowering consumers to self-service the entire end-to-end healthcare process; from searching, to booking, to payments, and claims. A key aspect of this is about being more transparent about the end outcome."

Chief Officer, Major Australian Health Insurer

The treatment

Opportunities for better healthcare delivery experiences

Based on the four issues previously identified, we've focussed on three real opportunities for change. Areas where consumer experience and provider efficiency can be dramatically improved in the administration of significant areas of Australian healthcare.

Digitise and automate booking and administration

Orchestrate an integrated consumer journey

Use contemporary technology to avoid legacy limitations

We fully explored these opportunities – while continuing to lean on the findings from our research.

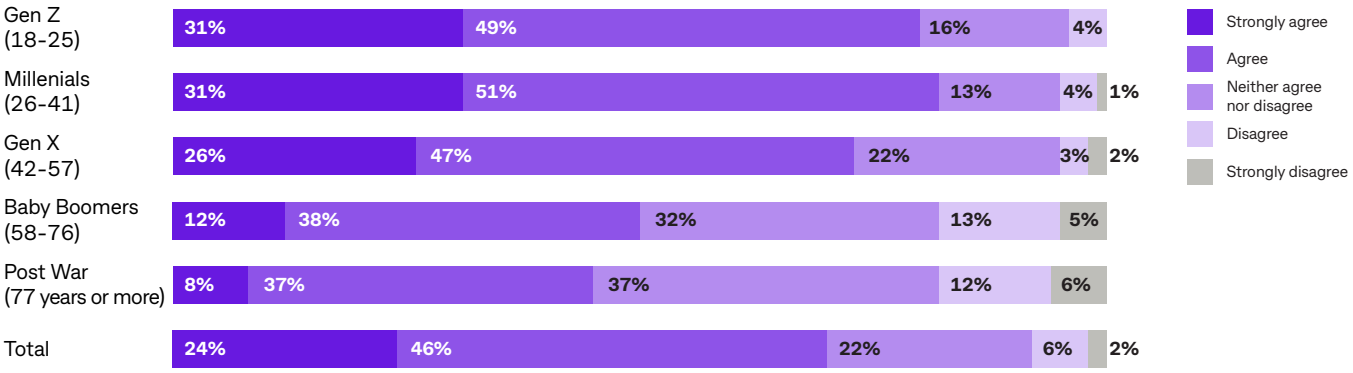
Digitise and automate booking and administration

Healthcare providers acknowledge there is ample opportunity to increase digitisation and automation, 82% recognised there was either significant or some opportunity for improvement.

The most beneficial changes were seen as:

- **Reducing manual processing of claims and payments** – healthcare providers can then focus their resources on the quality of healthcare treatment.
- **Increasing digitisation of booking, administration and sending reminders** – providers recognise these are likely to improve consumer satisfaction – 71% of consumers said they agree or strongly agree that a fully-digital process would make it easier to book appointments.
- **Making the manual booking process largely redundant** – for the average provider with just two administrative staff, they could deploy these staff hours far more effectively.
- **Better utilising existing digital platforms** – 68-72% of providers in our survey have a digital and automated process but many are not fully utilising them.

Consumers' belief that bookings, claims and payments will be easier and faster via a fully-digital process



Providers' self-assessed opportunity for automation and digitisation in current processes

Orchestrate an integrated consumer journey

The current end-to-end delivery of healthcare still operates in silos – often resulting in a frustrating consumer experience and an inefficient use of provider's staff time.

By re-framing the consumer's experience, providers can solve both issues. Specifically:

- **Adopting an 'ask once' approach** – using information that has been verified and validated recently – typically via digitised consumer accounts and forms. Clearly, this allows for more personalised engagement with consumers plus a reduction in operating overheads spent capturing, storing and retrieving consumer information manually. Importantly, three quarters of consumers said they're comfortable with storing their Medicare and health insurance data in an app if it can streamline the booking-claim-payment process (i.e., 74% of respondents agree/strongly agree).
- **Empowering consumers to make more informed decisions** – by filling the consumer's knowledge gaps in relation to healthcare – anything from questions about service costs, the proportion covered by Medicare, to basics like a provider's address and opening hours. An online tool, like an artificial intelligence chatbot, could triage consumer questions by directing them to the most relevant party (i.e., provider, health insurer, or government).
- **Tailoring responses further with linked information** – by linking the front-end online tool with a back-end all-in-one platform containing personal, Medicare, and health insurance details, including previous booking, payment and claims information.
- **Encouraging movement of information between providers** – so when consumers move from one provider to another there is no need to 'start again' in providing information.
- **Proactively remind consumers to use their entitlements** – for instance if a consumer has unused extras benefits set to expire next month, messages could be sent nudging them to make use of it.

By proactively using data and analytics, with appropriate consent, not only can we improve health and wellbeing outcomes, but simultaneously encourage greater and more timely use of healthcare providers' services.

Which is better for everyone.

Consumers' agreement that they are comfortable storing Medicare and health insurance data in an app, if that streamlines the booking-claim-payment process

Use contemporary technology to avoid legacy limitations

Put simply, healthcare providers can offer an 'Uber-like' experience for consumers by adopting more contemporary payments management systems. That way both the consumer and provider are largely unaware of the transaction process and exceptions can be managed with minimal fuss.

The keys to achieving this are:

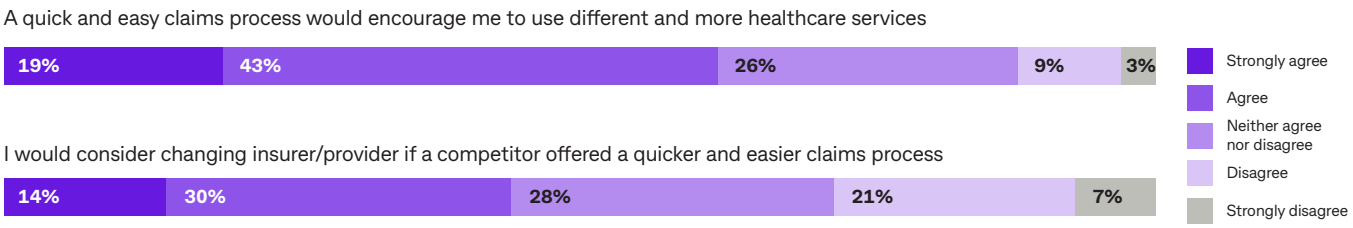
- **Shifting from ownership to new ways to access technology** – such as adopting cloud or platform services to reduce the burden of maintaining and operating legacy technologies on premises; often these legacy technologies are not used to their full potential and can be difficult to integrate and maintain.
- **Developing booking to payment processes on a single platform** – like Uber and other platforms that use 'embedded finance' to reduce friction in the purchasing process and opens a door to pre-payment or 'payment hold', which is an effective way to reduce the likelihood of 'no-shows'; typically, bookings and payments are separate solutions for many providers.
- **Offering a variety of payment options** – like other payments options (e.g., Union Pay, Alipay, etc.) to help improve affordability and access to treatment; providers typically offer only major cards and cash as payment methods, requiring patients to fully settle payment during their visit, a potential source of stress (e.g., vulnerable individuals, international workers, students, and visitors).
- **Building greater flexibility into a fully digitised claims processing platform** – that would include Medicare and the ~40 different Australian health funds, while also being adaptable to support a variety of insurance cover innovations such as on-demand or flex cover (e.g. HCF's Flip and Bupa's FLEXtras); this could lead to greater inclusivity of payer options and could be more adaptable to trends in private health insurance, as well as support new Government healthcare initiatives (e.g., targeted healthcare benefits, etc.).

Together, the adoption of these technology capabilities, which are available today, offer a more seamless consumer experience, while reducing the bookings, administration, and record keeping overheads for providers.

And consumers are already looking for this change. 61% said a quick and easy claims process would encourage them to use different healthcare services. Crucially, 44% of consumers said they would consider changing provider or insurer if offered a quicker and easier claims process. So, to optimise their claims process, providers need to work proactively with insurers and other healthcare stakeholders.

It's the key to satisfied patients and staff.

Consumer's attitude to changing insurer/provider and use of healthcare services



Interventions for change

Although not a comprehensive list, we have identified three key enablers of change for Australian Healthcare.

01

INCREASE COLLABORATION ACROSS THE HEALTHCARE ECOSYSTEM

The focus needs to be on excellence in end-to-end consumer experience – while retaining the current quality of care. Clearly, healthcare providers cannot achieve this alone. They need the support and collaboration of all key industry stakeholders – including Government, private health insurers and technology partners.

Government has a crucial role to play here. As the biggest payer and stakeholder within the healthcare industry, greater alignment between public and private sectors has the potential to drive enormous efficiencies.

02

TRANSFORM PROVIDERS BEDDED-IN WORKING PRACTICES

Providers will need to be adept at change and adoption of new working practices. This leads to better consumer experience as well as efficiency for the provider.

For example, providers will need to move from manual bookings and payments to new, automated technologies. Payments need to be a connected and integrated experience but, crucially, need to feel invisible to consumers. Double-handling will need to be eliminated for providers.

But changing working practices doesn't come naturally to providers, who are singularly focused on patient care.

For change to happen, change is needed. For this, providers will need to:

– Foster capacity for change – helping them find the time and bandwidth to learn and implement.

– Build capability for change – so they know how to effectively and efficiently upgrade.

The ultimate aim is to have providers operating in a more consumer-centric mindset across their business – from bookings and reminders to payments and claims.

03
LEVERAGE INDUSTRY-WIDE DATA STANDARDS FOR HEALTHCARE

The aim is to facilitate data exchange and build consumer confidence in the use of their personal health data.

Providers need to ensure the technology and infrastructure used in other parts of the business (e.g., bookings, administration, practice management system) is integrated with their payment platform – for one end-to-end experience for consumers.

Clearly, Government has already played a crucial role in driving these standards. A national digital health strategy has been established. Plus, there are tax incentivises for businesses who build out their digital capability – from websites to cloud computing to payment platforms. However, more could be done – specifically for healthcare providers.

The success of any reinvigorated system will rely on enough early adopters reaching the critical mass point – from then on participants can start leveraging network efficiencies.

It's how we'll affect real change in healthcare.

"The target state for healthcare claims and payments should be an integrated end-to-end health platform where transactions are cardless, claim submissions are automated, payments are instantaneous, and practice management systems are updated in real-time."

Chief Officer, Major Australian Health Insurer

A picture of health

In conclusion, we can help each other

Australia has a healthcare system we should all be proud of. However, just like healthcare systems in other OECD nations, the system remains complex and costs are rising. Couple that with the inevitable mounting demand of an aging population and there is a real risk that affordability, quality, and service will be put under stress.

There is a clear opportunity to improve the consumer experience across the healthcare journey, from end-to-end. By unlocking a virtuous feedback loop with less friction in delivery we can drive better consumer engagement, and in turn, maximise health outcomes for all Australians.

Taking our cues from other, more contemporary, experiences can lead to effective but relatively simple solutions for the consumer – from bookings to payments and every step in between. By removing some of the stress of the consumer experience we can simultaneously reduce providers' overheads so that they can refocus their resources on what really matters – the health of their patients.

We believe there are enablers to this change that the healthcare industry needs in order to unlock this potential – like data sharing and updating working practices. What's critical is embracing collaboration across the healthcare industry.

It is our sincere wish that you share our excitement at the potential to apply innovations in consumer experience and technology-enabled process efficiency.

It's all within our reach, so let's choose these healthy options.

Methodology

The 'Healthy Options' Report explores the current end-to-end delivery of healthcare in Australia from the perspective of consumers and healthcare providers. The inefficiencies and opportunities to improve healthcare delivery in Australia that have been identified within this report are drawn from primary research conducted with consumers and providers of healthcare.

The study consisted of KPMG:

- Surveying a nationally representative sample of Australian household decision-makers who have experienced end-to-end healthcare delivery in the past 12 months and made a private health insurance claim. A total of 1,108 Australian consumers completed the survey. The survey aimed to understand the current end-to-end healthcare consumer experience and identify consumer knowledge, needs and expectations.
- An additional consumer survey cohort of 2,291 Australian consumers who responded to the survey but didn't qualify because they either don't hold private health insurance or haven't made a claim in the past 12 months, were asked a small number of questions to ascertain why this is the case.
- Surveying a total of 150 healthcare providers across Australia, including GPs, dentists, specialists, and allied health providers. The aim of the survey amongst healthcare providers was to understand the end-to-end administration experience and challenges that providers face delivering the end-to-end experience.

The survey findings are based on analysis of the responses provided by survey participants. The responses of survey participants are assumed to be accurate and reliable; no data cleaning or validation was performed.

Key result snapshot

Survey respondents

- 52% of our survey respondents presently hold PHI.
- 48% do no hold PHI – consisting of 27% who have never held PHI and 21% who previously held PHI, but no longer do.

Consumer knowledge

- 78% of consumers said they know what services they can and can't claim on their private health insurance.
- 72% of consumers said they know what the claim limit is for their private health insurance.
- 69% of consumers said they know which healthcare providers are covered by their health cover.
- 85% of consumers said they know where to find information about their health cover and limits.
- 73% of consumers said they know where to find information about their unused extra benefits and expiry date.
- 76% of consumers said they know where to find information about healthcare provider eligibility, and whether they are preferred providers for their private health insurer.

Consumer behaviour

- Over half of consumers (i.e. 58% to 64%) never or only occasionally checked their health cover, before booking their healthcare service.
- One in two consumers (i.e. 49%) did not know how much of the cost of their last healthcare visit would be covered by Medicare and PHI, prior to their visit.
- Almost half of all consumers (i.e. 44%) got their information on total cost of treatment and split of cost between Medicare and private health insurance from their provider, of which:
  - 28% had the information proactively provided by the provider.
  - 16% had to request the information from the provider.
- 25% said they have forgotten to attend an appointment in the past, including 9% who have forgotten more often than not (i.e. always or most of the time).
- Over a third of consumers (i.e. 36%) said they have forgotten to bring their Medicare and/or PHI details (i.e. card/information) to healthcare visits in the past, including 12% who have forgotten more often than not (i.e. always, or most of the time).
- 13% of providers said that more often than not (i.e. always, or most of the time), they've been unable to process claims on the spot, due to consumers forgetting to bring their Medicare and/or PHI details.
- 87% of consumers said they were satisfied with the payment and claims process at their last healthcare visit.
- 61% said a quick and easy claims process would encourage them to use different and more healthcare services.
- 44% said they would consider changing provider and/or insurer if offered a quicker and easier claims process.

Digitisation and automation

- Currently majority of bookings (48%) are made via phone, 24% are made online, 22% in person (typically after the most recent visit) and 6% via other means, such as email and text message.
- Online bookings were most popular with Gen Z (18 to 25 years old) and Millennials (26 to 41 years old), with more than one third (36% and 34% respectively) booking their last healthcare visit online.
- Online bookings gradually drops as consumer age increases; 4% of Post War (over 77 years old) use online bookings.
- The majority (70%) of providers have an automated system for sending out appointment reminders, 21% still send manual reminders, and the remaining 9% don't send any reminders.
- 68-72% of providers have a digital and/or automated process, but many are not fully utilising them.
- 14% of providers based in regional area said they have a manual or primarily manual process, compared to only 5% of providers based in metropolitan areas.
- 70% of consumers said they agree or strongly agree that a fully-digital process (i.e. website or app) would make it much easier and quicker to book appointments and make payments and claims.
- Support for a digital process is particularly strong for younger age groups. e.g. 80% of Gen Z (18 to 25 years old) agree or strongly agree that a fully-digital process with be quicker and easier, but support is also substantial at older age groups. e.g. 45% of Post War (over 77 years old) agree or strongly agree.
- 82% of providers saw either significant or some opportunities to improve the level of automation and digitisation in their current processes.
- Three quarters of consumers (i.e. 74%) said they are comfortable (i.e. agree or strongly agree) with storing their Medicare and health insurance data in an app if it can streamline the booking-claim-payment process.

Information verification

- One in four providers (i.e. 28%) were dissatisfied with the time spent verifying consumers insurance cover and eligibility – the highest of all consumer interaction points.
- Providers indicated that questions about cost are the most common questions raised by consumers; 79% of providers listed 'cost of service', 56% listed 'health insurance coverage' and 53% listed 'Medicare coverage' as one of the most common questions.
- Booking related queries also feature strongly for providers; 57%of providers listed 'making booking', 35% listed 'changing or cancelling booking' and 28% listed 'reconfirming booking' as some common questions from consumers.
- The majority of consumers (i.e. 60%) were required to supply their details to the provider at both Check-in and Check-out, while 33% only needed to provide their health details once (either at Check-in or Check-out), and 7% did not need to provide any health details.
- 7% of providers said that errors in processing health insurance claims, meant the need for reprocessing more often than not (i.e. always, or most of the time).

Provider satisfaction

- One fifth (i.e. 21%) of providers said they were dissatisfied with the cost of using their claims and payment platform.
- 19% of providers said they were dissatisfied with the integration of their claims and payment platform with their accounting/finance software.
- 15% of providers said they were dissatisfied with the integration of their claims and payment platform with their practice management system.
- An additional 15% of providers indicated that internet connectivity and system outages were also significant hindrance.

Bill shock and claims denial

- 28% of consumers said their gap payment was higher than expected, more often than not (i.e. always, or most of the time), in the last few years. An additional 52% said they had half of the time, or occasionally experienced higher than expected gap payment.
- One in seven consumers (i.e.14%) have been denied claims which they were expecting to be covered by their health cover, more often than not (i.e. always, or most of the time), in the last few years.

Deterred consumers

- 14% of consumers said they have deferred booking a healthcare service more often than not (i.e. always, or most of the time), because of the effort required to find a provider and make a booking.
- 17% of consumers said they have deferred or avoided booking a healthcare service more often than not (i.e. always, or most of the time), because the service wasn't covered by their private health insurance cover.
- For those consumers not holding private health insurance, the reason why was broadly consistent for both those that never held and those that no longer do. The top three reasons respondents listed for not having private health insurance were – do not believe private health insurance offers good value for money, do not see need for private health insurance as rarely use services not covered by Medicare, and unused benefits when they had private health insurance.
- Amongst those consumers that currently hold private health insurance, 20% indicated they have not made a health insurance claim in the last 12 months.
- For those consumers who have private health insurance but did not make a claim in the last 12 months, the most common reason was that they did not use healthcare services in the last 12 months (i.e. 33%). However, a large proportion of consumers also indicated they did not claim because they were unsure if they could claim (i.e. 20%), the services used were not covered by their health cover (i.e. 14%), the health providers used were not covered by their health cover (i.e. 8%).

Endnotes

1. The Commonwealth Fund. (2021). *Mirror, Mirror 2021 – Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries.*
2. Australian Prudential Regulation Authority. (2022). *Quarterly Private Health Insurance Statistics December 2021.*
3. Ibid.
4. The Commonwealth Fund. (2021). *Mirror, Mirror 2021 – Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries.*
5. Ibid.
6. Gallup. (2020) *Gallup World Poll Database.*
7. The Australian Institute of Health and Welfare. (2022). *Health Expenditure Australia 2019-20.* Other non-government refers to health spending by injury compensation insurers and other sources of private income.
8. Ibid. Other services includes consumer transportation services, aids and appliances, and administration.
9. Ibid.
10. Australian Government Department of Health. (2021). *Dashboard, Summary Statistics – Metrics.*
11. OECD. (2021). *OECD Health Statistics 2021 Database.*
12. Ibid.
13. Ibid.
14. Private Healthcare Australia. (2021). *Health Funds are committed to easing cost of living pressures on Australian families*; Private Healthcare Australia/Evaluate. (2021). *Reprised 2021 with matched data from Discovery Health.*
15. The Australian Institute of Health and Welfare. (2021). *Older People.*
16. ABS. (2021). *Patient Experiences in Australia: Summary of Findings.*
17. IPSOS. (2021). *Global Health Service Monitor 2021.*
18. The Australian Institute of Health and Welfare. (2022). *Health Expenditure Australia 2019-20.*

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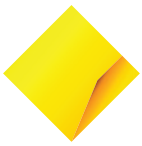

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