Submission in response to the Australian Government's public consultation on its funding for private patients in public hospitals options paper, *Options to reduce pressure on private health insurance premiums by addressing the growth of private patients in public hospitals*

15 September 2017

Table of Contents

1 Introduction 1
2 Responses to the Department of Health's proposed options for reform 3
2.1 Option 1: Limit private health insurance benefits to the medical costs of private treatment in public hospital with no benefits paid to the hospital 3
2.2 Option 2: Prevent public hospitals from waiving any excess payable under the patient's policy .. 3
2.3 Option 3: Remove the requirement for health insurers to pay benefits for treatment in public hospitals for emergency admissions 4
2.4 Option 4: Remove the requirement on health insurers to pay benefits for episodes where there is no meaningful choice of doctor or doctor involvement 4
2.5 Option 5: Make changes to the National Health Reform Agreement's National Efficient Price determination and funding model 4
3 General response to the Department of Health's options paper 6
4 Key considerations for any reform to private health insurance arrangements 8
4.1 Guiding principles for reform 8
4.2 Commonwealth stewardship 8
4.3 Hospital funding reflects Australia's mixed public and private system 8
4.4 Factors driving growth of private health insurance use in public hospitals 10
4.5 Private patients in public hospitals 10
4.6 Health workforce and regional, rural and remote setting implications 13
4.7 Out-of-pocket medical costs devaluing private health insurance 13
4.8 Take up and use of private health insurance policies 14
4.9 Private Health Insurance Rebate 15
4.10 Insurance pricing aligned with business risk faced in a Government-supported environment 16
4.11 Moving the system toward value-based healthcare 17
5 Conclusion 18
5.1 AHHA recommendations 18

1 Introduction

The Australian Healthcare and Hospitals Association (AHHA) is pleased to provide this submission in response to the Australian Government's public consultation on its funding for private patients in public hospitals options paper, *Options to reduce pressure on private health insurance premiums by addressing the growth of private patients in public hospitals*.

AHHA is Australia's national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high quality healthcare to benefit the whole community.

Foundational principles of Australia's universal healthcare system include that clinicians are free to provide their services as private providers; and that patient choice is available, both for services from clinicians and from hospitals.

Changes to one part of the health system will impact other areas. While the Commonwealth Government has responsibility for the regulation and conduct of the private health insurance industry, changes to private health insurance arrangements have the potential to significantly impact the public healthcare and hospital system managed and delivered by state and territory governments.

In many parts of regional, rural and remote Australia, there are no private hospitals available. For patients to exercise choice regarding clinicians, the opportunity to use private health insurance in public hospitals must be preserved.

Recruitment and retention of workforce in regional, rural and remote areas is also underpinned by the opportunity for providers to be able to offer private services in public hospitals.

In the children's hospital sector there are few, if any, private hospital options.

The state and territory public healthcare and hospital sector relies on the current funding arrangements, which includes private health insurance as a source of revenue. Removing the right of Australians to elect to be treated as a private patient using their private health insurance in a public hospital, as codified in Schedule G of the 2011 National Health Reform Agreement, would remove a source of funding that will force costs back onto state and territory governments and consequently increase public health service activity.

The state and territory public healthcare and hospital sector reasonably expects the current set of conditions as outlined in the 2011 National Health Reform Agreement. It could be argued that any unilateral changes by the Commonwealth Government to these conditions should be compensated by the Commonwealth Government for lost revenue to the state and territory public healthcare and hospital sector.

The public analysis provided by the Commonwealth in relation to previously proposed directions for reform of the Federation underscore the tenuous fiscal position of the states and territories to bear such shocks to their public finances. This would further entrench the recognised difficulties of providing needed public services in an environment of well-known and significant vertical fiscal imbalance between the Commonwealth and the states and territories. Acknowledgement of the

unsustainability of this vertical fiscal imbalance was a significant aspect of the public discourse on the proposed reforms to the Federation.

State and territory departments of health have protocols and guidelines regarding communications with patients about the use of private health insurance, and associated complaints mechanisms.

The Commonwealth must proactively engage with the health sector and state and territory governments to ensure that any proposed changes to private health insurance regulations maintain and improve health outcomes as well as support equity, accessibility and sustainability of the broader Australian health system to the benefit of the whole community.

The Commonwealth is demonstratedly concerned in the options paper with the growth of private patients in public hospitals. But it should first be recognised that the larger percentage increases have occurred off small bases and should not be misinterpreted with respect to the nominal impact on patient volumes. Furthermore, while there has been growth in the number of private patients treated in public hospitals, Attachment 1 to the options paper shows that the proportion of private and self-funded patient separations has only modestly increased over the four years considered. At the national level, 13.3% of separations in activity based funded hospitals in 2012–13 were by private or self-funded patients. In 2015–16 this proportion rose to 14.7%, an increase of 1.4 percentage points.

2 Responses to the Department of Health's proposed options for reform

As a general observation in relation to the five options to limit the use of private health insurance in public hospitals, the proposals only consider the first round effects without regard to likely subsequent responses by consumers and the broader impact this would have on the market for private health insurance products. To the extent that the value of private health insurance is reduced in the manner envisaged in these options, it is most likely it would be healthier people that would abandon their private health insurance in response. This would then exacerbate the remaining pooled risk of private health insurance holders. This would then lead to greater pressure to increase premiums further undermining the perceived value of private health insurance. Any changes in policy as they relate to private health insurance needs to be mindful of the how the pooled risk of policy holders will be impacted.

2.1 Option 1: Limit private health insurance benefits to the medical costs of private treatment in public hospital with no benefits paid to the hospital

'This could be implemented by changes to subordinate legislation under the Commonwealth Private Health Insurance Act 2007. This would not require a change to the National Health Reform Agreement because hospitals could still choose to raise charges against private patients, but insurers would not be able to pay a benefit.'

Option 1 would be a unilateral change by the Commonwealth Government that would have a negative financial impact on the public healthcare and hospital system in states and territories across Australia.

Option 1 would lead to significant health consumer detriment and reduce the value of private health insurance, which could encourage individuals to abandon their private health insurance coverage. It would devalue insurance policies that only cover public hospitals, and it would limit patient and physician choice in the selection of prostheses should they wish to use prostheses not purchased in the public system.

If this option were implemented, there would also need to be a modified form of activity based payment made to public hospitals to fund the costs incurred by the hospital that would no longer fall within the scope of services covered by private health insurance. This modified payment would then need to be either partly or fully funded by the Commonwealth given their reduced role in funding hospitals services through the Private Health Insurance Rebate, or patients would need to be charged an uninsurable out-of-pocket cost. This latter possibility would likely further entrench well recognised consumer concerns on the value of private health insurance and exacerbate health inequalities.

2.2 Option 2: Prevent public hospitals from waiving any excess payable under the patient's policy

'This option would need to be implemented by states and territories. There is no legislative mechanism available to the Commonwealth to enforce implementation.'

Option 2 would lead to significant health consumer detriment and reduce the value of private health insurance, which could encourage individuals to abandon their private health insurance coverage. This would result in additional out-of-pocket expenses for health consumers and exacerbate health inequalities.

2.3 Option 3: Remove the requirement for health insurers to pay benefits for treatment in public hospitals for emergency admissions

'While it could be implemented by changes to subordinate legislation under the Commonwealth Private Health Insurance Act 2007, it would be desirable to amend the National Health Reform Agreement as well. A reduction in insured episodes would be contingent on accurate categorisation of patients by hospital staff.'

Option 3 would lead to significant health consumer detriment and reduce the value of private health insurance, which could encourage Australians to abandon their private health insurance coverage.

Option 3 would also disadvantage patients with chronic conditions who would want their own cardiologist, immunologist or other physician to treat them.

If implemented unilaterally by the Commonwealth Government, Option 3 would have a negative financial impact on the public healthcare and hospital system in states and territories across Australia.

Rather than arbitrarily constraining consumer choice in the manner proposed in this option, it would be more effective to consider measures that ensure the spirit of Schedule G of the 2011 National Health Reform Agreement is maintained.

2.4 Option 4: Remove the requirement on health insurers to pay benefits for episodes where there is no meaningful choice of doctor or doctor involvement

'While this could be implemented by changes to subordinate legislation under the Commonwealth Private Health Insurance Act 2007, it would be desirable to amend the National Health Reform Agreement as well.'

Option 4 would lead to significant health consumer detriment and reduce the value of private health insurance, which could encourage Australians to abandon their private health insurance coverage and exacerbate health inequalities.

Option 4 would require significant and ongoing administrative cost to determine on a continuous basis which hospitals, locations and types of services do not present 'meaningful choice of doctor or doctor involvement'.

Option 4 would disadvantage individuals with private health insurance living in regional, rural and remote Australia.

If implemented unilaterally by the Commonwealth Government, Option 4 would have a negative financial impact on the public healthcare and hospital system in states and territories across Australia.

2.5 Option 5: Make changes to the National Health Reform Agreement's National Efficient Price determination and funding model

'This option would require working with the Independent Hospital Pricing Authority to ensure that the private patient adjustment to the NEP appropriately adjusts for all private patient income… T*here are a number of states which do not adjust their own funding to public hospitals to recognise private patient revenue. This creates an additional incentive for public hospitals to admit private patients. The option proposes engaging with states to encourage amendments to their service level agreements to ensure that reductions in the NEP for private patients are reflected in state funding levels.'*

AHHA rejects any assertion that the Independent Hospital Pricing Authority (IHPA) is not making appropriate adjustments to the National Efficient Price determination according to agreed practices and methodologies.

3 General response to the Department of Health's options paper

The assumption outlined in the Commonwealth Department of Health's options paper that the way to reduce pressure on private health insurance premiums is to exclusively focus on the use of private health insurance in public hospitals is unsubstantiated, and it is plainly evident that the paper's title, *Options to reduce pressure on private health insurance premiums by addressing the growth of private patients in public hospitals*, presupposes a position. Unfortunately, this presupposed position is not evidence based and ignores the multifactorial reasons contributing to premium increases.

While the main driver of premium increases has been increases in benefits paid by insurers, which reflects increased demand for health services, the options papers fails to note that the costs of drugs[1] and medical devices[2,3] are also recognised in Australia as key drivers of costs in both public and private hospitals.

The options paper states 'There does not appear to be any clinical or demographic reason for the relatively rapid growth of private admissions in the public sector', but it fails to unpack the well-documented pressures on Australia's healthcare system due to rapidly increasing rates of chronic disease combined with Australia's ageing population who require specialist oversight.

The options paper also fails to consider a patient's desire for continuity of care—whether an emergency or elective admission—as a contributing factor.

While the options paper states 'The rapid growth in privately insured episodes in public hospitals is a concern for private health insurance costs', it does not acknowledge or unpack the fact that these patients would nonetheless be eligible to use their private health insurance in private hospitals.

The options paper notes private hospitals are increasing the volume of beds offered, but it does not acknowledge that public hospitals provide the overwhelming majority of emergency, paediatrics and intensive care—all of which are more costly, not routine and more complex.

The option paper's lack of granular and publicly available data does not allow for fully informed policy making. Aggregate data disguises underlying distributions of outcomes creating an incomplete, or worse misleading, understanding of the policy problem to be addressed. In the case of elective surgery waiting times, aggregate data does not control for complexity once again providing an incomplete and potentially misleading understanding of the public policy to be addressed.

The options paper ignores length of stay data where the relative length of stay in public hospitals was shorter than private hospitals,[4] whereby could be argued public providers are delivering private activity at a more efficient price and at a savings for health funds.

---

[1] Duckett, S and Banerjee, P 2017. *Cutting a better drug deal*. Grattan Institute: https://grattan.edu.au/wp-content/uploads/2017/03/886-Cutting-a-better-drug-deal.pdf

[2] ABC News 2016, Private Healthcare Australia blames steep health premiums on fixed prices for medical devices: http://www.abc.net.au/news/2016-08-22/costly-health-insurance-blamed-on-fixed-prices/7771568

[3] Private Healthcare Australia 2017. Senate Committee confirms prostheses list benefits unacceptably high. Media release: http://www.privatehealthcareaustralia.org.au/senate-committee-confirms-prostheses-list-benefits-unacceptably-high/

[4] Australian Institute of Health and Welfare 2017. Admitted Patient Care 2015–16: Australian hospital statistics. Health Service Series No. 75. Cat. No. HSE 185. p 36: https://www.aihw.gov.au/getmedia/3e1d7d7e-26d9-44fb-8549-aa30ccff100a/20742.pdf.aspx?inline=true

The options paper is also deficient for not acknowledging or providing any discussion on the growth of profits among and returns to equity among for-profit private health insurance providers. There is evidence that profitability in the private health insurance industry is strong.[5]

For evidence-informed decision making, it is vital for the Commonwealth Government to consider the multifactorial reasons why private health insurance premiums are increasing, and why patients are electing to use their private health insurance at a public hospital.

[5] Private Health Insurance Administration Council, *Competition in the Australian Private Health Insurance Market Research Paper 1 June 2015*, p 34: http://www.apra.gov.au/PHI/PHIAC-Archive/Documents/Competition-in-the-Australian-PHI-market_June-2015.pdf

4 Key considerations for any reform to private health insurance arrangements

4.1 Guiding principles for reform

AHHA considers that any proposed changes to private health insurance rules and regulations should be assessed against a set of guiding principles, including whether the proposed changes maintain and improve health outcomes, and support equity, accessibility and sustainability of the broader Australian health system to the benefit of the whole community.

4.2 Commonwealth stewardship

The Commonwealth Government has a vital role to play in the stewardship of the health system, and in August 2011 it entered into a National Health Reform Agreement with all states and territories, which set out the shared intention of the jurisdictions to work together to improve health outcomes for all Australians and ensure the sustainability of the Australian health system.[6]

While the Commonwealth walked away from growth funding provisions for public hospitals in this agreement in its 2014–15 Budget,[7] it has recommitted to working with states and territories on hospital funding and health reform, and agreed new growth funding arrangements up to 2019–20 with the states and territories via the Council of Australian Governments in 2016.[8]

Changes to one part of the health system will impact other areas. While the Commonwealth Government has responsibility for the regulation and conduct of the private health insurance industry, changes to private health insurance arrangements have the potential to significantly impact the public healthcare and hospital system managed and delivered by state and territory governments.

Commonwealth leadership on health funding reform, including rules and regulations around private health insurance, is critical because all Australians depend on a well-resourced public health system, particularly if they require emergency or complex care, and if they are unable to afford private care.

All Australians should have access to affordable, high quality care, regardless of how much money they have or where they live.

4.3 Hospital funding reflects Australia's mixed public and private system

About 90% of care in public hospitals and 32% of care in private hospitals is funded by governments.[9]

The number of separations that were funded by governments in public and private hospitals combined increased by an average of 2.7% each year between 2010–11 and 2014–15. In the same period, the number of separations funded by private health insurance across the two sectors increased by 5.9%.[10]

---

[6] Council of Australian Governments 2011. National Health Reform Agreement: http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-agreement.pdf

[7] Russell L 2014. Analysis of 2014–15 Health Budget: Unfair and Unhealthy: https://ses.library.usyd.edu.au/bitstream/2123/11981/1/2014-15healthbudget.pdf

[8] Council of Australian Governments 2016. COAG Meeting Communiqué 1 April 2016: http://www.coag.gov.au/meeting-outcomes/coag-meeting-communiqu%C3%A9-1-april-2016

[9] Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

[10] Australian Institute of Health and Welfare 2016. Admitted patient care 2014–15: Australian hospital statistics. Health services series no. 68. Cat. no. HSE 172. Canberra: AIHW. table 7.5.

Between 2009–10 and 2014–15, after adjusting for inflation, total funding for public hospitals increased by an average of 5.8% each year. The proportion of public hospital funding by the Australian Government has remained around 38%—putting more pressure on state and territory governments and other funding sources.[11]

More private hospital care is being funded by both governments and insurers. For private hospitals, the number of separations funded by governments increased by an average of 7.3% each year between 2009–10 and 2014–15. Since 2013–14, separations in private hospitals increased by 5.6% for both those funded by governments and those funded by private health insurance.[12]

Private hospital funding from state and territory governments has almost doubled over the past decade—and is growing faster than funding for public hospitals. State and territory governments' recurrent expenditure in private hospitals in 2014–15 was $621 million, an increase of 19.4% on the previous year, and almost double the expenditure in 2004–05 (in constant prices, $314 million). This represents an average annual growth rate over the decade of 7.1%. In comparison, the average annual growth rate in state and territory government recurrent expenditure in public hospitals was 4.7% over the same period.[13]

In 2014–15, the net benefits paid by private health insurers in public hospitals was $1.06 billion. This was a growth of 9.6% over the previous year. In the same period, the net benefits paid by private health insurers in private hospitals was $6.913 billion, or growth of 6.4% over the previous year.[14]

Private health insurers use more of their funds on their own administration (8.8% or $1.23 billion in 2014–15) than in funding public hospital services (7.6% or $1.06 billion in 2014–15).[15]

There were more than 5.7 million separations in public hospitals during 2014–15, and of these 14.1% (815,000) were funded by private health insurers. Between 2008–09 and 2014–15, the number of separations in public hospitals funded by private health insurance increased by an average of 10.3% each year, or 4.4 percentage points over the period.[16] However, the rate of growth in the number of bed days funded and benefits paid by private insurers for care in public hospitals is slower. As a proportion of bed days paid by private insurers across both public and private hospitals, public hospital care represented 10.4% of bed days in June 2009, increasing to 12.4% in June 2016. As a proportion of benefits paid for public and private hospital care by private health insurers, the public hospital share increased from 3.4% in June 2009 to 4.3% in June 2016.[17]

While we know that private activity in public hospitals grew faster, it has come off a much lower base.

---

[11] Australian Institute of Health and Welfare 2016. Health expenditure Australia 2014–15. Health and welfare expenditure series no. 57. Cat. no. HWE 67. Canberra: AIHW. table A7 and table A10.

[12] Australian Institute of Health and Welfare 2016. Health expenditure Australia 2014–15. Health and welfare expenditure series no. 57. Cat. no. HWE 67. Canberra: AIHW. Table 3.7

[13] Australian Institute of Health and Welfare 2016. Health expenditure Australia 2014–15. Health and welfare expenditure series no. 57. Cat. no. HWE 67. Canberra: AIHW. Table 3.7

[14] Australian Institute of Health and Welfare 2016. Health expenditure Australia 2014–15. Health and welfare expenditure series no. 57. Cat. no. HWE 67. Canberra: AIHW. Table 3.13

[15] Australian Institute of Health and Welfare 2016. Health expenditure Australia 2014–15. Health and welfare expenditure series no. 57. Cat. no. HWE 67. Canberra: AIHW Table 3.12

[16] Independent Hospital Pricing Authority 2017. Private Patient Public Hospital Service Utilisation. Table 1

[17] Australian Prudential Regulation Authority. Benefit Trends. December 2016—issued 14 February 2017: http://www.apra.gov.au/PHI/Publications/Pages/Statistical-Trends.aspx

4.4 Factors driving growth of private health insurance use in public hospitals

The Independent Hospital Pricing Authority's (IHPA) recent report on public hospital service utilisation by private patients[18] examined the extent to which activity-based funding, and its implementation in the states and territories, had contributed to increased use of private health insurance in public hospitals.

Beyond the scope of the IHPA report was analysis of the type of insurance products used in public hospitals, and the impact of the increasing number of product offerings from private health insurers with high gaps and multiple exclusions, including public hospital only insurance products.

Statistics published by the Australian Prudential Regulation Authority[19,20] do not identify public hospital only insurance policies; however, data are published related to exclusionary and non-exclusionary hospital insurance policies. In the period covered by the IHPA report, the growth in exclusionary policies has been substantial. Of the approximately 9.5 million hospital policies in June 2009, around 10% were exclusionary policies. By June 2016, 37% of the more than 11.3 million policies were exclusionary.

The AHHA call for more nuanced data on exclusionary products to be made publicly available to help understand if the significant rise in exclusionary private health insurance products is resulting in policy holders opting to use their insurance in a public hospital rather than a private hospital. This may also be a purely rational response by individuals to maximise value from an insurance product many have only purchased in response to government policies designed to increase take-up of private health insurance in circumstances in which they otherwise would not.

4.5 Private patients in public hospitals

The 2011 National Health Reform Agreement[21] between the Commonwealth, states and territories sets out the architecture and major structural reforms for Australia's health system and provides for more sustainable funding arrangements including recognising the right for patients to use their private health insurance in public hospitals—Schedule G codifies these arrangements.

In a tight funding environment, state and territory governments plan on private revenue to contribute funding at the margin to help resource public hospitals, and indeed subtract this amount from budget allocations—called own source revenue.[22,23] Nationally, private-sourced revenue represents around $1 billion per annum of funding for public hospitals.

---

[18] Independent Hospital Pricing Authority 2017. Private Patient Public Hospital Service Utilisation.

[19] Australian Prudential Regulation Authority. Membership Trends - December 2016 (issued 14 February 2017): http://www.apra.gov.au/PHI/Publications/Pages/Statistical-Trends.aspx

[20] Australian Prudential Regulation Authority. Benefit Trends - December 2016 (issued 14 February 2017): http://www.apra.gov.au/PHI/Publications/Pages/Statistical-Trends.aspx

[21] Council of Australian Governments 2011. National Health Reform Agreement: http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-agreement.pdf

[22] D King, Private Patients in Public Hospitals, April 2013, p 27: https://www.ahsa.com.au/web/freestyler/files/Private%20Patients%20in%20Public%20Hospitals%20May%202013.pdf

[23] Better health, better care, better value: WA Health Reform Program 2015–2020, Government of Western Australia Department of Health: http://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Health%20Service%20Boards/Better-Health-Better-Care-Better-Value-WA-Health-Reform-Program.ashx

When a health consumer with private health insurance is treated as a private patient in either a public or private hospital, Medicare will pay 75% of the Medicare Benefits Schedule (MBS) fee of the medical services provided during the hospital stay and for medicines through the Pharmaceutical Benefits Scheme. Medicare does not pay for any other costs associated with the admission such as hospital accommodation, theatre fees, prostheses or medicine.[24] In some instances, public hospitals cover gap costs, so patients do not have additional out-of-pocket expenses.

AHHA members have advised that it is always patient choice whether or not they use their private health insurance in a public hospital as set out in Schedule G of the 2011 National Health Reform Agreement: patients are provided with information clarifying their rights with regard to using insurance and out-of-pocket costs in accordance with state or territory health department codes of conduct. Patients may elect to exercise their right to choose their doctor, and may agree to support the operation of the hospital by electing to utilise their private health insurance. Use of private health insurance does not necessarily guarantee access to a private room, nor preferential access to services.

In 2015–16, the relative length of stay in public hospitals (0.96) was shorter than private hospitals (1.1).[25] A significant saving for health funds. It could be argued public providers are delivering private activity at a more efficient price.

Data reported recently by the Australian Institute of Health and Welfare on differences in waiting times provide no insight to acuity or case mix, both of which impact waiting times.[26] AHHA public hospital members have advised they always ensure patients without private health insurance are never clinically disadvantaged.

It is important to note that published data do not separate the different urgency categories patients are placed into, which consists of different clinically recommended treatment times—treatment within 30, 90 and 365 days for Category 1, 2 and 3 respectively.

AHHA calls for better data to be made publicly available to understand the use of private health insurance in public hospitals. This data should be disaggregated to the hospital level and should identify the case-mix of patients using the public system and private health insurance in public and private hospitals, and include disaggregations that control for private health insurance policy classes.

The Commonwealth Government needs to reach an agreement with state and territory governments regarding the analysis of private health insurance utilisation in Australia, which includes its use in public hospitals compared with private hospitals. Conclusions are too early to be drawn from the aggregated data currently publicly available.

There are very few instances of official complaints regarding the use of private health insurance in public hospitals, notwithstanding popular claims to the contrary by health insurers and private hospitals.

In New South Wales, which has by far the largest use of private health insurance in public hospitals, there were only five complaints in 2015–16, out of a total of 11,842 issues raised to the New South

[24] Operations of PHI Annual Report 2013–14, PHIAC, November 2014, p 14.

[25] Australian Institute of Health and Welfare 2017. Admitted Patient Care 2015–16: Australian hospital statistics. Health Service Series No. 75. Cat. No. HSE 185. p 36: https://www.aihw.gov.au/getmedia/3e1d7d7e-26d9-44fb-8549-aa30ccff100a/20742.pdf.aspx?inline=true

[26] AIHW 2017. Admitted patient care 2015–16: Australian hospital statistics. Health services series no. 75. Cat. no. HSE 185. Canberra: AIHW.

Wales Health Care Complaints Commission. Of these, only three were deemed as requiring investigation, and only one was substantiated.[27]

As noted in table 1 below, data obtained through correspondence with the Commonwealth Minister for Health indicated minimal numbers of complaints lodged with the Commonwealth's Private Health Insurance Ombudsman regarding individuals electing to use their private health insurance in public hospitals.

Table 1: Private Health Insurance Ombudsman data on incidence of private patient elections complaints 2012–13 to 2016–17 YTD

	Private patient election complaints	All complaints	Percentage of private patient election complaints
2012–13	6	2,955	0.00203%
2013–14	10	3,427	0.00291%
2014–15	3	4,265	0.00070%
2015–16	6	4,416	0.00135%
2016–17	6	4,792	0.00125%

Source: 7 August 2017 correspondence from the Commonwealth Minister for Health to the AHHA

AHHA recommends these data be made publicly and regularly available as part of the Ombudsman's annual reporting.

Conversely, AHHA contends that there are circumstances in which patient choice would be negatively limited should there be any change to arrangements regarding use of private health insurance in public hospitals. These include access to private health care in regional, rural and remote areas, and access to care in the children's hospital sector where there are few, if any, private hospital options. AHHA members have advised that there would be an outcry from families if patients were unable to use private health insurance and unable to have their choice of treating physician. This would further entrench the inequality already being suffered by many rural and remote holders of private health insurance, an inequality recognised and being addressed by the Private Health Ministerial Advisory Committee.

Some health insurers offer policies that only cover patients for treatment in a public hospital. It has been argued that these policies are inconsistent with the objective of reducing pressure on public hospitals and do not provide value for money.[28] These insurance policies do not support patient choice, as the patient is effectively limited to using their insurance in public hospitals. The AHHA does not support the continuing availability of these policies.

While it is likely the existence of these public hospital only policies lowers pressure on premium increases as it changes the risk distribution of insured policy holders, it is also likely 'healthy' people are choosing cheap 'junk' policies, including public hospital only policies, to avoid paying additional Medicare Levy Surcharge. If this is the case, and the Commonwealth Government removes the Private Health Insurance Rebate from junk policies, these members would then be incentivised to take out higher level of policy coverage, which would in turn reduce pressure on premiums because these private health insurance policy holders are healthier.

[27] Health Care Complaints Commission. *Annual Report 2015–16: Protecting Health and Safety*. Sydney. Table A.2 and table A.17.

[28] Issues for consideration at roundtables on PHI, Australian Government Department of Health PHI Consultation, November 2015.

4.6 Health workforce and regional, rural and remote setting implications

As part of employment terms and conditions, many state and territory jurisdictions provide senior medical officers employed by the jurisdiction to have the option to participate in private practice arrangements. This aligns with the National Health Reform Agreement's provision that a patient has the right to elect to be treated as a public or private patient in a public hospital. Private practice arrangements are also prominent within rural and regional areas to both attract health workforce and allow rural and remote patients to elect to use their private health insurance at their local hospital rather than travel a significant distance to be treated at a private hospital.

AHHA calls on the Commonwealth Government to work with state and territory governments on any reforms to private health insurance arrangements to ensure health workforce requirement and retention efforts in regional, rural and remote settings are not compromised.

The availability of regional data on private health insurance coverage and use would provide greater insight into when treatment of private patients in the public system is the result of a lack of availability of private facilities in that region.

4.7 Out-of-pocket medical costs devaluing private health insurance

Australians spend more on out-of-pocket healthcare costs than the OECD average. In Australia, out-of-pocket costs account for 20% of healthcare expenditure. While this is slightly higher than the OECD average of 19%, by contrast, out-of-pocket costs only account for 14% of health spending in Canada, 13% in New Zealand and 10% in the United Kingdom—all of which have similar health systems with significant government funding.[29] The OECD notes that 'given the current level of out-of-pocket payments in Australia, there is a need to ensure that policy options aimed at improving the appropriate use of care do not unduly affect the most vulnerable and the overall burden of out-of-pocket payment in the community more generally.'

The Commonwealth Fund's analysis of 11 advanced economy health systems flags Australia's cost related problems as a barrier to access of care.[30] Out-of-pocket costs stop people from seeking healthcare—particularly people on low incomes and in need of care.[31,32]

Dr Jeffrey Harmer AO, chair of the Australian Government's Private Health Ministerial Advisory Committee, states that large medical out-of-pocket costs are often unexpected and a major issue undermining consumer confidence in private health insurance.[33]

---

[29] OECD 2015. Health at a Glance 2015. How does Australia compare? p 3: https://www.oecd.org/australia/Health-at-a-Glance-2015-Key-Findings-AUSTRALIA.pdf

[30] Schneider E, Sarnak D, Squire D, Shah A & Doty M 2017. *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better US Health Care*, The Commonwealth Fund: http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/assets/Schneider_mirror_mirror_2017.pdf

[31] Kiil A & Houlbert K 2014. 'How does copayment for health care services affect demand, health and redistribution? A systematic review of the empirical evidence from 1990 to 2011', *The European Journal of Health Economics*, vol 15, issue 8, pp 813–828.

[32] Duckett S & Breadon P 2014. 'Out-of-pocket costs: hitting the most vulnerable hardest'. Grattan Institute submission to the Senate Standing Committee on Community Affairs inquiry into out-of-pocket costs in Australian healthcare p 6: https://grattan.edu.au/wp-content/uploads/2014/07/Grattan_Institute_submission_-_inquiry_on_out-of-pocket_costs_-_FINAL.pdf

[33] Harmer, J 2017. 'Seeking better value for consumers', *Health Voices*, issue April: http://healthvoices.org.au/issues/april-2017/seeking-better-value-consumers/

Australian academics and thought leaders have written on the topic of out-of-pocket medical costs, and a call for greater pricing and fee transparency is the common recommendation to address the issue—particularly for medical specialists.[34,35,36] Patients often rely on their general practitioner to make the choice of specialist for them through the referral process. Patients and general practitioners should know what specialists charge and the outcomes achieved to inform joint decision-making and the referral process.

As Medicare already holds information about the fees specialists and general practitioners charge for each consultation or procedure, AHHA recommends specialist and general practitioner fees be published at a minimum by procedure name indicating the top and bottom decile, median fee and the Medicare fee in order to increase price transparency and inform decision making. This information should be timely, regularly updated and reported by Primary Health Network region or lower relevant patient catchment areas.

This recommendation is consistent with the approach being recommended in the Productivity Commission's inquiry into increasing application of competition, contestability and informed user choice to human services.[37]

4.8 Take up and use of private health insurance policies

At 31 March 2017, 46.5% of Australians had hospital treatment cover in addition to the coverage available through the Australian Government's universal Medicare program for primary healthcare and public hospitals and 55.5% of Australians had some form of general treatment (ancillary) cover.[38]

While less than half of Australians, at 46.5%, have hospital treatment cover, it is important to note the Australian Bureau of Statistics reports that almost a quarter of insured people elected not to use their hospital treatment cover and choose to be treated in the public system on their most recent hospital visit.[39,40]

---

[34] Duckett S 2016. 'Many Australians pay too much for health care—here's what the government needs to do', *The Conversation*: https://theconversation.com/many-australians-pay-too-much-for-health-care-heres-what-the-government-needs-to-do-61859

[35] Sivey P 2016. 'How much?! Seeing private specialist often costs more than you bargained for', *The Conversation*: https://theconversation.com/how-much-seeing-private-specialists-often-costs-more-than-you-bargained-for-53445?sg=afd7312c-9be1-4bbb-a72d-7a855e0848a1&sp=1&sr=3

[36] Russell L 2015. 'For real health reform, turn the spotlight on specialists' fees', *The Conversation*: https://theconversation.com/for-real-health-reform-turn-the-spotlight-on-specialists-fees-37111?sg=afd7312c-9be1-4bbb-a72d-7a855e0848a1&sp=1&sr=10

[37] Productivity Commission 2017. Reforms to Human Services: http://www.pc.gov.au/inquiries/current/human-services/reforms/draft

[38] Australian Prudential Regulation Authority 2017. Statistics. Private Health Insurance Quarterly Statistics March 2017 (released 16 May 2017): http://www.apra.gov.au/PHI/Publications/Documents/1705-QPHIS-20170331.pdf

[39] Russell L 2017 'Getting rid of junk health insurance policies is must tinkering at the margins of a much bigger issue' *The Conversation*: https://theconversation.com/getting-rid-of-junk-health-insurance-policies-is-just-tinkering-at-the-margins-of-a-much-bigger-issue-82749

[40] Australian Bureau of Statistics *Health Services: Patient Experiences in Australia, 2009* released 30 July 2010 p23: http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/4DE1EBF2E29AAC71CA2577730022B837/$File/4839055001_2009.pdf

The proportion of Australians with private health insurance has remained relatively stable since 2000 following the Commonwealth Government's introduction of three major surcharge and incentive schemes meant to encourage the uptake of private health insurance following a prolonged period of decline.[41] The means-tested Private Health Insurance Rebate is intended to assist people meet the cost of private health insurance, the Medicare Levy Surcharge is intended to encourage higher income earners to have private hospital cover and Lifetime Health Cover loadings is meant to encourage Australians to purchase hospital insurance earlier in life and to maintain their cover.[42] Australia's private health insurance market remains dependent on these surcharges and incentive schemes to maintain current levels of private health insurance coverage.

4.9 Private Health Insurance Rebate

In 2016–17 the Australian Government spent more than $6.2 billion on the Private Health Insurance Rebate and in 2017–18 the Australian Government is estimated to spend more than $6.4 billion.[43] The policy objective of this subsidy is to assist Australians meet the cost of private health insurance.

Other commentators have argued the Commonwealth's total subsidy is much higher when considering the costs associated with the direct outlays on the rebate, exemptions from income tax due to the rebate and other revenue foregone from high-income earners who would otherwise pay the Medicare Levy Surcharge.[44]

There is international evidence that the cost of subsidising private health insurance exceeds the fiscal benefits to the public sector.[45,46]

Looking at Australian evidence, modelling from the Melbourne Institute of Applied Economic and Social Research shows that reducing the Private Health Insurance Rebate is likely to result in net public sector savings,[47] and analysis by the Grattan Institute shows that removing the Private Health Insurance Rebate could save governments $3.5 billion in annual public expenditure.[48]

This suggests the claims that limiting or abolishing the Private Health Insurance Rebate would significantly decrease the number of private insurance policy holders and result in unsustainable burdens on the public system are exaggerated.

A robust public interest test should be developed to measure whether this investment is worthwhile and in the interests of all Australian taxpayers. To the extent levels of private health insurances subsidies are decreased, these funds must be transparently re-allocated to other areas of the healthcare system in need of additional funding support.

---

41 Australian Government Department of Health. Annual Report 2012–13. Outcome 9: Private Health. Figure 9.1: Number of People with Private Hospital Cover, 1971–2013: http://www.health.gov.au/internet/main/publishing.nsf/Content/annual-report-1213-toc~12-13-2~12-13-2-1~12-13-9

42 D Seah, T Cheong & M Anstey 2013 The hidden cost of private health insurance in Australia, Australian Health Review 37(1), pp 1–3.

43 Budget 2017–18. Budget Strategy and Outlook Budget Paper No. 1. Table 8.1. Canberra.

44 Menadue, J, Facts on the $11b per annum private health insurance industry subsidy, posted 19 Nov 2015: http://johnmenadue.com/blog/?p=5014

45 C Emmerson, C Frayne & A Goodman 2001 Should private medical insurance be subsidized? Health Care UK, pp 49–65: http://www.ifs.org.uk/docs/private_med.pdf

46 AL Nicolás & M Vera-Hernández 2008, Are tax subsidies for private medical insurance self-financing? Evidence from a microsimulation model, Journal of Health Economics 27(5), pp 1285-1298.

47 TC Cheng 2013, Does Reducing Rebates for Private Health Insurance Generate Cost Savings? Melbourne Institute Policy Briefs Series, Policy Brief No. 3/13.

48 Balancing budgets: tough choices we need, Grattan Institute, November 2013, p. 71.

4.10 Insurance pricing aligned with business risk faced in a Government-supported environment

The annual average growth in private health insurance premiums across the industry from 2010 to 2017 was 5.6%.[49] Over the same period the annual average growth in CPI was 1.9%.[50] Holders of private health insurance should not be required to pay premiums any higher than enables insurers to earn an appropriate return on invested equity for the business risk that is being faced.

A significant feature of the business environment in which private health insurers operate is that much of the industry revenue is significantly underpinned by Commonwealth Government policies that place a high degree of certainty on this revenue. Such policies include Lifetime Health Cover and the Medicare Levy Surcharge, in addition to the Government subsidy to the industry's revenue streams through the Private Health Insurance Rebate estimated to be more than $6.2 billion in 2016–17 and $6.4 billion in 2017–18.[51]

Of note, the private health insurance industry's total after tax profits for the 12 months to June 2017 was $1.4 billion, which is a 15.5% increase on the previous year.[52] And the market share of for-profit insurers grew from 15.9% to 68.5% in a decade.[53]

A fundamental tenet of business financing and asset pricing is that returns are related to the risk that is borne. Yet through deliberate government policy, industry revenue has been significantly de-risked, and for many policyholders, the risk of uptake has essentially been removed.[54] The question then becomes whether returns to the private health insurance industry are commensurate with the business risk that is being faced. Note that as returns are in part a function of profitability, this also means that the efficiency of individual insurers and the industry as a whole must also be considered. As an example of the level of profitability within the private health insurance industry, one of the largest private health insurance providers in Australia, Medibank Private, reported a return on equity in the 2016 financial year of 27.6%.[55] NIB Holdings reported a return on equity in 2016 of 25.8%.[56]

The AHHA recommends that the Government initiate an inquiry into appropriate levels of profitability and returns to equity within the private health insurance industry, taking explicit account of Government policies that remove significant levels of uncertainty concerning industry revenues being received. The findings from this inquiry must then be used when evaluating the appropriateness of any requests from private health insurance providers to increase premiums on their products.

---

[49] http://health.gov.au/internet/main/publishing.nsf/Content/privatehealth-average-premium-round

[50] Australian Bureau of Statistics, 6401.0 - Consumer Price Index, Australia, Mar 2017, Canberra.

[51] Budget 2017–18. Budget Strategy and Outlook Budget Paper No. 1. Table 8.1. Canberra.

[52] Australian Prudential Regulatory Authority 2017. Statistics: Private Health Insurance Quarterly Statistics June 2017 (released 15 August 2017). p 11: http://www.apra.gov.au/PHI/Publications/Documents/1708-QPHIS-20170630.pdf

[53] Private Health Insurance Administration Council 2015. Competition in the Australian Private Health Insurance Market Research Paper 1 June 2015. p 31: http://www.apra.gov.au/PHI/PHIAC-Archive/Documents/Competition-in-the-Australian-PHI-market_June-2015.pdf

[54] For individuals whose incomes are above the relevant Medicare Levy Surcharge threshold, it is not economically rational to fail to purchase a complying private health insurance policy.

[55] Medibank Private Limited HY17 – Investor Presentation: https://www.medibank.com.au/content/dam/medibank/About-Us/investor-center/Results/1H17%20Results%20Investor%20Presentation%20FINAL.pdf

[56] NIB Holdings Annual Report 2016: http://investorreports.com.au/nib/2016/2016-annual-report

4.11 Moving the system toward value-based healthcare

Value-based care is emerging as a solution to address rising healthcare costs, clinical inefficiency and service duplication, and to make it easier for people to get the care they need when it is needed. Value in healthcare is measured by looking at the outcome achieved by a particular type of care or treatment, divided by cost of providing that care. Activity is readily monitored through volume and process based measures, while safety and quality measures are less easily captured and monitored. Capacity to measure outcomes is increasing with improved technical expertise and expanding recognition of its importance.

The aim of value-based healthcare is to achieve the best outcomes at the lowest cost, while also providing the right services by the right person at the right location at the right time. This departure from the traditional fee-for-services model will necessarily involve the integration of care across different services.

Any proposed reforms to private health insurance should consider the current shift toward value-based healthcare and should consider the introduction of value-based insurance design[57] in the United States, which was a response to rising healthcare costs.

The goal of value-based insurance design is to decrease the cost of health care while increasing the effectiveness of health services by structuring health insurance in a way that incentivises and drives patients and providers toward the most valuable services. Cost and health outcomes data are analysed to determine the relative value of a given service, in terms of both medical outcomes and cost. To increase patient uptake of high-value services, patients are motivated to seek out and use recommended services with financial incentives, such as lower deductibles or out-of-pocket costs. And to discourage use of services that are not effective or whose expense is not justified—such as emergency department care for minor illnesses or surgery when physical therapy has not been attempted—higher out-of-pocket costs should be applied.

As currently being explored in the Queensland Government discussion paper[58] on expanding healthcare and patient safety reporting across Queensland's health system, reporting should be standardised between public and private services. This to facilitate moving Australia's healthcare system toward value-based healthcare.

[57] National Centres for Chronic Disease Prevention and Health Promotion 2015. *Issues Brief: Understanding Value-based Insurance Design*: https://www.cdc.gov/nccdphp/dch/pdfs/value_based_ins_design.pdf

[58] Queensland Health 2017. Discussion Paper: Expanding healthcare quality and patient safety reporting across Queensland's health system: https://www.health.qld.gov.au/__data/assets/pdf_file/0028/667504/discussion-paper-patient-safety-reporting.pdf

5 Conclusion

The Australian health system and its model of universal healthcare are complex—with public and private providers, public and private sources of funding, and concepts of patient choice and equity of access, clinicians as business owners and as employees, sitting side by side. Changes to that system, such as potentially limiting the use of private health insurance in public hospitals, need to be made with care as there are many possible consequences including: funding pressures for public hospitals; difficulties with recruiting and retaining clinicians; reducing choice for patients whose preferred clinician may also prefer to practise in a public hospital; and decreasing the value proposition for private health insurance where private hospital services may not be available. These issue should be examined as part of an overall review of health system funding in Australia—to ensure that we maintain a strong universal health system with care available and affordable for all who need it, not just those who can afford it.

Any reforms must ensure that public hospital resources are sufficient to deliver services to all patients who require healthcare in a timely manner, regardless of where they live, how much they earn, or if they can afford private health insurance.

For evidence-informed decision making, it is vital for the Commonwealth Government to consider the multifactorial reasons why private health insurance premiums are increasing, and why patients are electing to use their private health insurance at a public hospital.

To address these concerns, it is vital that the Commonwealth proactively engage with state and territory governments along with the health sector based upon its health system stewardship role.

5.1 AHHA recommendations

Data

- The Commonwealth Government should reach an agreement with state and territory governments regarding the analysis of private health insurance utilisation in Australia, which includes its use in public hospitals compared with private hospitals.

Data—private health insurance in public hospital use

- The Commonwealth Government should make available better data to understand the use of private health insurance in public hospitals. This data should be disaggregated to the hospital level and should identify the case-mix of patients using the public system and private health insurance in public and private hospitals, and include disaggregations that control for private health insurance policy classes.

Data—exclusionary private health insurance policies

- The collection and analysis of more nuanced data on exclusionary products should be made publicly available to help understand if the significant rise in exclusionary private health insurance products is resulting in policy holders opting to use their insurance in a public hospital rather than a private hospital.

Data—complaints

- Official complaints data regarding the use of private health insurance in public hospitals should be made publicly and regularly available as part of the Ombudsman's annual reporting.

Health workforce

- The Commonwealth Government should work with state and territory governments on any reforms to private health insurance arrangements to ensure health workforce requirement and retention efforts in regional, rural and remote settings are not compromised.

Market transparency and out-of-pocket costs

- To increase transparency and the efficiency of the health sector market, and to address public concern over unanticipated out-of-pocket costs, specialist and general practitioner fees should be published at a minimum by procedure name indicating the top and bottom decile, median fee and the Medicare fee. This information should be timely, regularly updated and reported by Primary Health Network region or lower relevant patient catchment areas.

Private health insurance rebate

- A robust public interest test should be developed to measure whether this investment is worthwhile and in the interests of all Australian taxpayers. To the extent levels of private health insurances subsidies are decreased, these funds must be transparently re-allocated to other areas of the healthcare system in need of additional funding support.
- The private health insurance rebate should be removed from 'junk' policies.

Private health insurance industry profitability

- The Commonwealth Government should initiate an inquiry into appropriate levels of profitability and returns to equity within the private health insurance industry, taking explicit account of Government policies that remove significant levels of uncertainty concerning industry revenues being received. The findings from this inquiry must then be used when evaluating the appropriateness of any requests from private health insurance providers to increase premiums on their products.

Value-based insurance design

- Any proposed reforms to private health insurance should consider the current shift toward value-based healthcare and the introduction of value-based insurance design as a response to rising healthcare costs.
- Reporting should be standardised between public and private services to facilitate moving Australia's healthcare system toward value-based healthcare.

Australian Healthcare and Hospitals Association
Unit 8, 2 Phipps Close

Deakin ACT 2600
PO Box 78

Deakin West ACT 2600
P: 02 6162 0780
F: 02 6162 0779
E: admin@ahha.asn.au
W: ahha.asn.au
@AusHealthcare
facebook.com/AusHealthcare
linkedin.com/company/australian-healthcare-&-hospitals-association

ABN: 49 008 528 470