Submission to the

Private Health Insurance Consultations Submission

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Contact:

Alison Verhoeven
Chief Executive
Australian Healthcare & Hospitals Association
T: 02 6162 0780 | F: 02 6162 0779 | M: 0403 282 501
Post: PO Box 78, Deakin West, ACT 2600
Location: Unit 8, 2 Phipps Close, Deakin, ACT
E: averhoeven@ahha.com.au
W: www.ahha.asn.au

Executive summary

The Australian Healthcare and Hospitals Association (AHHA) makes the following recommendations in its submission to the review of private health insurance:

Any changes to private health insurance arrangements should be assessed against the principles of 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.

Specifically, the AHHA recommends:

Simpler products, better communication

- mandated simplification and consistency of private health insurance policy product information provided across the sector to allow for 'like for like' comparison of the approximately 25,219 private health insurance products open for new policy holders
- the Commonwealth Government invests in promoting PrivateHealth.gov.au nationally on an on-going basis
- the private health insurance industry be required to prominently promote PrivateHealth.gov.au across their media platforms and as part of their advertising campaigns as a condition of receiving government support and funding
- a mandated method of communicating policy changes to consumers under the Private Health Insurance Act, which should guarantee timely communication and allow consumers adequate time to change product or provider without being penalised or inconvenienced
- mandated product simplification aimed at a reduction in the number of exclusionary products for greater 'like for like' product comparison, which should be grouped under the following three product categories: **top category** being a comprehensive level of insurance; **medium category** being a mid-level health cover; **basic category** being a minimal level of insurance required to meet requirements related to the Lifetime Health Cover loading and the Medicare Levy Surcharge and that cover patients for treatment in a public hospital only, allowing consumer choice of health provider including where private hospital facilities are not available
- investigation of the feasibility of private health insurance policy comparison rates, similar to the requirement for advertisers of consumer debt products.

Abolition (or better targeting) of the Private Health Insurance Rebate

- the abolition of the Private Health Insurance Rebate in its entirety with the savings redirected to the public healthcare system
- if the Private Health Insurance Rebate is retained, it should only be applied against private health insurance hospital cover that falls within AHHA's recommended mandated product simplification groupings: top category; medium category; and basic category
- if the Private Health Insurance Rebate is retained, any application of the rebate to general treatment cover should only apply to policies covering only safe and effective evidence-based treatments known to maintain and improve the health of consumers, such as dental services, and that treatments without an evidence base not be covered
- concurrently, the Medicare Benefits Schedule (MBS) should include items to support access to evidence-based primary and sub-acute health services such as dental, physiotherapy and psychology services as part of bundled health packages currently under consideration in the review of primary health care

- savings from the abolition (or scaling back) of the Private Health Insurance Rebate should be redirected to public healthcare system funding, including the broadening of MBS items as recommended in the point above

Policies meeting consumer need

- private health insurance providers should be required to offer policies for rural and remote consumers that include coverage for transportation and accommodation to undergo treatment in metropolitan centres, where that treatment is not available in their geographic region
- private health insurance providers be encouraged to work together with Indigenous health organisations and consumer representatives to develop more culturally appropriate products and preferred provider arrangements

Better business practices

- an enquiry be undertaken by Government into appropriate levels of profitability and returns to equity within the private health insurance industry, taking explicit account of the reduced risk associated with Government policies that remove significant levels of uncertainty concerning industry revenues to be received
- the Commonwealth Government urgently review the prosthesis listing process as well as the allegations received by the Australian Competition and Consumer Commission (ACCC) with regards to anti-competitive and ethically questionable rebating arrangements
- the retention of community rating as set out in the Private Health Insurance Act 2007
- the retention of Lifetime Health Cover loadings
- the retention of the Medicare levy surcharge
- where medical services are provided on referral from the hospital in an outpatient, community or home setting, that these services be eligible for cover through private health insurance
- that private health insurance providers should not be permitted to establish networks of preferred health service providers offering discounted service provision nor to establish their own facilities for a range of health services and treatments if they retain eligibility for the Private Health Insurance Rebate

Equity and accessibility assurance for the non-insured

- the Commonwealth must clearly define its expectations of the role of private health insurers in primary care, ensure open and transparent evaluation of these initiatives, and any increased role for private health insurers in primary care must neither reduce access nor increase costs for non-insured consumers
- innovation in the delivery of primary health care services and initiatives that promote prevention and early intervention, but reiterates that the Commonwealth Government must ensure prevention strategies are available to all Australians, not just those with private health insurance.

Introduction

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide a submission as part of the Private Health Insurance Consultations process, which is focused on the value of private health insurance for consumers and its long term sustainability.

The 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.

Medicare, Australia's publicly funded universal healthcare cover, was founded on the principle of universality of access regardless of a person's financial circumstances. It was developed to support a fee-for-service structure for a comprehensive range of services, providing health benefits and value for money, and on the basis that pricing should support high-quality service provision. While Medicare has largely served Australians well over the past 30 years, there is a rising burden of out-of-pocket costs,[1] and only around 56 per cent of the population obtain additional private health insurance coverage, due arguably to the complexity of the products, perceptions regarding the value of benefits they offer and product costs.[2]

Guiding principles

The 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.

Information and complexity

Australians have expressed concerns about the complexity of private health insurance products and the lack of information provided by insurers. According to the Private Health Insurance Administration Council (PHIAC), as of June 2015 there were approximately 25,219 private health insurance products open for new policy holders.[3] The ACCC's most recent report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance makes observations that describe the complexities in health insurance policies that prevent making easy comparisons, accurate assessments of costs and, in some cases, possible misrepresentation of products and their value.[4]

Additionally, the Private Health Insurance Ombudsman (PHIO) indicated a common theme of increased complaints with the quality of information provided to consumers about health insurance

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1 How much do we spend on health?, Australian Institute of Health and Welfare viewed 27 November 2015: http://www.aihw.gov.au/australias-health/2012/spending-on-health/

2 Information and informed decision making. A report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance. For the period 1 July 2013 to 30 June 2014, ACCC report, 2015, pp 2–3.

3 Competition in the Australian PHI Market, PHIAC Research Paper 1, June 2015, p 42.

4 Information and informed decision making. A report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance. For the period 1 July 2013 to 30 June 2014, ACCC report, 2015, pp 2–3.

policies and claiming benefits.[5] This complexity and lack of information is leading to market failure[6] and resulting in consumer decision making being negatively affected.[7]

The AHHA recommends mandated simplification and consistency of product information provided across the sector to allow for 'like for like' comparison of the approximately 25,219 private health insurance products open for new policy holders. This will increase the transparency of important differences between policies.

The PrivateHealth.gov.au website is an Australian Government initiative, managed by the Commonwealth Ombudsman that provides a standard information statement for every health insurance policy available from every registered health fund, allowing consumers to search all health insurance policies and compare what is covered through the standard information statement. However, public awareness of the website is low.[8]

The AHHA recommends the Commonwealth Government invests in promoting PrivateHealth.gov.au nationally on an on-going basis. The AHHA equally recommends that the private health insurance industry be required to prominently promote PrivateHealth.gov.au across their media platforms and as part of their advertising campaigns as a condition of receiving government support and funding.

Insurers often vary their policies to change the procedures and benefits that are included and excluded. Insurers also change the arrangements that they have in place with third party providers. Many of these changes have the potential to cause detriment to policy-holders. Currently it is at the discretion of the insurer how to communicate policy changes to customers, which has led to a range of varied processes for providing such information.[9]

The AHHA recommends a mandated method of communicating policy changes to consumers under the Private Health Insurance Act, which should guarantee timely communication and allow consumers adequate time to change product or provider without being penalised or inconvenienced.

Exclusionary products

Some health insurance policies have exclusions or restrictions, which mean particular services are not covered by those policies. In 2014–15, the number of policies for hospital cover that exclude certain medical services and also require patients to pay an excess and co-payment significantly increased.[10]

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5 Annual Report 2013–14, PHIO p. 6.

6 Information and informed decision making. A report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance. For the period 1 July 2013 to 30 June 2014, ACCC report, 2015, p 1.

7 Information and informed decision making. A report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance. For the period 1 July 2013 to 30 June 2014, ACCC report, 2015, p 18.

8 Information and informed decision making. A report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance. For the period 1 July 2013 to 30 June 2014, ACCC report, 2015, pp 28–9.

9 Information and informed decision making. A report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance. For the period 1 July 2013 to 30 June 2014, ACCC report, 2015, p 33.

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

Under the Private Health Insurance Act there is no limit on the number of services that can be restricted or excluded provided minimum benefits are provided for psychiatric, rehabilitation and palliative care services.[11]

The PHIAC notes that the growing practice of private health insurance providers offering exclusionary products to consumers is the industry's response to the significant growth in private health service provision in the face of premium increases that regularly exceed the general rate of growth of household income. Approximately 30 per cent of private health insurance policies now have important exclusions such as joint replacement costs and cardiac treatments.[12] As of June 2014, approximately 52 per cent of policies held included one or more exclusions or restrictions, a jump from 45 per cent on the previous year.[13]

Both the ACCC[14] and the PHIO[15] state that complaints from the public about exclusions have increased. Private health insurance consumers increasingly do not know what, if any, exclusions are contained in their policies, and this is resulting in unexpected out-of-pocket cost, exclusions and restrictions or waiting periods for consumers.

The increasing number of exclusionary products does not ultimately deliver value for money to consumers, and the lack of transparent product information compounds this issue. To allow for greater transparency, consistency and comparability for the 52 per cent of Australians with exclusionary private health insurance, the AHHA recommends mandated product simplification aimed at a reduction in the number of exclusionary products for greater 'like for like' product comparison, which should be grouped under the following three product categories: **top category** being a comprehensive level of insurance; **medium category** being a mid-level health cover; **basic category** being a minimal level of insurance required to meet requirements related to the Lifetime Health Cover loading and the Medicare levy surcharge and that cover patients for treatment in a public hospital only, allowing consumer choice of health provider including where private hospital facilities are not available.

As part of this streamlining of the number and types of private health insurance products available to the public, the AHHA recommends investigation of the feasibility of private health insurance policy comparison rates, similar to the requirement for advertisers of consumer debt products.[16] This would add to the transparency of product offerings and improve market competition.

Effective use of Government incentives

To address the long decline in health insurance participation since the 1980s there are three major Australian Government incentives in place to encourage take-up of private health insurance: the means-tested Private Health Insurance Rebate to assist people meet the cost of private health insurance; the Medicare Levy Surcharge to encourage higher income earners to have private hospital

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11 Section 72–1 Private Health Insurance Act.

12 Operations of PHI Annual Report 2013–14, PHIAC, November 2014, p 5.

13 Information and informed decision making. A report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance. For the period 1 July 2013 to 30 June 2014, ACCC report, 2015, p 19.

14 Information and informed decision making. A report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance. For the period 1 July 2013 to 30 June 2014, ACCC report, 2015, pp 19–21.

15 Annual Report 2013–14, PHIO p 6.

16 National Consumer Credit Protection Act 2009, Part 10.

cover; and Lifetime Health Cover loadings to encourage Australians to take out private hospital insurance earlier in life and to maintain their cover.[17]

In 2014–15 the Australian Government spent $5.8 billion on the Private Health Insurance Rebate, meant to assist Australians meet the cost of private health insurance.[18] 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.[19] Across the forward estimates, there will be an estimated and projected expenditure of $27.1 billion on the private health insurance rebate and a further $7.24 billion of estimated tax expenditures by exempting the private health insurance rebate from declarable income.[20]

There is international evidence that the cost of subsidising private health insurance exceeds the fiscal benefits to the public sector. [21,22]

Domestically, 2013 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. The modelling showed that a 10 per cent reduction in premium rebates was expected to lead to a 1.4 per cent decrease in the proportion of Australians with private health insurance. Using 2007–08 expenditure data, the modelling found that the predicted decrease in the number of privately insured individuals would result in a $144 million increase in total public expenditure on public hospital treatment as more Australians rely on the public system. However, the modelling also indicates government expenditure on the rebate would decrease by $359 million. Therefore, in a 10 per cent reduction in premium rebates would deliver net savings in the order of $215 million.[23]

Analysis by the Grattan Institute in 2013 shows that removing the Private Health Insurance Rebate could save governments $3.5 billion in annual public expenditure where $5.5 billion in savings realised from the eliminated rebate is offset by an increase in demand for public hospital service.[24]

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. The AHHA supports the abolition of the Private Health Insurance Rebate in its entirety with these savings being re-directed to the public health system. However, should the rebate be retained, its application should be limited to products which meet the simplified products in the three categories specified in the point above.

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

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

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

20 Commonwealth of Australia, Budget 2015-16: Budget Paper No. 1, Canberra.

21 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

22 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.

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

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

Further, any application of the rebate to general treatment cover should only apply to policies covering only safe and effective evidence-based treatments known to maintain and improve the health of consumers.

Currently, health treatments and procedures such as complementary and alternative medicine are available through general treatment cover, which is eligible for the Private Health Insurance Rebate. These types of treatments do not have a reliable evidence base that supports their effectiveness for treating health conditions. A March 2015 paper by the National Health and Medical Research Council stated people may be putting their health at risk if they reject or delay safe and effective evidence-based medical treatments for homeopathy treatments,[25] and the Commonwealth has stated, 'most alternate therapies have not been assessed for efficacy or safety. Some have been studied and found to be harmful or ineffective'.[26] The Natural Therapies Review Advisory Committee has also recently provided its report to Government in which it stated that, "clear evidence has not been found" of the clinical effectiveness of natural therapy services.[27]

Should the Government decide to remove the Private Health Insurance Rebate for all general treatment cover, the AHHA contends that the Medicare Benefits Schedule (MBS) should be broadened to support access to evidence-based primary and sub-acute health services such as dental, physiotherapy and psychology service, for example, as part of bundled health packages currently under consideration in the review of primary health care.

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 2015 was 5.73 per cent.[28] Over the same period the annual average growth in health inflation was 3.88 per cent, while general consumer price inflation was 2.45 per cent.[29] 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 within is that much of the industry revenue is significantly underpinned by 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 of an estimated $6.341 billion in 2015-16 rising to $7.3 billion in 2018-19.[30]

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,

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25 Evidence on the Effectiveness of Homeopathy for Treating Health Conditions, NHMRC Information Paper, March 2015, pp 5–6.

26 Complementary and alternative therapies, Australian Government Cancer Australia, published 2004, revised and updated 2010: https://canceraustralia.gov.au/publications-and-resources/position-statements/complementary-and-alternative-therapies

27 Australian Government Department of Health, 2015, Review of the Australian Government Rebate on Natural Therapies for Private Health Insurance, Commonwealth of Australia, page 3.

28 http://health.gov.au/internet/main/publishing.nsf/Content/privatehealth-average-premium-round (accessed 3 December 2015).

29 Australian Bureau of Statistics, Consumer Price Index, Australia, Cat No 6401.0 (accessed 3 December 2015).

30 Commonwealth of Australia, Budget 2015-16: Budget Paper No. 1, Canberra.

and for many policy holders, the risk of uptake has essentially been removed.[31] 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.

The AHHA recommends that the Government initiate an enquiry 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 to be received. The findings from this enquiry must then be used when evaluating the appropriateness of any requests from private health insurance providers to increase premiums on their products.

Value for rural and remote consumers

The value of private health insurance for rural and remote consumers is considerably reduced when it can be difficult to access private hospital and general cover services in rural and remote areas.

While Commonwealth Government incentives attempt to increase the use of private hospital services to reduce pressure on public inpatient facilities, rural and remote Australia has a substantially lower level of private health fund membership, which could be attributed to the limited availability of private inpatient facilities in rural and remote Australia. This makes private health insurances policies less attractive to rural and remote consumers.[32] In effect, those private health insurance policy holders that do not have reasonable access to private hospital services are subsidising those that do have reasonable access.

A 2012 study in *Health & Place* notes 'government subsidies of private health insurance further disadvantage rural populations where private health care is generally not available'.[33]

Additionally, the ACCC notes that private health insurance preferred provider schemes potentially disadvantage policy holders from rural and remote Australia who pay the same premiums as policy holders from metropolitan centres but receive lower benefits for comparable services because they have less choice, resulting in greater out-of-pocket expenses.[34]

The AHHA recommends that because rural and remote private health insurance policy holders do not receive similar value as metropolitan policy holders, and because Commonwealth incentives attempt to increase to number of private health insurance policy holders and the use of private hospital services, private health insurance providers should be mandated to offer rural and remote policy holders transportation and accommodation support to undergo private procedures in metropolitan centres. To ensure equity of costs incurred across health insurance providers, a risk equalisation pool should be developed such that the risk-adjusted costs associated with such a scheme are equitably shared across insurers.

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[31] 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.

[32] B Lokuge, R Denniss, R & TA Faunce 2005 Private health insurance and regional Australia, MJA 182 p 290.

[33] L Bourke, JS Humphreys, J Wakerman & J Taylor 2012 Understanding rural and remote health: a framework for analysis in Australia, Health & Place 18(3), p 500.

[34] Information and informed decision making. A report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance. For the period 1 July 2013 to 30 June 2014, ACCC report, 2015, p 35.

Aboriginal and Torres Strait Islander peoples

The uptake and perception of value of private health insurance among Aboriginal and Torres Strait Islander peoples is low. Data published by the Australian Institute of Health and Welfare (AIHW) in 2015 indicate that among people in non-remote areas, only 20 per cent of Aboriginal and Torres Strait Islander adults had private health insurance in 2012–13, compared with 57 per cent of all Australian adults.[35] However, this is an increase when compared with 15 per cent covered by private health insurance in 2004–05.[36]

Among Aboriginal and Torres Strait Islander peoples with private health insurance, 63 per cent reported 'security, protection or peace of mind' as a reason for their coverage. Among those without private health insurance, the main reasons reported for not having such insurance were 72 per cent indicating they 'can't afford it or too expensive' and 22 per cent indicating 'Medicare cover is sufficient'.[37]

Several studies published over the last decade indicate that services provided by Aboriginal Community Controlled Health Services are valued and preferred by their Aboriginal clients.[38]

The AHHA recommends that private health insurance providers be encouraged to work together with Indigenous health organisations and consumer representatives to develop more culturally appropriate products and preferred provider arrangements.

Private patients in public hospitals

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 per cent of the MBS fee of the medical services provided during the hospital stay. Medicare does not pay for any other costs associated with the admission such as hospital accommodation, theatre fees, prostheses or medicine.[39]

From 2005–06 to 2010–11 public patients in public hospitals increased by 16 per cent. Over the same period, private patients in public hospitals increased by 50 per cent. By 2010–11, 10 per cent of all patients in public hospitals were private patients, compared to 7.8 per cent in 2005–06.[40]

Many insurers offer policies that only cover patients for treatment in a public hospital. Some stakeholders have argued that these policies are inconsistent with the objective of reducing pressure on public hospitals and do not provide value for money.[41]

While the current arrangement diverts privately insured patients away from private hospitals, policies that cover private treatment in a public hospital do allow patients in public hospitals choice of their healthcare provider, private or semi-private room and that ability to use public facilities which often

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35 Australian Institute of Health and Welfare 2015. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW, p 150.

36 Australian Institute of Health and Welfare 2015. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW, p 158.

37 Ibid.

38 Deeble Institute for Health Policy Research 2014. The relative effectiveness of Aboriginal Community Controlled Health Services compared with mainstream health services, issues brief no 12, published 16 September 2014.

39 Operations of PHI Annual Report 2013–14, PHIAC, November 2014, p 14.

40 D King, Private Patients in Public Hospitals, April 2013, p 2: https://www.ahsa.com.au/web/freestyler/files/Private%20Patients%20in%20Public%20Hospitals%20May%202013.pdf

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

have more services than private hospitals. They also allow public hospitals to compete with private hospitals, and if private hospitals want to be part of public-private partnerships, equally public hospitals should be able to act in this space. Overall, these arrangements ensure better consumer choice on the type of healthcare available for them to receive.

In a competitive market place, state and territory governments also plan on private revenue to contribute funding at the margin to help with the resourcing of public hospitals, and indeed subtract this amount from budget allocations—called own source revenue.[42,43]

The AHHA recommends that private health insurance providers continue to offer policies that only cover for treatment in a public hospital as a private patient.

Prostheses listing and reimbursement processes

Insurers are required to pay a benefit for all prostheses listed on the Prostheses List, with that benefit set by the Prostheses List Advisory Committee. The prostheses listing process is administratively complex. Stakeholders have raised many issues with the Commonwealth Department of Health, including that the process results in inflated prices which are passed onto consumers in premiums.[44]

The ACCC also indicates that it has received several submissions calling for an urgent review of the supply of prostheses in the private health system with 'several allegations made of anti-competitive and ethically questionable rebating arrangements reached between prostheses manufacturers and private hospitals.'[45]

The AHHA recommends the Commonwealth Government urgently review the prosthesis listing process as well as the allegations received by the ACCC with regards to anti-competitive and ethically questionable rebating arrangements. This should be done with a view to ensuring the most cost effective and competitively neutral arrangements are available for prosthesis acquisitions among both public and private operators.

Community rating and risk equalisation

In Australia, private health insurance is community-rated, which entitles all private health insurance policy holders to purchase the a given product, at the same price, with a guaranteed right to renew their policy. As set out in the Private Health Insurance Act 2007, to ensure that everybody who chooses has access to health insurance, the principle of community rating prevents private health insurers from discriminating between people of the basis of their health or for any other reason.[46,47]

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42 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

43 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

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

45 Information and informed decision making. A report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance. For the period 1 July 2013 to 30 June 2014, ACCC report, 2015, p 36.

46 How health funds work, Private Health Insurance Ombudsman: http://www.privatehealth.gov.au/healthfunds/howhealthfundswork/

47 Private health insurance glossary of commonly used terms: Community rating. Australian Government Department of Health.

Community rating represents international best practice and facilitates affordable access to private health care for all Australians.[48] However, some stakeholders have suggested that the current arrangements reduce the insurers' incentive to manage their own costs and focus on prevention.[49]

The AHHA recommends the retention of community rating as set out in the Private Health Insurance Act 2007. This is a natural complement to our universal public health system. Any move away from community rating is a slippery slope that could see health consumers charged higher premiums or rejected from coverage based on their age, weight and genetic disposition to chronic conditions and other types of illness. This is a threshold issue where to discriminate against one segment of society would ultimately lead to calls for other segments to be equally targeted for other forms of risk-seeking behaviour.

While community rating takes a population based approach to the insuring of people with respect to biological and life course factors, proponents of risk stratification based upon behavioural considerations arbitrarily identify what such behaviours might be. If person who smokes was to be charged a higher premium because of the greater health risk they face, why not a person that skis, rides a bike on the road or fails to consistently follow a healthy diet? Any such arbitrary identification of "risky behaviour" also fails to acknowledge the social context in which this often occurs, such as was recognised by all sides of politics in the 2013 Community Affairs References Committee report on the social determinates of health.[50]

Risk equalisation and the Risk Equalisation Trust Fund (RETF) are vital in ensuring that the community rating model of private health insurance pricing is sustainable, by distributing the costs of very expensive claims and those of older members across the entire industry. According to the PHIAC, during 2013–14:

> as a result of demographic factors as well as increased utilisation, the amount subject to distribution between insurers under the RETF had grown to $435 million—more than double the $198 million recorded seven year ago in 2006–07. This rate of growth is considerably in advance of the overall growth of the industry reinforcing the important role risk equalisation will continue to play as the industry moves into the next stage of its development.[51]

Community rating and risk equalisation is an effective means of avoiding adverse selection on the part of insurers. Equally, Lifetime Health Cover is an effective means of avoiding adverse selection on the part of consumers. Taken together, this community level risk pooling should not be diluted by stratifying individuals based on particular characteristics.

The AHHA recommends that community rating be retained in tandem with risk equalisation, and that risk stratified policies should not be permitted to be offered by private health insurers.

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48 Private Health Insurance Community Rating System, Private Healthcare Australia: http://www.privatehealthcareaustralia.org.au/private-health-insurance-community-rating-system/

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

50 Community Affairs References Committee, Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation" (2013).

51 Operations of PHI Annual Report 2013–14, PHIAC, November 2014, page 5.

Coverage of selected non-admitted hospital procedures

Private health insurance does not routinely cover medical services that are provided out-of-hospital. Some of these services, such as chemotherapy and rehabilitation services, were previously provided to admitted hospital patients, but due to developments in clinical practice can now be provided in outpatient, community or home settings.[52]

The AHHA recommends that where medical services are provided on referral from the hospital in an outpatient, community or home setting, that these services be eligible for cover through private health insurance.

Preferred providers and insurers as providers

Increasingly private health insurance providers are establishing networks of preferred health service providers offering discounted service provision[53] as well as establishing their own facilities for a range of health services and treatments, such as in aged care,[54] dentistry[55] and optometry.[56]

The ethical principle of minimising the harmful effects of excessive power being concentrated in the hands of one person or group requires that a separation exists between the prescribing of therapeutic products from their dispensing and sale. An argument exists that contravening this separation constitutes a prima-facie conflict of interest and may amount to notifiable conduct under the Health Practitioner Regulation National Law provisions.[57]

Similarly, the move of private health insurance providers to establish networks of preferred health service providers as well as their own service delivery facilities constitutes a growing concentration of power to the insurance providers away from independent service providers and consumers and could be perceived as a prima-facie conflict of interest.

The AHHA recommends that private health insurance providers should not be permitted to establish networks of preferred health service providers offering discounted service provision nor to establish their own facilities for a range of health services and treatments if they retain eligibility for the Private Health Insurance Rebate.

Private health insurers and primary care

A number of trial projects in primary care were initiated by private health insurers in 2014, and it is likely that there will be further development of this work in the future. The effective and efficient funding, provision and coordination of primary health care services is critical for a sustainable health system which aims to improve health outcomes and reduce overall health care costs. However, any involvement of private health insurers in primary care must not be to the detriment of those who do not have private insurance, and the Commonwealth Government must ensure that non-insured patients are afforded equal access to primary care.

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

[53] Medibank Members' Choice: http://www.medibank.com.au/health-insurance/members-choice/

[54] Bupa Aged Care: http://www.bupa.com.au/healthandcaring/index.html?s_cid=116326r1460#aged

[55] Bupa Dental Clinics: http://www.bupa.com.au/healthandcaring/index.html?s_cid=116326r1460#dental

[56] Bupa Optical Care: http://www.bupa.com.au/healthandcaring/index.html?s_cid=116326r1460#optical

[57] M Parker, J Wardle, M Weir & C Stewart 2011 Medical merchants: conflict of interest office product sales and notifiable conduct, Medical Journal of Australia 194(1), pp 34–7.

The AHHA welcomes innovation in the delivery of primary health care services. Initiatives that promote prevention and early intervention and improve the coordination of care should be encouraged. The Commonwealth must clearly define its expectations of the role of private health insurers in primary care, and any increased role for private health insurers in primary care must neither reduce access nor increase costs for non-insured consumers.

The AHHA also recommends an open and transparent evaluation of private health insurer initiatives as essential and should be publicly released to inform debate. The evaluation of private health insurer initiatives and the primary care system overall would be greatly enhanced by the availability of patient based data rather than service level data.

Preventive health

In her 28 October 2015 address to the National Press Club, Commonwealth Minister for Health Sussan Ley underscored the value of better preventive health and early intervention measures. While investing in preventive health measures generates a short term cost, it will also create savings in reduced health care costs down the track. This has been recognised by private health insurers in the primary care trials described above.

The Intergenerational Report released by the Treasurer in March 2015 highlighted drivers of health spending and projected Commonwealth Government spending on health services to increase from 4.2 per cent of gross domestic product (GDP) in 2014-15 to 5.5 per cent of GDP in 5054-55. An effective way to in part address concerns about future fiscal pressures is to take earlier steps to prevent health conditions from occurring, delaying the onset and reducing the severity of any conditions. Preventive health is an effective means of contributing to this goal while simultaneously improving quality of life.

The AHHA welcomes innovation in the delivery of primary health care services and initiatives that promote prevention and early intervention, but reiterates that the Commonwealth Government must ensure prevention strategies are available to all Australians, not just those with private health insurance.

Ambulance services

Ambulance care is an essential component of a universal health system, providing life-saving treatment and transition into hospital care. The current variable system of ambulance service funding across jurisdictions does not support equitable access to potentially lifesaving care.

While not identified as an issue for the industry roundtable discussions lead by the Department of Health, the AHHA is concerned that people living in states and territories that do not have universal coverage for ambulance services may not be aware of the importance of obtaining ambulance insurance. This may leave individuals with substantial out-of-pocket costs should they need to utilise this service. While private health insurance can be obtained that covers the use of ambulances, people who have not purchased such insurance remain exposed to a potentially significant financial risk.

The AHHA recommends that the Government consider removing ambulance insurance from private health insurance policies and replacing it instead with a universal scheme for ambulance coverage. This could be funded as part of the redirection of funds from the private health insurance rebate towards the public healthcare system.

Conclusion

The review of private health insurance is a complex and important task, and the AHHA welcomes the opportunity to support its work. The AHHA commends the recommendations outlined in this submission and expects they will be taken into account as Australia strives toward building a modern, 21st century health system founded on evidence-based medical procedures and practices that are safe, effective and available to all Australians without discrimination.

The AHHA is also concerned that the various reviews underway within the health portfolio, in addition to the Government's major white paper processes on reform of the Federation and of the tax system, be considered together and in a coordinated manner. Fragmented and piecemeal reform will not optimise the health system, and must be avoided in order to ensure improved services for all Australians and a sustainable healthcare system.