



**Value and affordability of private health insurance and
out-of-pocket medical costs**

Australian Senate Standing Committee on Community Affairs

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1 Introduction

The Australian Healthcare and Hospitals Association (AHHA) welcomes this opportunity to provide this submission as part of the Australian Senate Standing Committee on Community Affairs' inquiry into the value and affordability of private health insurance and out-of-pocket medical costs.

The AHHA is Australia's national peak body for public hospitals and healthcare 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.

1.1 Guiding principles for reform

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.

1.2 Highly ranked healthcare system

The Australian healthcare system is built on a solid foundation, with Medicare and strong public healthcare and hospital sectors providing the basis for universal access to quality healthcare services. Australians have enjoyed access to universal healthcare for more than 30 years, through a system 'which achieves good results relatively efficiently. Health expenditure in Australia is about the same as the OECD average, at 8.8% of GDP. Life expectancy at birth is the sixth highest in the OECD, at 82.2 years.'¹

Australia's healthcare system consistently outperforms other OECD countries when comparing key health indicators and costs. But in common with many OECD countries, Australia's health sector is confronting challenges including an ageing population, a growing burden of chronic disease and increasing costs for health services. A complex system of mixed public-private sector responsibilities for governance, funding and service delivery means care can be fragmented, and oversight of the system can be compromised.

1.3 Mixed public-private system

While the development of policy responses to address these challenges can be complicated by the mixed public-private system, there is considerable support in Australia for a strong public health sector, complemented by market competition and consumer choice through private sector health services.

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.² The proportion of Australians with private health insurance has remained relatively stable since 2000

¹ OECD 2015. OECD health policy overview: Health policy in Australia. p 1:

<https://www.oecd.org/australia/Health-Policy-in-Australia-December-2015.pdf>

² 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>

following the Commonwealth Government's introduction of three major surcharges and incentive schemes meant to encourage the uptake of private health insurance following a prolonged period of decline.³

Attempts by governments to reduce the role of the public sector in health service delivery have met with substantial public backlash, particularly where voters believe health services will be less accessible and less affordable. At the time of the 2016 Australian election, 60% of voters nominated health as the most important issue influencing their voting intention, and 55% nominated investment in health and hospitals services as the priority issue for the incoming government.⁴

Public-sector health services are provided by Commonwealth, state, territory and local governments. Private-sector health service providers include private hospitals and medical practitioners in private practices. In 2014–15, health spending in Australia was estimated at \$162 billion—more than two-thirds of which came from Commonwealth, state, territory and local governments.⁵

Some of the \$108 billion spent by governments on health was transferred to the private sector including to private health insurers via subsidies (\$6 billion), private health service providers including general practitioners and specialists (\$22 billion), pharmaceuticals (\$9 billion) and private hospitals (\$5 billion). Private health insurers contributed \$8 billion to expenditure in hospitals in 2014–15.⁶

1.4 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.⁷

While the Commonwealth walked away from growth funding provisions for public hospitals in this agreement in its 2014–15 Budget,⁸ 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 2016.⁹

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,

³ 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>

⁴ Murphy, K. 2016. Health and Medicare the most important issues for voters in federal election, poll finds. The Guardian. 26 July. Viewed 11 Jan 2017 at:

<https://www.theguardian.com/australia-news/2016/jul/26/health-and-medicare-the-most-important-issues-for-voters-in-federal-election-poll-finds>

⁵ Australian Institute of Health and Welfare (AIHW). 2016. Health expenditure Australia 2014–15. Health and welfare expenditure series no. 57. Cat. no. HWE 67. Canberra: AIHW (pages vii and 44).

⁶ Australian Institute of Health and Welfare (AIHW). 2016. Health expenditure Australia 2014–15. Health and welfare expenditure series no. 57. Cat. no. HWE 67. Canberra: AIHW (Table A3).

⁷ Council of Australian Governments 2011. National Health Reform Agreement:

http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-agreement.pdf

⁸ 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>

⁹ 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>

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.

2 The value and affordability of private health insurance and out-of-pocket medical costs

While health costs keep rising by more than inflation, the willingness the Commonwealth Government has demonstrated to approve insurance premium increases greater than health inflation does nothing to exert downward pressure on health costs.¹⁰

2.1 Out-of-pocket medical costs

Both the OECD and The Commonwealth Fund note that 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.¹¹ 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.¹²

Out-of-pocket costs stop people from seeking healthcare—particularly people on low incomes and in need of care.^{13,14}

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.¹⁵

¹⁰ Pascoe M 2017. ‘Forget the banks – health insurance makes them look like amateurs’ Sydney Morning Herald. Viewed at: <http://www.smh.com.au/business/banking-and-finance/forget-the-banks--health-insurance-makes-them-look-like-amateurs-20170224-gukprj.html>

¹¹ OECD 2015. Health at a Glance 2015. How does Australia compare?:

<https://www.oecd.org/australia/Health-at-a-Glance-2015-Key-Findings-AUSTRALIA.pdf>

¹² 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

¹³ 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.

¹⁴ 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

¹⁵ 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.^{16,17,18} 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 for common procedures 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, the AHHA recommends specialist and general practitioner fees be published by procedure name indicating the top and bottom decile, median fee and the Medicare fee in order to increase price transparency and informed decision making. This information should be timely, regularly updated and reported by Primary Health Network region.

This recommendation is consistent with the approach being recommended in the Productivity Commission's inquiry into introducing competition and informed user choice in human services.¹⁹

2.2 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, there is limited availability of private inpatient facilities in rural and remote Australia. This makes private health insurances policies less attractive to rural and remote consumers.²⁰ In effect, those private health insurance policyholders that do not have reasonable access to private hospital services are subsidising policyholders who do have reasonable access.

A 2012 study in *Health & Place* notes 'government subsidies of private health insurance further disadvantage rural populations where private healthcare is generally not available'.²¹

Additionally, the Australian Competition and Consumer Commission (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

¹⁶ 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>

¹⁷ 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>

¹⁸ 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>

¹⁹ Productivity Commission 2017. Reforms to Human Services:

<http://www.pc.gov.au/inquiries/current/human-services/reforms/draft>

²⁰ Lokuge B, Denniss R, Faunce R & TA 2005. 'Private health insurance and regional Australia', *MJA* 182 p 290.

²¹ Bourke L, Humphreys JS, Wakerman J & Taylor J 2012. 'Understanding rural and remote health: a framework for analysis in Australia', *Health & Place* 18(3), p 500.

benefits for comparable services because they have less choice, resulting in greater out-of-pocket expenses.²²

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 the 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.

2.3 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 in 2015 indicate that among people in non-remote areas, only 20% of Aboriginal and Torres Strait Islander adults had private health insurance in 2012–13.²³ However, this is an increase when compared with 15% covered by private health insurance in 2004–05.²⁴

Among Aboriginal and Torres Strait Islander peoples with private health insurance, 63% 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% indicating they 'can't afford it or too expensive' and 22% indicating 'Medicare cover is sufficient'.²⁵

Several studies published over the last decade indicate that services provided by Aboriginal Community Controlled Health Organisations are valued and preferred by their Aboriginal clients.²⁶ Services provided by these organisations are funded primarily through Medicare and grants, but not private health insurance.

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.

The AHHA considers it an oversight that Aboriginal and Torres Strait Islander representation is not included in the membership of the Commonwealth's Private Health Ministerial Advisory Committee, and the AHHA recommends that Aboriginal and Torres Strait Islander representation be included in current and future Commonwealth advisory work on private health insurance.

²² Australian Consumer and Competition Commission 2015. *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*, report, p 35.

²³ 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.

²⁴ 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.

²⁵ 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.

²⁶ 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.

2.4 Older consumers

Research from the National Senior's Productive Ageing Centre²⁷ shows older Australians maintain private health insurance policies for security, protection and peace of mind, choice of doctor, ability to be treated as a private patient in hospital and to be able to access treatment sooner. The main reason for Australians over 50 years of age not purchasing health insurance was affordability.

3 Private and public hospital costs and the interaction between the private and public hospital systems including private patients in public hospitals and any impact on waiting lists

3.1 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.²⁸

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%.²⁹

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.³⁰

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.³¹

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.³²

²⁷ Temple J & Adair T 2011. 'A carrot and a big stick: understanding private health insurance and older Australians', NSPAC Research Monograph no 1, National Seniors Productive Ageing Centre. Canberra: https://nationalseniors.com.au/system/files/2011_PACReport_Monograph_CarrotBigStick.pdf

²⁸ Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

²⁹ 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.

³⁰ 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.

³¹ 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

³² 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

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.³³

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.³⁴ 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 10.38% 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 2016.³⁵

3.2 Private health insurance overhead vs. public hospital services

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).³⁶

3.3 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 patients³⁷ examined the extent to which activity-based funding, and its implementation in the states and territories, had contributed to the increase in 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, and including public hospital only insurance products.

Statistics published by the Australian Prudential Regulation Authority^{38,39} 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 11,328,577 policies were exclusionary.

During the same period, changes to the private health insurance rebate income testing arrangements reduced the share of funding provided by the Australian Government through the rebate scheme.

³³ 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

³⁴ Independent Hospital Pricing Authority 2017. Private Patient Public Hospital Service Utilisation. Table 1

³⁵ Australian Prudential Regulation Authority. Benefit Trends. December 2016—issued 14 February 2017: <http://www.apra.gov.au/PHI/Publications/Pages/Statistical-Trends.aspx>

³⁶ 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

³⁷ Independent Hospital Pricing Authority 2017. Private Patient Public Hospital Service Utilisation.

³⁸ Australian Prudential Regulation Authority. Membership Trends - December 2016 (issued 14 February 2017): <http://www.apra.gov.au/PHI/Publications/Pages/Statistical-Trends.aspx>

³⁹ Australian Prudential Regulation Authority. Benefit Trends - December 2016 (issued 14 February 2017): <http://www.apra.gov.au/PHI/Publications/Pages/Statistical-Trends.aspx>

Coinciding with this, the proportion of overall hospitals expenditure funded by private health insurers increased from 7.4% in 2011–12 to 8.3% in 2013–14.⁴⁰

3.4 Private patients in public hospitals

The 2011 National Health Reform Agreement⁴¹ 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 for Australia's health system 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 with the resourcing of public hospitals, and indeed subtract this amount from budget allocations—called own source revenue.^{42,43} Nationally, private-sourced revenue represents around \$1 billion per annum of funding for 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% of the Medicare Benefits Schedule (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.⁴⁴ In many instances, public hospitals cover any 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: patients are provided with information clarifying their rights with regard to use of insurance and any 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 insurance does not necessarily guarantee access to a private room, nor preferential access to services.

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.⁴⁵ AHHA public hospital members have advised they always ensure patients without private insurance are never clinically disadvantaged.

⁴⁰ Australian Institute of Health and Welfare 2016. Australia's health 2016 [1]. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

⁴¹ Council of Australian Governments 2011. National Health Reform Agreement: <http://www.federalfinancialrelations.gov.au/content/npa/health/archive/national-agreement.pdf>

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%20Board/s/Better-Health-Better-Care-Better-Value-WA-Health-Reform-Program.ashx

⁴⁴ Operations of PHI Annual Report 2013–14, PHIAC, November 2014, p 14.

⁴⁵ AIHW 2017. Admitted patient care 2015–16: Australian hospital statistics. Health services series no. 75. Cat. no. HSE 185. Canberra: AIHW.

There are very few recorded complaints made through official complaints processes regarding the use of private health insurance in public hospitals, notwithstanding 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 Wales Health Care Complaints Commission. Of these, only three were deemed as requiring investigation, and only one was substantiated.⁴⁶

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. In addition to previously cited issues regarding access to private care in regional, rural and remote areas, in the children’s hospital sector 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 insurance and unable to have their choice of treating physician.

Some 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.⁴⁷ 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.

Better data is required to understand the use of private health insurance in public hospitals. This data should be disaggregated to hospital level and should identify the case-mix of patients using the public system and private health insurance in public and private hospitals. More nuanced data on exclusionary products is needed. And more detail is needed on the number of complaints received at jurisdictional level on the use of private health insurance in public hospitals. This is further expanded in section 6.

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

See section 2.1.

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

5.1 Information and complexity

Australians have expressed concerns about the complexity of private health insurance products and the lack of information provided by insurers. 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 insurance⁴⁸ states that there are a range of poor practices adopted by some insurers around how

⁴⁶ Health Care Complaints Commission. *Annual Report 2015–16: Protecting Health and Safety*. Sydney. Table A.2 and table A.17.

⁴⁷ Issues for consideration at roundtables on PHI, Australian Government Department of Health PHI Consultation, November 2015.

⁴⁸ Australian Competition and Consumer Commission. 2016. *Communicating changes to private health insurance benefits: 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 2014 to 30 June 2015*. Available at:

they notify consumers of changes to their private health insurance benefits, and these practices negatively impact consumers through bill shock, inadequate insurance coverage, lost switching or porting opportunities, and by limiting access to healthcare. It also notes the Australian private health insurance industry continues to increase in complexity, driven in part by a greater number of policies, changes to available benefits, and the rise of non-comprehensive policies. The ACCC goes on to state that research revealed examples of communication of changes to the benefits provided by private health insurers that might breach consumer laws.

The Private Health Insurance Ombudsman noted an increase in complaints in 2015–16 and the challenges of understanding and using a health insurance policy once it has been purchased.⁴⁹

The AHHA recommends mandated simplification and consistency of product information provided across the sector to allow for ‘like for like’ comparison of private health insurance products open for new policyholders. This will increase the transparency of important differences between policies.

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.

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.

The AHHA recommends the Commonwealth Government invests in promoting PrivateHealth.gov.au nationally on an on-going basis. The AHHA recommends that the private health insurance industry equally 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.

5.2 Exclusionary products

Some health insurance policies have exclusions or restrictions, which mean particular services are not covered by those policies.

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.⁵⁰

As noted in section 3.3, statistics published by the Australian Prudential Regulation Authority^{51,52} related to exclusionary and non-exclusionary hospital insurance policies indicated the number of exclusionary hospital policies jumped from around 10% in June 2009 to 37% by June 2016.

https://www.accc.gov.au/system/files/1109_Private%20Health%20Report%202014-15_FA1_web.pdf

⁴⁹ Private Health Insurance Ombudsman 2016 State of the Health Funds Report. Relating to financial year 2015–16:

<http://www.ombudsman.gov.au/publications/state-of-the-health-funds-report/2016-state-of-the-health-funds-report2>

⁵⁰ Section 72–1 Private Health Insurance Act.

⁵¹ Australian Prudential Regulation Authority. Membership Trends - December 2016 (issued 14 February 2017): <http://www.apra.gov.au/PHI/Publications/Pages/Statistical-Trends.aspx>

⁵² Australian Prudential Regulation Authority. Benefit Trends - December 2016 (issued 14 February 2017): <http://www.apra.gov.au/PHI/Publications/Pages/Statistical-Trends.aspx>

The value of exclusionary policies in private hospitals is clearly less than in public hospitals where gap payments are often covered by the hospital. And some policies provide coverage only in public hospitals and are cynically marketed by insurers at the same time as they seek to restrict insurance use in public hospitals.

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, the AHHA recommends mandated product simplification aimed at a reduction in the number of exclusionary products for greater 'like for like' product comparison.

The Government's current consideration of mandating simplified health insurance policies to gold, silver and bronze categories must ensure that the bronze category, its lowest cost category, does not discriminate against: women, for example by excluding obstetrics; people with chronic disease, for example by excluding some cardiac care services; or disadvantaged population groups, for example by excluding coverage for appropriate mental health services.

6 The use and sharing of membership and related health data

Better data reporting disaggregated to hospital level on private health insurance use would be useful to inform understanding of the drivers of the use of private health insurance, and analysis of the impact of capped funding arrangements by Commonwealth, state and territory governments. This would also assist in understanding the funding pressures experienced in public hospitals.

More detailed information needs to be provided that isolates where and how private health insurance is being used by patients in different hospitals across the country, and the circumstances in which it is used. Understanding patient case-mix is important, for example, patients who have private health insurance but end up in public hospitals as insured patients may be different as they may have greater urgency due to complexity not able to be managed in the private sector. More nuanced data on exclusionary products is also needed.

Better data will usefully inform future National Health Reform Agreement discussions between Commonwealth, state and territory governments on the impact of private patients in public hospitals.

7 The take-up rates of private health insurance, including as they relate to the Medicare Levy Surcharge and Lifetime Health Cover loading

The Medicare Levy Surcharge and Lifetime Health Cover loading are two of three major surcharges and incentive schemes used by the Australian Government to encourage the uptake of private health insurance among Australians.

The Medicare Levy Surcharge is levied on payers of Australian tax who do not have private hospital cover and who earn above a certain income. The surcharge aims to encourage individuals to purchase and retain hospital insurance. The surcharge covers payers of Australian tax and their dependents. The surcharge is calculated at the rate of 1% to 1.5% of a tax payer's income and is in addition to the Medicare Levy of 2% (rising to 2.5% from 1 July 2019), which is paid by most Australian taxpayers.⁵³

⁵³ Private Health Insurance Ombudsman. Medicare Levy Surcharge:
<http://www.privatehealth.gov.au/healthinsurance/incentivessurcharges/mls.htm>

Lifetime Health Cover is designed to encourage people to take out hospital insurance earlier in life and to retain their cover. This is to lower the pooled risk of insured people which should decrease upward pressure on insurance premiums. If an Australian tax payer does not have hospital cover with an Australian registered health fund by the tax payer's Lifetime Health Cover base day and they then decide to purchase hospital insurance later in life, the tax payer will pay a 2% loading on top of the standard premium for every year over the Lifetime Health Cover base day. In most cases, the Lifetime Health Cover base day is the later of 1 July 2000 or the 1 July following the tax payer's 31st birthday.⁵⁴

These policy levers led to significant take-up of private health insurance, particularly the introduction of Lifetime Health Cover from 1 July 2000. However, since then, the level of Australians with private health insurance has remained relatively stable.⁵⁵

When discussing Australia's private health insurance market, commentary will stress healthy market competition and consumer choice,⁵⁶ but the reality is Australia's private health insurance market is dependent on major surcharges and incentive schemes. The effect of these policy settings is that for many Australians it would be economically irrational to not purchase and retain private health insurance.

Section 10 considers whether or not the Australian Government's annual subsidy to private health insurance providers through the Private Health Insurance Rebate is an effective use of Commonwealth funds.

8 The relevance and consistency of standards, including those relating to informed financial consent for medical practitioners, private health insurance providers and private hospitals

As noted in section 2.1, patients often rely on their general practitioner to make the choice of specialist for them through the referral process. Patients also rely on medical specialists once in hospital to inform decision making. To increase price transparency and informed decision making, fees should be published 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.

9 Medical services delivery methods, including healthcare in homes and other models

9.1 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

⁵⁴ Private Health Insurance Ombudsman. Lifetime Health Cover:

<http://www.privatehealth.gov.au/healthinsurance/incentivessurcharges/lifetimehealthcover.htm>

⁵⁵ 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>

⁵⁶ Private Health Insurance Administration Council 2015. *Competition in the Australian Private Health Insurance Market*. Research paper 1, published June 2015:

http://www.apra.gov.au/PHI/PHIAC-Archive/Documents/Competition-in-the-Australian-PHI-market_June-2015.pdf

to admitted hospital patients, but due to developments in clinical practice can now be provided in outpatient, community or home settings.⁵⁷

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.

10 The current government incentives for private health

10.1 Effective use of Government incentives

To address the 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 cover; and Lifetime Health Cover loadings to encourage Australians to purchase hospital insurance earlier in life and to maintain their cover.⁵⁸

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.⁵⁹ This subsidy is meant 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.⁶⁰

There is international evidence that the cost of subsidising private health insurance exceeds the fiscal benefits to the public sector.^{61,62}

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% reduction in premium rebates was expected to lead to a 1.4% 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, a 10% reduction in premium rebates would deliver net savings in the order of \$215 million.⁶³

⁵⁷ Issues for consideration at roundtables on PHI, Australian Government Department of Health PHI Consultation, November 2015.

⁵⁸ D Seah, T Cheong & M Anstey 2013 The hidden cost of private health insurance in Australia, Australian Health Review 37(1), pp 1–3.

⁵⁹ Budget 2017–18. Budget Strategy and Outlook Budget Paper No. 1. Table 8.1. Canberra.

⁶⁰ Menadue, J, Facts on the \$11b per annum private health insurance industry subsidy, posted 19 Nov 2015: <http://johnmenadue.com/blog/?p=5014>

⁶¹ 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

⁶² 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.

⁶³ TC Cheng 2013, Does Reducing Rebates for Private Health Insurance Generate Cost Savings? Melbourne Institute Policy Briefs Series, Policy Brief No. 3/13.

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, based on the \$5.5 billion (now more than \$6 billion) in savings realised from the eliminated rebate being offset by an increase in demand for public hospital service.⁶⁴ 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.

The AHHA supports the abolition of the Private Health Insurance Rebate in its entirety with these savings being transparently re-directed to the public health system. However, should the rebate be retained, its application should be limited to products which meet the simplified gold, silver and bronze products.

Further, any application of the rebate to general treatment cover should only apply to policies covering 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,⁶⁵ 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'.⁶⁶ 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.⁶⁷

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

⁶⁴ Balancing budgets: tough choices we need, Grattan Institute, November 2013, p. 71.

⁶⁵ Evidence on the Effectiveness of Homeopathy for Treating Health Conditions, NHMRC Information Paper, March 2015, pp 5–6.

⁶⁶ 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>

⁶⁷ Australian Government Department of Health, 2015, Review of the Australian Government Rebate on Natural Therapies for Private Health Insurance, Commonwealth of Australia, page 3.

10.2 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%.⁶⁸ Over the same period the annual average growth in CPI was 1.9%.⁶⁹ 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 of more than \$6.2 billion in 2016–17 and more than an estimated \$6.4 billion in 2017–18.⁷⁰

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.⁷¹ 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%.⁷² NIB Holdings reported a return on equity in 2016 of 25.8%.⁷³

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.

11 Any other related matter

11.1 Community rating and risk equalisation

In Australia, private health insurance is community-rated, which entitles all private health insurance policyholders to purchase 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 can access health insurance, the principle of community rating prevents private health insurers from

⁶⁸ <http://health.gov.au/internet/main/publishing.nsf/Content/privatehealth-average-premium-round>

⁶⁹ Australian Bureau of Statistics, 6401.0 - Consumer Price Index, Australia, Mar 2017, Canberra.

⁷⁰ Budget 2017–18. Budget Strategy and Outlook Budget Paper No. 1. Table 8.1. Canberra.

⁷¹ 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.

⁷² 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>

⁷³ NIB Holdings Annual Report 2016: <http://investorreports.com.au/nib/2016/2016-annual-report>

discriminating between people on the basis of their health or for any other reason.^{74,75} Community rating represents international best practice and facilitates affordable access to private healthcare for all Australians.⁷⁶ However, some stakeholders have suggested that the current arrangements reduce the insurers' incentive to manage their own costs and focus on prevention.⁷⁷

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 a 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.⁷⁸

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.

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.

⁷⁴ How health funds work, Private Health Insurance Ombudsman:

<http://www.privatehealth.gov.au/healthfunds/howhealthfundswork/>

⁷⁵ Private health insurance glossary of commonly used terms: Community rating. Australian Government Department of Health.

⁷⁶ Private Health Insurance Community Rating System, Private Healthcare Australia: <http://www.privatehealthcareaustralia.org.au/private-health-insurance-community-rating-system/>

⁷⁷ Issues for consideration at roundtables on PHI, Australian Government Department of Health PHI Consultation, November 2015.

⁷⁸ 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).

11.2 Preferred providers and insurers as providers

Increasingly private health insurance providers are establishing networks of preferred health service providers offering discounted service provision⁷⁹ as well as establishing their own facilities for a range of health services and treatments, such as in aged care,⁸⁰ dentistry⁸¹ and optometry.⁸²

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.⁸³

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.

Preferred provider arrangements limit patient choice and the associated value they perceive for their private health insurance cover, particularly in regional and rural areas where they may be unable to access the insurer's preferred providers, and in circumstances where they may have long-standing relationships with trusted healthcare providers.

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.

11.3 Private health insurers and primary care

The AHHA welcomes innovation in the delivery of primary healthcare services. Initiatives that promote prevention and early intervention and improve the coordination of care should be encouraged.

The AHHA calls on the Commonwealth Government to clearly define its expectations of the role of private health insurers in primary care, and any increased role for private health insurers in primary healthcare must neither reduce access nor increase costs for non-insured consumers.

11.4 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.

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,

⁷⁹ Medibank Members' Choice: <http://www.medibank.com.au/health-insurance/members-choice/>

⁸⁰ Bupa Aged Care: http://www.bupa.com.au/healthandcaring/index.html?s_cid=116326r1460#aged

⁸¹ Bupa Dental Clinics: http://www.bupa.com.au/healthandcaring/index.html?s_cid=116326r1460#dental

⁸² Bupa Optical Care: http://www.bupa.com.au/healthandcaring/index.html?s_cid=116326r1460#optical

⁸³ 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.

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. The Commonwealth Government would need to closely monitor insurers to ensure that the savings from not offering ambulance cover are passed on as reduced premiums.

12 Conclusion

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.

In many parts of regional, rural and remote Australia, there are no private hospitals available—and 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.

State and territory health departments have protocols and guidelines regarding communications with patients about the use of private health insurance, and associated complaints mechanisms. A more fulsome analysis of public hospital service utilisation by private patients would examine how these protocols are implemented in hospitals, and any related complaints data.

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.

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

12.1 AHHA recommendations

PrivateHealth.gov.au

- The Commonwealth Government should invest in promoting PrivateHealth.gov.au nationally on an on-going basis.
- Private health insurance providers should 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.

Private health insurance policy design

- To allow for 'like for like' comparison of private health insurance products open for new policyholders, the Commonwealth should mandate simplification and consistency of product information provided across the sector. This will increase the transparency of important differences between policies.
- As the Commonwealth Government works through the development of simplified gold, silver and bronze categories for private health insurance, the bronze category, its lowest cost category, must not discriminate against: women, for example by excluding obstetrics; people with chronic disease, for example by excluding some cardiac care services; or disadvantaged population groups, for example by excluding coverage for appropriate mental health services.

Private health insurance policy design—Aboriginal and Torres Strait Islander peoples

- Private health insurance providers should be encouraged to work together with Indigenous health organisations and consumer representatives to develop more culturally appropriate products.
- It is an oversight that Aboriginal and Torres Strait Islander representation is not included in the membership of the Commonwealth's Private Health Ministerial Advisory Committee, and Aboriginal and Torres Strait Islander representation should be included in current and future Commonwealth advisory work on private health insurance.

Private health insurance policy design—ambulance

- The Commonwealth Government should 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. The Commonwealth Government would need to closely monitor insurers to ensure that the savings from not offering ambulance cover are passed on as reduced premiums.

Private health insurance policy design—non-admitted hospital procedures

- Where medical services are provided on referral from the hospital in an outpatient, community or home setting, these services should be eligible for cover through private health insurance.

Private health insurance policy design—primary care

- The Commonwealth Government should clearly define its expectations of the role of private health insurers in primary care, and any increased role for private health insurers in primary healthcare must neither reduce access nor increase costs for non-insured consumers.

Private health insurance policy design—rural and remote

- 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 the 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.

Communicating private health insurance policy changes

- The Commonwealth Government should mandate a 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.

Private Health Insurance Rebate

- The Commonwealth Government should abolish the Private Health Insurance Rebate in its entirety with these savings being transparently re-directed to the public health system. However, should the rebate be retained, its application should be limited to products which meet the simplified gold, silver and bronze product specifications.
- Any application of the rebate to general treatment cover should only apply to policies covering safe and effective evidence-based treatments known to maintain and improve the health of consumers.
- Should the Government decide to remove the Private Health Insurance Rebate for all general treatment cover, the AHHA contends that the MBS should be broadened to support access to evidence-based primary and sub-acute health services such as dental, physiotherapy and psychology services, for example, as part of bundled health packages currently under consideration in the review of primary healthcare.

Community rating and risk equalisation

- The Commonwealth Government should retain community rating as set out in the Private Health Insurance Act 2007 in tandem with risk equalisation, and that risk stratified policies should not be permitted to be offered by private health insurers.

Data

- Better data is required to understand the use of private health insurance in public hospitals. This data should be disaggregated to hospital level and should identify the case-mix of patients using the public system and private health insurance in public and private hospitals. More nuanced data on exclusionary products is needed. More detail is also needed on the number of complaints received at the jurisdictional level on the use of private health insurance in public hospitals.

Price transparency and informed decision making

- In order to increase price transparency and informed decision making, specialist and general practitioner fees should be published by procedure name indicating at a minimum the top and bottom decile, median fee and the Medicare fee, and reported by Primary Health Network region in a timely and regular manner.

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.

Private health insurance industry—preferred providers

- 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.



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