Chapter 5
Private health insurance

Introduction

5.1 The private health insurance industry in Australia comprises 34 private health insurers. At the end of 2012–13, 47 per cent of the Australian population was covered for hospital treatment by a health insurance policy and 54.9 per cent was covered by a general treatment policy. 85.5 per cent of insured persons are insured for both hospital and general treatment policies.[1]

5.2 This chapter discusses the following term of reference:

(f) the role of private health insurance.

5.3 The majority of the evidence received by the committee with respect to the role of private health insurance related to individuals' out-of-pocket costs associated with private health insurance premiums as well as costs incurred when accessing private health services. The committee also received evidence related to the notion of private health insurers making a contribution to primary healthcare services.

5.4 This chapter will first present the evidence received on the role of private health insurers in primary healthcare and then the evidence received about out-of-pocket costs associated with the private health system.

Private health insurance in primary healthcare

5.5 Private health insurance in Australia covers treatment in private hospitals, treatment in public hospitals as a private patient and treatment by allied health professionals who do not receive a Medicare rebate. Under the *Private Health Insurance Act 2007*, it is prohibited for private insurers to cover services for which a Medicare benefit is payable.

5.6 Although the 2014–15 Budget did not include specific initiatives relating to the expansion of private health insurance services, the Budget papers did include the following information:

> In line with its commitment to reducing red tape, the Australian Government will review the private health insurance regulatory framework to ensure it does not place an unnecessary regulatory burden on providers, while ensuring consumer and health system needs are protected.[2]

5.7 The committee notes that since the National Commission of Audit released its report, there has been speculation and media commentary about whether the current

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1 Private Health Insurance Administration Council, *The Operations of Private Health Insurers Annual Report 2012-13*, September 2013, p. 20.

2 Department of Health, *Budget related paper No. 1.10, 2014-15 Health Portfolio Budget Statements, Private Health*, May 2014, p. 119.

situation will be amended in such a way to allow private health insurers to expand to cover primary healthcare.

5.8 Submitters were concerned that the entrance of private insurers into primary healthcare would serve to both increase out-of-pocket costs for individuals and facilitate the creation of a 'two-tiered' healthcare system that would significantly disadvantage those without private health insurance.[3]

5.9 The Australia Institute noted that allowing private health insurers to cover out-of-pocket expenses in primary care may assist those who can afford private health insurance to offset costs but that such a change ' would increase the cost of primary health services and inequality of access to these services as more and more Australians would be likely to delay seeing the doctor'.[4]

5.10 Professor Stephen Jan told the committee:

> Our concern about that is that that potentially leads to cost escalation and in a sense undermines the whole idea of trying to contain costs. When you allow insurers to cover the full cost of the gap then potentially that gap gets bigger and bigger. We know from the US that, when private health insurers are allowed to enter into that area, inevitably there are cost escalations that potentially undermine the whole initiative we are talking about.[5]

5.11 Submitters cautioned that extending private health insurance into general practice may impact on a doctor's ability to provide services.[6]

5.12 The National Aboriginal Community Controlled Health Organisation submitted that studies have indicated that Aboriginal and Torres Strait Islander people have a much lower uptake of private health insurance. Any moves to expand the role of private health insurers into the delivery of primary health care services risks further alienation of Aboriginal and Torres Strait Islander people from health care services.[7]

5.13 The New South Wales Nurses and Midwives' Association submitted:

> In terms of the role of private health insurance, local and global evidence shows that the more private health insurance is used to fund health care, the more expensive that health system becomes, without any improvement in the quality of care.[8]

5.14 The Australian Council of Social Service (ACOSS) also expressed concern about proposals to allow private health insurance into primary healthcare:

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3 See for example, Doctors Reform Society of Australia, *Submission 26*, [p. 4]; Combined Pensioners & Superannuants Association of NSW Inc, *Submission 32*, p. 3.

4 The Australia Institute, *Submission 1*, p. 6.

5 Professor Stephen Jan, *Committee Hansard*, 3 July 2014, p. 3.

6 See for example, Australian Nursing & Midwifery Federation, *Submission 50*, p. 8.

7 National Aboriginal Community Controlled Health Organisation, *Submission 42*, p. 4.

8 New South Wales Nurses and Midwives' Association, *Submission 68*, p. 3.

> While consumers should be able to access particular models of care, and have choice of provider and practitioner, there are concerns about a model that promotes private health insurance as a way 'to jump the queue' and to access timely health care. All Australians should be able to access the care they need, at the time they need it.
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> Further, ACOSS is particularly concerned about proposals to allow private health insurance into primary healthcare. We are concerned that this will further encourage the emergence of a two tier health system, where those with financial means are able to access the care they need, when they need it, while those without private health insurance will be less able to access appropriate care.[9]

5.15 The Queensland Aboriginal and Islander Health Council (QAIHC) noted that if private health insurers entered the primary healthcare setting, this would create competition between services and community controlled health organisations such as QAIHC will be unable to compete.

> …QAIHC may potentially lose its core functions including our ability to collect, analyse, interpret and report of data and across AICCHS. The amalgamation of community controlled health organisations will result in poorer health outcomes for Aboriginal and Torres Strait Islander people, a loss of employment, a gap in primary health service delivery and more burden on the health care system.[10]

5.16 The committee received some limited evidence indicating that there may be merit in expanding the role of private health insurance.

5.17 The Royal Australian College of General Practitioners (RACGP) suggested that discussion about the role of private health insurance should be a much broader and separate discussion from out-of-pocket costs. However, the RACGP also noted:

> The RACGP believes that, under strictly agreed conditions, there is a possible role for private health insurers to support the delivery of general practice services that are not currently funded by Medicare. The RACGP does not support amendment of the *Private Health Insurer Act 2007*.[11]

5.18 On 17 June 2014, the Senate referred the Private Health Insurance Amendment (GP services) Bill 2014 to the Community Affairs Legislation Committee for inquiry and report. This private Senator's Bill seeks to amend the *Private Health Insurance Act 2007* to clarify that private health insurers may not enter into arrangements with primary care providers that provide preferential treatment to their members.[12]

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9 Australian Council of Social Service, *Submission 61*, p. 12.

10 Queensland Aboriginal and Islander Health Council, *Submission 58*, p. 9.

11 The Royal Australian College of General Practitioners, *Submission 20*, p. 6.

12 Private Health Insurance Amendment (GP Services) Bill 2014, *Explanatory Memorandum*, p. 2.

Role of private health insurers to reduce out-of-pocket costs

5.19 Submissions received from Medibank Private and Bupa Australia highlighted the important role that private health insurance plays in the Australian healthcare system. Bupa advised that in the 12 month period to March 2014, private health insurers paid more than $16.5 billion in healthcare benefits. In addition:

> Further indicative of the significant contribution that PHI makes to the system as a whole, in 2012/13, $7.4 billion in benefits paid were paid by health insurers for treatment in private hospitals and $899 million in benefits were paid for treatment in public hospitals. In 2012/13, private hospitals treated 4 out of every 10 hospital admitted patients, representing 41 per cent of all hospital separations.[13]

5.20 Other evidence provided to the committee questioned whether private health insurers do play a role in reducing out-of-pocket costs in healthcare for individuals.

5.21 Services for Australian Rural and Remote Allied Health submitted:

> The limited availability of private health services in rural and remote Australia directly affects the capacity of private health insurance to assist consumers residing in those settings with their out-of-pocket health costs.[14]

5.22 The Australian Dental Association (ADA) argued that private health insurance holds a special place in health service delivery that, in the ADA's view, is not warranted.[15]

5.23 Evidence from ACOSS acknowledged the role of private health insurers in Australia's health system, but emphasised the need to acknowledge that 'private health insurance is increasingly a luxury that cannot be afforded by many households on low incomes'.[16] ACOSS also questioned the efficacy of maintaining the private health insurance rebate. This was a view shared by other witnesses to the inquiry.[17]

Out of pocket costs associated with the private health system

5.24 Submitters and witnesses provided examples of the high out-of-pocket costs incurred when receiving treatment in the private health system and cited occasions when patients reported lack of disclosure about the total out-of-pocket costs that would be incurred.

5.25 Particular reference was made to costs associated with breast cancer treatment[18] and circumstances when surgical medical technology is not included on

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13 Bupa Australia, *Submission 76*, pp 5–6.

14 Services for Australian Rural and Remote Allied Health, *Submission 34*, p. 6.

15 Australian Dental Association, *Submission 57*, p. 10.

16 Australian Council of Social Service, *Submission 61*, p. 11.

17 See for example, Australian Council of Social Service, *Submission 61*, pp 11–12; Ms Annie Butler, *Committee Hansard*, 29 July 2014, p. 36.

18 Breast Cancer Network Australia, *Submission 51*, p. 9.

the federal government's mandatory reimbursement list known as the Prostheses List.[19]

5.26 The Breast Cancer Network Australia submitted that women with breast cancer who have treatment in the private health system often incur high out-of-pocket costs. Many women report that they were unaware that their private health insurance would not cover all of the costs associated with their treatment.[20]

5.27 Cancer Voices Australia submitted that privately insured individuals often report lack of up-front disclosure for the total out-of-pocket costs associated with cancer surgery, drugs and radiotherapy.[21]

5.28 The committee notes evidence from the Macular Disease Foundation Australia (the Foundation) that many elderly people struggle to maintain their private health insurance but feel compelled to do so to maintain choice and access to treatment. Maintaining access to treatment is becoming increasingly important due to the limited availability of public outpatient treatment for wet macular degeneration. The Foundation explained the frustration experienced when individuals incur out-of-pocket costs for wet macular degeneration treatment provided by an ophthalmologist in the doctor's rooms as they are unable to access their private health insurance to cover this gap. In contrast, if the same treatment was received in a private hospital or day clinic, individual cost is reduced as they are able to access assistance through private health insurance.[22]

5.29 The committee also received evidence indicating that individuals are experiencing difficulties to meet the out of pocket costs of private health insurance. National Seniors Australia submitted:

> Older Australians are committed to maintaining their private health insurance for as long as possible. The main reasons given by the over 50s for purchasing private health insurance are security, protection or peace of mind followed by choice of doctor, private treatment and shorter waiting times for treatment. People on pensions and allowances and lower income earners are more likely to report that they are unable to afford private health insurance.
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> However, their ability to contribute to the cost of their own health care and decrease the burden on the public health system is under attack due to rising out-of-pocket health costs, capping of Medicare rebates, the phasing out of the Net Medical Expenses Tax Offset, higher proposed thresholds for the Extended Medicare Safety Net and the recently announced changes to the private health insurance rebate.[23]

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19 Mr David Ross, *Committee Hansard*, 29 July 2014, p. 51.

20 Breast Cancer Network Australia, Submission 51, p. 9.

21 Cancer Voices Australia, *Submission 14*, p. 3.

22 Macular Disease Foundation Australia, *Submission 96*, p. 7.

23 National Seniors Australia, *Submission 55*, pp 11–12.

Dental services

5.30 With the exception of a small number of public dental programs and services, dental services are provided almost exclusively by private providers. Individuals accessing these services frequently incur high out-of-pocket costs and many Australians take out private health insurance as a mechanism to reduce out-of-pocket costs.

5.31 The Australian Dental Association (ADA) explained that individuals with private health insurance are often required to pay the difference between the service fee charged and the rebate paid by the private health insurer. According to the ADA, the discrepancy between the fees charged and the level of rebate has increased since 2001.[24]

5.32 The ADA noted that the increasing gap being paid by way of increasing out-of-pocket costs has an adverse impact on private health insurance members' attendance levels for care.[25]

Preferred providers

5.33 The committee was advised that approximately 50 per cent of general practice dentists participate in the preferred provider system.

5.34 The ADA submitted that the 'preferred provider' system entered into between private health insurers and providers has a negative impact on out-of-pocket expenses.

> The ADA can advise that there are cases where the non-preferred provider's entire fee is less than the rebate offered to the preferred provider patient. Yet, because the out-of-pocket expense is less, staff of the fund promote the preferred provider as being cheaper.[26]

5.35 Further to this, the ADA argued that the preferred provider system is inequitable because often dentists are refused entry to the system because of the number of dentists in the area that are already preferred providers.[27]

Ensuring a high level of information disclosure

5.36 Evidence provided to the committee noted the importance of individuals being adequately informed of the costs associated with treatment before it has taken place.

5.37 The committee notes that it may be challenging to ensure that individuals are fully informed of costs associated with their treatment at every stage of the process. However, it is very important that comprehensive information is provided before treatment occurs and that patients are encouraged to seek clarification.

5.38 Professor Peter Brooks explained some of the challenges associated with informed consent because of the perceived power imbalance in the relationship

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24 Australian Dental Association, *Submission 57*, p. 5.

25 Australian Dental Association, *Submission 57*, p. 6.

26 Australian Dental Association, *Submission 57*, p. 11.

27 Mrs Eithne Irving, *Committee Hansard*, 3 July 2014, p. 29.

between the patient and the doctor. Even when patients are informed about the out-of-pocket costs, they are often reluctant to ask questions or seek clarification as they fear it may jeopardise or delay their treatment. Professor Brooks emphasised the importance of improving health literacy so that individuals feel more empowered to initiate conversations about treatments and the associated costs.[28]

5.39 The Department of Health reiterated that it is important for patients to be informed about the costs associated with their treatment but acknowledged that there are challenges:

> When you are talking about a single piece of surgery, that can and does happen. But if you are talking about somebody receiving treatment over a period of time for cancer, for example, then you get a whole range of treatments. That is the situation I am talking about where a decision made quite early on about which way to go has significant downstream impacts, many of which no-one can know at the time the decision is made. It is very hard to predict what they will be.[29]

5.40 The Australian Society of Anaesthetists (ASA) told that committee that health insurers have a responsibility to make patients aware of the details of their health insurance policy, particularly if they do not have a known gap policy. The ASA emphasised that this information should be provided by private health insurers at the outset. Although anaesthetists try to make sure that the information is available to patients, they 'should not be relied upon to be the only source'.[30]

5.41 Medibank Private and Bupa Australia reiterated the importance that individual policy holders are fully aware of the services covered under their insurance policies.

5.42 Drawing on research undertaken by IPSOS Australia (market research organisation who conduct the IPSOS health care and insurance indicator survey), Medibank private concluded that there are three conditions that contribute to consumers acceptance of out-of-pocket expenses:

- communication: that the out-of-pocket cost is communicated;
- certainty: limited variation in the out-of-pocket amount originally advised; and
- manageability: consumers need to feel that they can manage the cost otherwise it will act as a deterrent to accessing healthcare.[31]

5.43 Catholic Health Australia submitted that more needs to be done to ensure that consumers are informed about the appropriateness of their private health insurance

28 Professor Peter Brooks, *Committee Hansard*, 3 July 2014, p. 6.

29 Mr Richard Bartlett, *Committee Hansard*, 3 July 2014, p. 68.

30 Dr Mark Sinclair, *Committee Hansard*, 3 July 2014, p. 22.

31 Mr James Connors, *Committee Hansard*, 3 July 2014, p. 36.

policy for their life circumstances. Information about the potential out-of-pocket costs should be readily available on an ongoing basis.[32]

5.44 Bupa Australia argued that increased transparency about hospital and specialist charges is fundamental to consumers having greater access to information:

> From our point of view, getting a degree of transparency about how specialists and hospitals charge for things—and making that available to consumers—would be a significant step in the right direction. Given the amount of taxpayer and private health fund money that is tied up in this, we believe that is a completely reasonable ask. Many other organisations are required to divulge these things to the consumer. It would also allow us as an industry to do some of the things that we rightfully have responsibility to do. If transparency were available, we could develop software technology for our members, telling them in advance what the particular products, and the particular doctors they are wanting to see, might mean for them.[33]

Committee view

5.45 The committee notes the concerns raised by some witnesses about private health insurers making a contribution to primary healthcare services. The committee notes that the Private Health Insurance Amendment (GP services) Bill 2014 has been referred to the Community Affairs Legislation Committee for inquiry and report by 26 August 2014.

5.46 The committee notes the evidence received which cautioned against extending the scope of private health insurance into primary health care.

5.47 The committee accepts that private health insurers already play a significant role in the delivery of health services and contribute to improving health outcomes for the Australian community.

5.48 The committee was concerned to hear personal accounts throughout the inquiry in relation to individuals incurring very high out-of-pocket costs for treatment in the private health system. The committee notes that often payment was required with very little notice given of the costs involved or a limited understanding of the full terms and conditions of their private health insurance policies.

5.49 Given that individuals with private health insurance often face large out of pocket costs and informed financial consent is often inadequate, better mechanisms are required to ensure patients are fully informed about treatment costs, before initial treatment as well as throughout any follow up treatment.

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32 Catholic Health Australia, *Submission 63*, p. 6.

33 Dr Dwayne Crombie, *Committee Hansard*, 3 July 2014, p. 37.