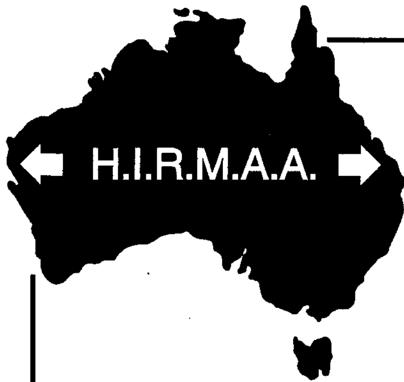

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HEALTH INSURANCE RESTRICTED MEMBERSHIP ASSOCIATION OF AUSTRALIA

PRESIDENT:
M. J. Bassingthwaighte
LYSAGHT PEOPLECARE

All Correspondence should be addressed to:
EXECUTIVE DIRECTOR:
Norman Branson
23 Millbank Drive
Mt. Eliza Vic. 3930
Ph/Fax: (03) 9787 3660
Mobile: 0400 922 712

5 May 2005

Mr James Catchpole
Committee Secretary
Standing Committee on Health and Ageing
Parliament House
Canberra ACT 2600

Dear Mr Catchpole

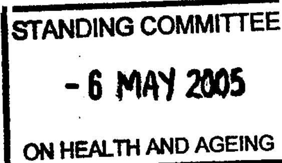
Commonwealth Parliamentary Enquiry into Health Funding

Appended is a submission to the above enquiry submitted on behalf of the Health Insurance Restricted Membership Association of Australia.

The Association wishes to make you aware that we are willing to personally present to the Committee if this is seen as appropriate and would welcome participation in any process designed to benefit the privately insured population of Australia.

Yours sincerely

Norman W Branson
Executive Director.



INTRODUCTION

The Health Insurance Restricted Membership Association of Australia (HIRMAA) represents the fourteen private health insurance companies registered under the National Health Act as restricted membership health funds. These funds have a contributor membership of over 275,000 with coverage of approximately seven hundred thousand Australians.

It is the intention of the Association to address the issues under sub paragraphs d) and e) of the issues under consideration by the Committee within its terms of reference. It is not intended that this submission will be all encompassing nor will it answer definitively all the questions raised within the terms of reference. It is our intention to highlight what we consider to be significant issues and to canvass some possible solutions.

This submission will be restricted to the hospital and medical component of the process and not dwell on those health activities which would normally be covered under the Ancillary arm of private health.

It is important that there be a recognition and continuance of a clear demarcation of the two sectors of health provision. The publicly funded Medicare sector is one to which all Australians are required to contribute. The private sector is one where individuals make a conscious decision to pay an additional voluntary contribution to avail themselves of some choices which are not available to them under the publicly funded option. One outcome of this is that $5.4 billion additional funding is available within the Australian global hospital system; additional dollars that would not be available were it not for the privately insured population.

This statement can be made in dollar terms and it has some impact, but what really needs to be considered in this debate is the medical outcomes associated with these additional dollars. The private hospital system in Australia has grown, particularly over the past two decades, in size and complexity. No longer is it just a cottage hospital industry catering for lower level hospital procedures but is now a highly sophisticated multi functional health delivery system. The private sector now provides over 55% of all elective surgery admissions to Australian hospitals consistently performing the highest percentage of joint replacement surgery, high levels of cardiac surgery and many other complex surgical and medical procedures. There also needs to be recognition of the part the private health network now plays in accident and emergency facilities throughout the nation and the continuing advancements being made in preventative measures to keep sick patients outside of hospital. We will develop this latter issue later in this presentation.

The Government and the broader community also need to recognise that the willingness of the insured population can only be guaranteed to continue if the public perceive a real distinction between that which is provided "free" through Medicare and that which insured consumers choose to pay additionally through their health insurance premiums. Consumers of private health make this conscious decision to contribute additional dollars because of the choice they are able to achieve when contributing. The choice of timing. The choice of

practitioner. The choice of facility. Whenever the consumer sees these fundamental choices being eroded or provided free to others who have not made an additional contribution (with the exception of veterans) they perceive a devaluation of their own commitment.

There have been occasions in Australia when various Governments both State and Federal have floated the possibility of utilizing the private sector to overcome workload and waiting period problems within the public sector. When these schemes are floated it makes it extremely difficult for insurers to convince their loyal membership that the additional cost burden they have willingly accepted is justified. The insured member sees the uninsured having free access to private facilities for which they themselves have paid a high price.

SUSTAINABILITY OF THE PRIVATE SECTOR

The general community seem to be able to understand the Consumer Price Index but find difficulty in comprehending why the health cost index increases at rates sometimes twice or even three times the CPI.

While within the industry it is relatively easy to show that the ageing population and the increased sophistication and cost of medical technology contributes in a major way to the increases in private insurance contribution rates it is difficult to get this across to the general public and even media commentators.

It is important that all segments of the private industry and the Government are seen to be acting to find ways of reducing the impact of this cost impost on the consumer if the system is to remain sustainable.

An important way of reducing the cost, (and this is not a panacea for all cost rises) is to allow for insurance funds to introduce innovative ways of treating persons outside the hospital gates. Our Association is aware of proposals currently before the Department of Health and Ageing which are designed to allow for programs of health provision previously not covered within a fund's hospital table. These proposals are in their embryonic stage of development and urgent approval for the principle needs to be given.

Some health funds have already developed programs which can loosely be described as wellness programs which facilitate the management of chronic patients outside hospital. These programs have been shown to significantly benefit select patient groups and as such it is important that any legislative impediment to the continued use and development of such innovations be removed.

Of similar importance is to provide an environment where the most appropriate setting is utilised for the treatment of patients. That is the system must not be regulated to the extent where it is only feasible to provide care in an acute hospital setting. By facilitating this change insurers would be able to reduce cost while maintaining quality of outcome, particularly when dealing with aftercare following complex surgical and medical procedures.

Your Committee has also asked for commentary regarding relationships between the various segments of the industry and quite rightly points to the benefits that are attainable when these relationships are positive. In a competitive environment it is not always possible to maintain positive relationships and the fact that one arm of the system (the insurers) are heavily regulated and this regulation does not extend to the other parties sometimes makes the equation unequal. Our Association makes the following comments with respect to relationships with the major sectors of the industry:

- Public Hospital Sector. Privately insured patients have a right to choose to utilise their private health insurance or to be treated under their Medicare entitlements as a public patient. It is unfortunate that some public hospital networks perceive private health insurance and privately insured patients as another revenue source. Public hospitals need to accept that they should only charge a private patient if the patient has made a conscious decision to be treated as a private patient and the treatment provided through this choice offers a different environment to that available to them as a public patient. Privately insured patients opting to use the public system should be free to make this choice and not 'encouraged' to pay through their insurer for treatment that they have contributed towards through their Medicare payments.
  Good relationships could be developed between public hospitals and insurers if the public networks could provide real private treatment in private facilities at competitive rates. If public hospital networks continue with the philosophy that privately insured patients are merely an additional revenue source then the relationships will be strained.

- Private Medical Practitioners. The relationship between health funds and private medical practitioners is relatively unstructured.
  There are two distinct schools of practice within the practitioner ranks, one where there is help and assistance in a tripartite arrangement between the doctor, the patient and the fund, and another where there is absolute antipathy towards such a system. The funds recognise that many practitioners regard the financial aspects of their relationship with patients as being purely between the doctor and the patient and do not wish to have a fund intercede within this relationship. On the other hand, there are practitioners who see the advantages to their patients of dealing with health funds. Whichever way a practitioner chooses to deal with his patient's ultimate financial responsibility, there needs to a completely open and transparent system of informed financial consent.
  The current half way house is not acceptable. Ideology should not be allowed to interfere with consumer rights in what can be a very expensive exercise for a patient. Practitioners should be compelled to inform their patients of the assistance they can gain from their health fund in addressing any possible gap costs and to itemise the gaps they know exist between their fees and the various refund benefits available to them.

- Private Hospitals. Although there is seemingly a symbiotic relationship between private hospitals and the third party funders, there are also the essential elements of competition at hand.
  There is statistical evidence to show that the utilisation within private hospitals has risen significantly since 1997. In 1997 occupancy rates for private

hospitals was at 65.8% this had risen to 75.6% by 2003. Even accounting for the increased number of health fund members over this period, it can be shown that private hospitals have benefited significantly. In 1997 there were 4.03 beds per thousand insured and this has dropped to 2.94 in 2003. A similar increase in utilisation is apparent in actual hospital admissions where there were 1.5 million in 1997 rising to 2.25 million in 2003. It could be argued that this is merely a result of the increase in membership following lifetime healthcover but more targeted statistics show that whereas in the past twelve months there has been an increase of 0.3% of persons covered under private hospital insurance, there has been an increase of 178,000 hospital admissions or 8.4% over the corresponding period.
Given these statistics and the publicly acknowledged growing wealth of private hospital conglomerates it is difficult to be able to sustain an argument that allows for the surprising incidence of hospital gaps reappearing in fund benefit schedules.
While the Association does not advocate price control for hospitals even if it could be legislatively achieved, there may need to be ways the Government can intervene in the public interest when a pricing dispute between hospitals and health funds reaches a position that will significantly disadvantage the consumer/patient.
It is difficult to understand a system of regulation that requires health funds to submit to actuarial assessment when determining their contribution rates, but where no similar containment is applied in the equation to the hospital. Health funds have a responsibility to their consumers to limit cost increases wherever possible and this does not always engender particularly good relations with some hospital networks who are becoming increasingly large and powerful.

There is recognition that health costs are going to continue rising at levels beyond CPI. This will be as a consequence of factors which are unavoidable. The ageing population, the expectation of the population to better health outcomes, the high cost of medical devices, all of these factors will have an adverse impact and could lead to another round of reductions in the number of insured in the population unless these factors can be adequately managed.

A proactive approach is needed to be taken to ensure the sustainability of the private system. What is needed is a select group of people from across the whole private industry to be working under the auspices of Government, to develop cooperative strategies for sustainability. Such a group would almost inevitably need to include the ACCC and have as a goal real sustainable strategies for the next two decades.

INNOVATIVE WAYS TO MAKE PRIVATE HEALTH INSURANCE MORE ATTRACTIVE

It is unfortunate that private health insurance is viewed by many consumers differently to other insurance they purchase. Consumers have expectations that they will recoup their contributions to private health insurance in the short term as compared to their house insurance, or even motor vehicle insurance where they hope never to recoup their contribution.

This factor alone makes the product unattractive to many in the community, particularly the young and healthy who are needed to keep the system viable. Lifetime Healthcover has helped but it isn't the complete answer.

In trying to vary the product to make it more attractive, insurers need to comply with regulations surrounding the principles of community rating. Our Association is in no way opposed to community rating, but given strict adherence to the principle has been dented by Lifetime Healthcover penalties, then perhaps it is time to see if other minor changes could be introduced whilst still retaining the overall community rating principle.

The industry has from time to time opened discussion on a range of innovations that could overcome some of the difficulties associated with the two factors we have shown above; the mix of membership and community rating.

The issues brought forward in this proposal are not new. They have been canvassed before in numerous forums but it is now appropriate for them to again be reviewed.

- For the efficiency and effectiveness of the broader private health industry, health insurance needs to be able to attract and retain members whose claiming profile will contribute positively to the long term viability of the system. The categories of persons involved are those whose claiming profile is less than average and those of a younger age. The industry needs to be able to provide them with value for money to bring them into the system and then to retain them.

- The committee will be well aware of penalties associated with later age joining members, but the question of incentives to early joining and continuing low claiming members has not been fully evaluated.

- We are aware that the Department is currently investigating the issue of loyalty bonuses for long serving members and if this is satisfactorily resolved it will assist, but the solution must be broadly based and meet the needs of the target audience.

- One solution may be to allow a reduced premium to those who transfer from a dependent status to a full membership in their own right.

- Salary sacrifice provisions could be modified to allow employers and employees to reap the benefits of staff belonging to the highest levels of health insurance. It is well known that substantial organisations in the past have reviewed their commitment to staff benefits and excluded health insurance as an item because of the fringe benefit tax implications. Employees likewise have not seen the value of using salary sacrifice for private health insurance because of the fringe benefit tax implications. Given the total community benefit accruing from private health insurance and its contribution to the total health equation Fringe Benefit Tax treatment is again worthy of consideration.

These are just a few possible areas open to the Government and the industry to further investigate and make private health insurance still more attractive.

Another issue though that needs to be addressed is being able to respond to adverse publicity about the product and indeed about the whole concept of private health.

- Positive publicity and promotion with respect to the extended community value of private health insurance is important. Too often the media commentators' view of the rebate is distorted and so the public perception is likewise distorted.
  The recent report *Preserving Choice (7 Apr 2003)* by Professor Ian Harper of the Melbourne Business School showed some of the community benefits attached to the private health insurance incentive package. These benefits need to be publicised to the Australian community in specifically targeted promotions. It is important that consumers of private health insurance receive positive feedback from promotions rather than the negative information promulgated via the less than supportive media. The industry and Government should be prepared to develop information packages designed to overcome the negative information brought forward and accentuate the community benefits accruing from the system of private health operating within a dual health system.

- Publicity also needs to be given to the true cost of the provision of health care in a way it can be readily understood by the community. The community is inundated with information about the billion dollar consequences of health provision; it comes from both State and Federal Governments. This means little the general consumer or taxpayer. They may be aware of the cost of a visit to their general practitioner but most would not appreciate that it costs around $18,000 for a hip replacement operation.

The Government and the Private Health industry need to become involved in promulgating the benefits to the community of the dual public/private health environment that operates in Australia.

CONCLUSION

HIRMAA is committed to working with Government to ensure the community continues to be able to enjoy the benefits associated with our dual system of health provision. We recognise its benefits not only to those who choose private health but the overall community benefits flowing from the additional voluntary funding private health insurance provides.
In closing our Association would like to draw attention to a comment made by Professor Ian Harper. "If people abandon private health insurance, the cost of providing public health care and the cost of PHI both rise, reflecting the loss of the implicit subsidy paid by those who take out PHI in addition to paying taxes to fund public health treatment."