Private Healthcare Australia

Better Cover. Better Access. Better Care.

Senate inquiry into the value and affordability of private health insurance and out-of-pocket medical costs
Response to Questions on Notice

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Question

The complex economic modelling provided by Evaluate lacks one significant variable – the effectiveness and outcome of care provided. It assumes these are equal in both public and private. Where patients make a choice to use PHI and jump the waiting lists do you think there is a risk of unnecessary surgery being performed?

Response

One of the benefits of private health insurance (PHI) is that patients have greater choice over when, where and by whom they are treated. Whilst patients being treated in a private hospital may have the ability to choose their day/time of treatment, there is no right to jump the waiting list for privately insured patients treated in a public hospital. The National Health Reform Agreement between the Commonwealth, states and territories requires that access to public hospital services be based on clinical need. PHA supports the principle that admission to any public hospital is prioritised on the basis of clinical need where a waiting list exists, and this should not be undermined for the purpose of financial gain. Australian Institute of Health and Welfare data has revealed this year that private patients treated in public hospitals are being treated faster than public patients, and this should be addressed by Australian governments in the next hospital agreement.

Legislation which currently prevents PHI from covering medical services that are provided out-of-hospital and covered by Medicare creates an obvious perverse incentive for doctors to admit patients to hospital, particularly for short-stay admissions when it is not clinically required. This is because in doing so, the provider can claim gap cover, and additional revenue if they have an additional financial stake in a short-stay hospital facility. This has fuelled huge growth in hospitalisation of patients previously treated in doctors' rooms and in the community, for everything from excision biopsies to cognitive behavioural therapy, and has inevitably put upward pressure on premiums. It would make much more sense to amend the legislation, permitting health funds to negotiate with providers for appropriate remuneration in an appropriate setting of care.

The current legislative restrictions also inhibit PHI from funding up-to-date models of care for chronic conditions which are based out-of-hospital, and out-of-hospital care which may help to avoid unnecessary hospitalisations. Such models of care are often more effective than hospital admission in terms of both quality and cost.

Question

How do you explain the significant variations in both medical and surgical care provided as outlined in the 2017 Atlas of Healthcare variation? For example, SA has much rates of total knee replacement than other states. SA also has much higher rates of non-malignant hysterectomy. Both these procedures are essentially elective. Are these examples of unnecessary surgery? Do those consumers place themselves at risk of complications they would not have experienced if they had waited?

Response

PHA believes that consumers should have access to transparent information about the cost and quality of medical services to empower them to make informed healthcare decisions. Healthcare providers have a key role to play in ensuring that consumers receive the best possible care by making cost and quality data public and taking action to address problems in clinical practice where these are identified. PHA supports the work of Medibank and the Royal Australasian College of Surgeons to report on variations in surgical practice, and encourages

other medical colleges to promote similar transparency.

There is the risk in systems like healthcare where there is a large information asymmetry between providers and consumers, supplier-induced demand occurs. This is when the number of medical interventions correlates with the number of health professionals and providers, rather than the prevalence of disease in a population. This can be a cause of clinical variation. The use of data to track utilisation of procedures, disease prevalence and clinical outcomes is critical to addressing this, as well as proactive workforce management by government.

PHA is not in a position to determine whether the South Australian examples you have identified represent unnecessary surgery. As there may be various reasons for surgical variation (such as clinician behaviour, financial incentives, clinical risk and demographic factors), a detailed examination of the individual cases would be required. PHA is also unable to advise on whether these consumers have placed themselves at greater risk of complications; it is a matter of clinical judgment to assess the risks and benefits of surgical intervention in each case.

Question

You discuss sharing of membership and related health data as a tool to manage fraud and inappropriate practice. What do you think is the degree of fraud in the Australian context? What is your estimate of inappropriate practice? How will individual member data help manage fraud? What data is needed to identify this?

Response

Reducing waste and inappropriate practice under the MBS will bring down the cost of premiums for the more than 13.5 million Australians who have private health insurance. PHA estimates that reducing improper payments in medical benefits by just 5% would deliver savings of $110 million to be passed on to consumers through lower premiums.

Under Australian government regulations, the 'trigger' for a health fund to pay a hospital claim is the MBS claim. While this protects the consumer from unexpected out-of-pocket expenses due to claims not being approved, it means health funds are highly dependent on the appropriate management of the MBS program to be able to manage their costs.

Traditionally, MBS payment integrity has been managed through the Professional Services Review (PSR) process, as well as fraud and compliance activities undertaken by the Department of Human Services. Through the performance of its statutory role, PSR protects patients and the community from the risks associated with inappropriate practice, and protects the Commonwealth from having to meet the cost of medical / health services provided as a result of inappropriate practice. Appropriate practice describes healthcare that is both medically necessary and clinically relevant. For example, billing a cosmetic surgery procedure to the MBS and a health fund would be considered inappropriate practice.

The main problem with the PSR process is that it relies heavily on the retrospective pursuit of financial gains by practitioners with the goal of recovering costs. This is cumbersome, involves long-drawn-out legal and administrative processes and is rarely successful.

PHA believes compliance could be considerably strengthened by using and combining available datasets to improve the detection of improper payments. Improper payments include unintentional errors, abuse, as well as fraud (intentional deception).

Modern data analytics provides the opportunity to better use data to give health professionals MBS claims feedback, thereby giving them the opportunity to proactively modify behaviour and

prevent fraud and inappropriate practice occurring in the first place. Health funds have already demonstrated the effectiveness of feedback in reducing inappropriate claims. Health professionals are aware 'someone is watching' and are given data about how they are claiming relative to their peers before any punitive action is taken. In 2016, compliance personnel in the Department of Human Services were merged into a single unit with MBS compliance at the Department of Health. This presents a unique opportunity to begin a preventive data analytic-based payment integrity and compliance regime, to leverage and back up the good work on the MBS Review.

Any such payment integrity program will have to move beyond assessing the validity of individual claims and address the claiming behaviour of individuals and groups of individuals. A comprehensive, behavioural analytics approach requires capabilities beyond the traditional skill set of the PSR and a mandate that goes from recovery of erroneously paid money to transparent monitoring and education of the provider population as well as claiming citizens. As the Government recently experienced with the Centrelink payment integrity effort, a thoughtful and pro-active communications and stakeholder management plan is imperative to the success of any such programs.

Currently, individual insurers are limited in their ability to detect improper payments. The data available to each insurer represents only a partial picture of services billed by providers. Unusual practice patterns or volumes may be obscured if only a small proportion of these services are visible to an insurer. Furthermore, insurers are often not in a position to refuse payment of fraudulent claims if Medicare has paid the claim.

It is therefore critical that a robust mechanism be established to manage compliance in the MBS program, and to ensure that services are provided appropriately. PHA believes that one way to enhance compliance is to adopt a collaborative approach with government payors, and match existing MBS and Hospital Casemix Protocol datasets to identify instances of fraud or inappropriate practice. Not only will this help to address rising costs and premium pressures, but insights generated from data analytics would enhance the impact of the Government's MBS review.

Question

The main benefit of 'Extras' cover is access to affordable dental care. Your own submission points out that insurance only paid the full dental fee in 9% !! of patients. This inquiry has had numerous submissions point out the ever-shrinking cover provided by dental extras insurance as there are not standard fees like the Medicare rebate. Would you support the government regulating fees for dentists in a manner similar to the MBS?

Response

PHA supports provider fee schedules as a way to give greater transparency and certainty to consumers about out-of-pocket costs.

After premium affordability, out-of-pocket costs are the major area of concern for health fund members. By contracting with dentists, health funds have been able to reduce uncertainty about out-of-pocket costs, and have been able to provide preventive dental services with no gaps in many cases.

Preferred provider arrangements have delivered efficiencies, kept downward pressure on premiums, and resulted in no or known gaps for consumers. The ACCC has noted, in its annual reports on private health insurance, that preferred provider arrangements can deliver benefits to

health fund members, most commonly in the form of a greater rebate, when they choose to have treatment at one of their health insurer's preferred providers.

Health funds pay $2.6 billion in benefits for dental care each year, which has increased by 8% per annum on average over the past five years.

Dental cover is a key reason consumers choose private health insurance, and their desperate need for predictability about quality and out-of-pocket costs is what is driving vertical integration and corporatisation in this sector.