Senate Community Affairs Reference Committee Inquiry into Private Health Insurance

Australian Association of Practice Management Ltd
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AAPM Submission – July 2017

The Australian Association of Practice Management (AAPM) is pleased to make this submission to the Senate Community Affairs Reference Committee Inquiry into Private Health Insurance (PHI). AAPM offers the following comments against the Terms of Reference for the Inquiry.

a. 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:

PHI should cover complete hospital and post-hospital/after care to encourage more people to maintain their PHI cover and avoid increased pressure on the public hospital system.

PHI policies which cover patients only for care in public hospitals increase pressure on the public system and should be reviewed.

b. The effect of co-payments and medical gaps on financial and health outcomes:

There can be a lack of transparency around co-payments and gap charges, and such charges often present significant challenges for patients, particularly older people and people with chronic and complex disease who are both at higher risk of needing medical care, and likely to have lower incomes and less ability to pay such charges. It is critical that comprehensive, transparent and consumer-friendly information about co-payments and gaps is provided to patients, so that they are in a position to provide informed financial consent. Information about co-payments and gap fees should be easily obtainable from a central reference source to enable patients to readily assess such gaps, supporting informed choice of providers.

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

Streamlining of policies, including simpler policies, consistent language, and fewer variations, will help consumers to better understand coverage, benefit levels, and exclusions, and make to informed choices. Better consumer information is needed on coverage, exclusions, and gap fees, as well as expected waiting times, out-of-pocket expenses, and after-care arrangements.

There is a real danger that without good information, consumers can seek to lower their premiums by excluding products and services that may in fact be very much needed by them as they age.

Health care practitioners and managers, and their professional colleges and associations, also require good information to support providers in informing consumers on issues such as coverage, exclusions, and gap fees and charges. One of the greatest challenges for health care providers lies around assisting patients with informed financial consent, given the huge variability in types and levels of PHI cover, and the variations in fees between practitioners.

Simplification and consistency, for example coverage in all standard extras packages of pathology/radiology services that are not covered by Medicare, would also assist consumers. It is also important that PHIs only fund services which are supported by an evidence base regarding safety and efficacy.

d. The use and sharing of membership and related health data:

Any and all use and sharing of membership and related health data should be based on informed consumer consent, with adequate data security measures in place; and should be for the purposes of improving health care and health outcomes rather than for commercial purposes. Access by all providers to the patient's shared health record is vital to maximise the goal of improving health care and outcomes. At a macro level, aggregated data from both the public and private health systems has potential to improve understanding of population-level health trends and improve health system responses. However big data, while useful, has its limitations and should not be used out of context or without understanding of its flaws. Big data alone must not be used to refuse or reduce access to health care.

e. The take-up rates of private health insurance, including as they relate to the Medicare levy surcharge and Lifetime Health Cover loading:

Many consumers choose not to take up PHI, or abandon their PHI coverage, due to affordability issues and/or concerns about coverage and exclusions. Addressing this will require policies to be simpler and clearer, more affordable, and more responsive to the changing needs of an ageing population with growing levels of chronic and complex illness. Policies that support consumers to engage in lifestyle change (such as healthy physical activity) should over time lead to reduced claims as wellness is improved and avoidable hospitalisations are reduced.

It is arguable that there should not be a penalty for consumers, in terms of higher Medicare levies, when they do not take out PHI, and that PHI should be independently able to demonstrate its value.

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

Informed financial consent is critical across all areas of care where there are out-of-pocket costs, including but not limited to in-hospital procedures; and there must be consistency in the approach to informed financial consent. Timeliness of informed financial consent is also important (for example ensuring that informed financial consent occurs prior to, not upon or following admission).

Standards relating to informed financial consent are relevant for every practice that participates in private billing. An open and transparent platform for comparing costs, gaps and co-payments could be designed to also capture patient consent. This would ensure that patients have access to all information needed to make an informed decision, rather than single quote options currently in place.

g. Medical services delivery methods, including health care in homes and other models:

PHI should cover complete hospital and post-hospital/after care to encourage more people to maintain their PHI cover and avoid increased pressure on the public hospital system.

In particular, PHI should cover home visits conducted by a community nurse, which are particularly valuable for the frail elderly and less mobile patients (as per the Department of Veterans' Affairs model). This would enable patients who can afford PHI to have better access to private nursing services, addressing the current situation where there are often long waiting lists for access to publicly-funded community nursing care, and freeing up public sector services for those unable to afford PHI. This should result in greater provision of home nursing care services outside the hospital sector, and a consequent decrease in potentially avoidable complications and hospitalisations. PHI should also cover non-Medicare rebated pathology and radiology items.

h. The role and function of:

- ***medical pricing schedules, including the Medicare Benefits Schedule, the Australian Medical Association fee schedule and private health insurers' fee schedules;***
- ***the Australian Prudential Regulation Authority (APRA) in regulating private health insurers, and***
- ***the Department of Health and the Private Health Insurance Ombudsman in regulating private health insurers and private hospital operators:***

No comments.

i. The current government incentives for private health:

Concerns have been raised by some of our members that the government-funded rebates are not seen as delivering value, and that the approval of PHI premium increases that are well above the CPI rate over several years is particularly problematic.

j. The operation of relevant legislative and regulatory instruments:

No comments.

k. Any other related matter:

Any proposals to extend PHI to broadly cover services provided in general practice require rigorous scrutiny and debate. The Royal Australian College of General Practitioners (RACGP) has warned that such approaches could compromise patient access to services, create a two-tiered system and increase health system costs, without delivering benefits. The Australian Medical Association (AMA)

has also warned that increasing involvement by insurers in the provision of care is pushing Australia towards a managed care approach. As recommended by the RACGP, if PHI is to be introduced to general practice, the key principles should be: preventing fragmentation and duplication of care; recognising and supporting the clinical independence of GPs; and supporting access based on need, not on PHI status. There may be benefit in PHI involvement in areas such as preventive healthcare, chronic disease prevention programs, CDM management and hospital avoidance programs (eg hospital in the home), co-ordination payments to GPs, and other supports to GPs and practices to meet patient needs.

Community rating should remain to protect older Australians and those from lower socioeconomic backgrounds who are likely to have poorer health.

Ancillary benefits which have evidence for improving integrated chronic disease management should be covered by PHI.

Telehealth for rural consumers should be covered by PHI. This offers a real opportunity to increase services to rural communities.

About AAPM

The Australian Association of Practice Management (AAPM) is the professional association for business managers of all healthcare practices including general practice, specialists, dentists and allied health as well as multi-disciplinary clinics. AAPM provides education, support, advice and advocacy for healthcare practice managers. Our aim is to ensure that they are able to effectively manage healthcare practices, that they are able to have the infrastructure and systems in place to provide a high quality health services to the Australian community, and that they are up to date with changes in the health sector. Consequently, AAPM is ideally placed to assist in implementing the government's primary healthcare reforms.

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