Consumers Health Forum OF Australia

SUBMISSION

Senate Inquiry: Value and Affordability of Private Health Insurance and Out-of-Pocket Medical Costs

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Executive Summary and Recommendations

Australian consumers find that Private Health Insurance (PHI) is increasingly unaffordable, confusing and are unsure about the value that it provides. Despite considerable government investment in the PHI industry, there is yet to be conclusive evidence that this investment is providing sufficient returns. We are concerned that government outlays in this area continues to increase, not decrease, despite this question of value not having been well established.

Because of this, reforms to PHI must centre around two key questions – how can PHI provide better value for the taxpayer, and how can it provide better value to consumers? Our submission explores the terms of reference and the key issues for consumers in light of these questions.

How PHI is, and should, be used in public hospitals has become a major issue in recent months, with parties from all sectors as well as both state and federal government contributing potential suggestions. As advocates for consumers, who do not have a financial stake in this, we offer suggestions which are based on the reality of consumers' use of their PHI and how their health system as a whole can best serve them.

Australian health consumers face considerable out of pocket costs, both when using PHI and when using the broader health system. In fact, Australian consumers bear among the highest out of pocket costs across the OECD countries[1]. These out of pocket costs are often hard to estimate or are not able to be estimated prior to treatment. Changes to how health professionals publicise their fees and how insurers work with health professionals and hospitals to communicate this to consumers are needed.

The design of Private Health Insurance policies is complex, with some current regulations helping consumers and others hindering their ability to use and understand them. A re-design of these policies is necessary to improve the usability of these products and ensure that they are perceived to be health products. Key elements of this redesign are the continuation of community rating, improving the basic Complying Health Insurance Product (CHIP) and removing within treatment category restrictions.

Finally, whether PHI provides value to the taxpayer has not been well established. We believe that a robust public interest test should be developed to measure whether this investment is worthwhile and in the interests of all Australian taxpayers.

We make the following recommendations:

The interaction between private and public hospital systems:

- That consumers' ability to choose to be private patients in public hospitals be maintained

[1] Jeyaratnam, E., Jackson-Webb, F. Infographic: comparing international health systems: https://theconversation.com/infographic-comparing-international-health-systems-30784, accessed 28/07/2017. 2014

- That PHI policies that are public hospital only should still attract the rebate given their importance for rural consumers
- There should be a recommitment to the principle of treatment according to clinical need in public hospitals backed up by improved monitoring and data collection on this issue

Out of pocket costs for consumers

- That further investigation is conducted into the impact of 'no gap' or 'known gap' arrangements on the quality and availability of healthcare
- Health professionals should make their fees publicly available, which will allow consumers to be better informed and compare their costs prior to accessing treatment
- The Department of Health work with health professionals and other key stakeholders to develop a process for a single quote on any episode that includes all health professionals costs
- That there should be a mandated information package which provides consumers with consistent and clear information about their products, with several types and depths of information provided throughout the process of purchase and use of PHI
- That informed financial consent procedures be strengthened and more regularly enforced by both health professionals and insurers

Product design

- That community rating be retained
- That the current maximum levels of excesses are retained and that consideration is given to indexing them in the future, against CPI
- That policies with benefit limitation periods and with co-payments other than excesses within mandated boundaries not be eligible for the government rebate

Membership rates and government incentives

- That a more robust public benefit test is developed to ensure that the community is receiving benefit from the high level of government investment in PHI
- That a Productivity Commission Inquiry be undertaken into the benefit of government involvement in the PHI sector.

Introduction

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers and those with an interest in health consumer affairs. CHF works to achieve safe, quality, timely and affordable healthcare for all Australians, supported by accessible health information and systems. We support the principles of consumer centred care and chief among these is the principle of universal health care[2]. Private Health Insurance (PHI) and concerns about medical costs are two of the area's most

[2] Consumers Health Forum of Australia. 2015-2018 Strategic Plan: https://chf.org.au/2015-2018-strategic-plan, accessed 28 July 2017.

frequently raised with CHF by the community. Because of this, PHI is one of our key areas of interest. We have been active participants in all waves of reform about PHI, including through representing the needs of consumers on the current Private Health Ministerial Advisory Committee. We welcome the Inquiry and are pleased to provide a submission to it.

PHI is important to the Australian health care system: it is intended to assist with the costs of care in the private system, to support choice of private provider and to help take the pressure off public hospitals. However, it is also overly complex, confusing to consumers and costs the federal government in excess of $6 billion per year[3]. With almost half of all Australians covered by a policy, it is vital that consumers have the confidence that policies are robust and will afford them access to critical treatments should the need arise.

In formulating this submission we have drawn on our wide experience with consumers including our previous submissions on the topic, the results of a 2015 survey to which 540 Australian health consumers responded and the articles written by a range of consumer advocates and policy makers for our journal, *Health Voices*. The survey we conducted provided insights into why consumers take out private health insurance, their satisfaction levels with their insurance policies and why they hold insurance. The report from the survey is attachment A to this submission. The PHI edition of *Health Voices* can be found at Appendix B.

Current reforms are occurring in an increasingly challenging economic environment for Australian consumers. Wage growth is low relative to increases to the cost of living and specifically healthcare costs. In this context, PHI premium increases at greater than CPI become particularly challenging for consumers to absorb. When compared to housing, electricity and basic healthcare costs PHI is a luxury product, which consumers are increasingly unable to justify. CHOICE's consumer pulse survey illustrates this – results from May 2017[4] revealed the lowest level of households living comfortably since June 2014. One of the main cost pressures for households is healthcare affordability; this was tied with household electricity prices as the top cost of living pressure.

These pressures cause us to question two of the key imperatives of the current reform agenda: that rates of consumers who have PHI should be increased and increasing government expenditure in the PHI industry is part of the solution to this. The decrease in rates of consumers who hold PHI are indicative of the poor value that consumers get for paying high premiums relative to the value that they can get from the public healthcare system. While we do not oppose government expenditure in this area, we believe that this investment should be better targeted to support the purpose for which it was introduced – to take pressure off the public hospital system through increasing the accessibility of the private hospital system.

Some public hospitals offer services that the private hospital system does not offer. For example, maternity services offered through public hospitals can afford access to a great range of service models, such as midwife led care and less medicalised birthing services, which some consumers have shown a preference for. Changes to such models of care, in

[3] Australian Commonwealth Government. Budget Paper number 1: table 8.1. Canberra: Australia; 2016.
[4] CHOICE. Australians worry most about electricity bills, health care: https://www.choice.com.au/money/budget/cost-of-living/articles/australian-households-worry-most-about-electricity-prices-healthcare-030417, accessed 21 July 2017. 2017

areas where formally there was a greater gap in the services offered in favour of the private system, contribute to the consumers' perception of low value of PHI.

PHI is particularly complex for consumers. Australians have low rates of health literacy, with current estimates suggesting that 60 per cent of the Australian population have low health literacy. These low rates have significant impacts on how consumers use, or fail to use, their private health insurance. Basic underpinning principles such as community rating are not understood which leads to consumers believing that insurers are able to charge them different prices based on whether they have pre-existing health conditions. These fundamental misunderstandings seem to not be taken into consideration by health insurers, as their advertising and communication with consumers shows.

While rising premiums have reflected surging health costs, Government policy including regulation, tax incentives and a rebate over the past 17 years has failed to translate into effective protection for consumers from rising premiums and out-of-pocket costs. The system and the rebate that subsidises it should take pressure off the public health system not contributed to it. Policy in this area needs to support and contribute to this goal.

The terms of reference for this inquiry and the broader conversation about PHI focus on hospital insurance. Because of this, our submission focuses on hospital insurance except for many sections in which we explicitly address general health cover. However, we believe the current reforms of PHI must not neglect general health cover. Our consumer survey and other work to date have found that Australians greatly value their general health cover, with more consumers holding general policies than hospital policies. A key reason for this is that it covers services which are only provided through the public system to consumers in specific circumstances, such as dental care to extremely low-income earners. For most of the population general cover provides a budgeting tool which allows them to afford these types of care. However, to this end there are currently issues in how insurers provide coverage. As discussed in the out of pocket section (page 12), rates of rebates have not increased commensurate to fees, which is leaving Australians who have done their best to obtain coverage for themselves increasingly out of pocket.

The interaction between private and public hospital systems

Term of reference 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

CHF are strong supporters of the ability for consumers to purchase PHI to allow them to choose their doctor and be treated in a setting of their choice. However, this system is far from well understood by consumers and has many complexities, which need further examination in the current policy debate.

One of these complexities is whether the choice of doctor that PHI may afford is a real choice, or an illusory one. While a choice of doctor may be realistic in some situations, we believe that many consumers do not understand that they will have the same doctor regardless of their health insurance status in many cases, such as where there a limited number of specialists in one field. This is often the case for people receiving treatment outside the major urban centres where they rely on visiting medical specialists.

Perception of reduced waiting lists for elective surgery through PHI

CHF's work with consumers has found that one of the main reasons they value having PHI which they can use in a public hospital is that it allows them to 'jump the queue' for elective surgery and obtain it in a period they are satisfied with, instead of the extremely long waiting lists that they perceive come with relying on the public system.

> *I feel forced to take out private health insurance because our public hospital system and waiting lists have blown out. This is the same way my children feel as well. We need a more reliable public system[5].*

This comment is interesting in that it shows that some consumers don't really have a desire to 'go private' and so would probably not bother with PHI or private treatment if the public system were better resourced.

We are concerned about this, as this practice undermines the universality of our public health system through the prioritising of consumers who can pay over consumers who need healthcare. This concern was illustrated through a recent report from the Australian Institute of Health and Welfare[6] which has suggested there may be a negative impact on elective surgery waiting lists which may be attributable to private patients being in public hospitals. However, the data from which these conclusions are drawn are not necessarily robust and there may be clinical reasons for this apparent trend[7]. There needs to be a recommitment by all stakeholders to the principle of treatment in the public system being based on clinical need. This should be supported by enhanced monitoring and data collection to allow for more investigation before major policy decisions are made in this area.

Public hospitals practices regarding private patients

Consumers should not be coerced or given information which they may perceive to be misleading about using their PHI in public hospitals. While we do not oppose State and Territory health departments asking consumers if they would like to use their PHI in public hospitals, the way they are asked is crucially important. Under the National Hospital Reform Agreement[8] (the NHRA page 59) there is a directive for public hospitals to have dedicated support for helping people elect to use their private health insurance. Our work to date has found that this directive is applied inconsistently, with practices varying from state to state. Given that consumers are often asked to make these decisions at a time of extreme stress

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[5] Consumers Health Forum of Australia. Consumer comment from CHF Private Health Insurance Survey report. 2015
[6] Australian Institute of Health and Welfare. Admitted patient care 2015–16: Australian hospital statistics. Health Series no.75. Cat. no. HSE 185. Canberra; 2017.
[7] Sivey P, Cheng T. Are private patients in public hospitals a problem? 2017.
[8] Council of Australian Governments. National Health Reform Agreement. 2011.

(e.g. when admitting themselves to a hospital emergency department), public hospitals need to ensure that their practices are considerate and appropriate and include appropriate provisions for informed financial consent (see section on information provision on page 16). Examples of these experiences include:

> *I had a minor operation at a Private Hospital. Pneumonia from op... Ended up in casualty at a major hospital for 14 hours on a trolley as there was no bed. Serious pain, no relief. A bed became available and I was asked am I "Private or Public"? No explanation. I said private and I just got bills as a result. Nearly died from all of this. Private insurance? What use? Too complicated and disappears when you really need despite having paid!!*[9]

> *when the public system denied me access to out of hospital care on the basis I would not use my private health insurance cover*[9]

Public hospital only policies contributions to PHI premiums

The final area of concern for CHF is how insurers factor in public hospital only policies to their premium calculations and projections. The peak body for for-profit private health insurers, Private Healthcare Australia (PHA), has suggested that public hospital 'cost shifting' or transferring the cost of public services to health funds in Australia is putting upward pressure on premium costs, in their estimation this accounts for 6% of PHI premium costs per year and that this amounts to 2.1% of all hospital funding[10]. While we accept that this figure may be correct, it is not a valid reason for an increase in premiums or a mechanism through which premiums should be able to be reduced. While we recognise the validity of the argument that insurers are paying in large part for care that would otherwise be covered by Medicare, insurers are under no obligations to offer these products. Due to this, if insurers continue to choose to offer these products these completely expected usage patterns should be factored into their cost structures and should not be an 'added burden' on premium costs.

An additional complexity to this argument is the potential for higher costs for insurers if people with PHI always opted for treatment in private hospitals and services. Whilst the same range of services is not always available some people might opt to move from public to private which could mean higher costs for the insurer.

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[9] Consumers Health Forum of Australia. Consumer comment from CHF Private Health Insurance Survey report. 2015
[10] Private Healthcare Australia. Ideas for improving the value and affordability of private health insurance: 2017-2018. 2017

Out of pocket costs for consumers

Terms of reference B: The effect of co-payments and medical gaps on financial and health outcomes and Hi: I 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

> *…on top of the premiums we pay for private health, the out-of-pocket costs can be unaffordable*[11]

Given the broad scope of this term of reference, we have addressed it in two sections: those out of pocket costs specific to the use of PHI, and those which occur in the broader health system.

Estimating out of pocket costs in PHI

Consumer's ability to accurately estimate the out of pocket costs they will face either in the lead up to or after treatment when using their PHI is extremely limited, particularly so when a complex treatment regime is concerned. This is due in part to the multitude of provider and payers involved in a private hospital stay (e.g. surgeon, hospital and insurer) and the current behavior of many of these players. While we appreciate that complications can and do occur, particularly in surgical interventions, we recommend that either the lead treating professional or the hospital collect all the information about pricing from these different providers and issue the consumer a single estimate of fees and, after treatment, an account. This single account would also allow insurers to provide a more accurate estimate of what they can cover to consumers.

Not all hospital related charges are covered by PHI

The proportion of out of pocket costs met by insurers is an extremely challenging area for consumers. As described in the PHIO's state of the health funds report, even among top hospital policies the percentage of hospital related charges covered by insurance funds varies considerably, both by state and by insurer. In NSW in 2015-16 the range varied from 79.9% (GMHBA) to 93.9% (Doctors' Health)[12]. This range and that the PHIO notes that a figure of 100% is 'likely to indicate small numbers' shows that health funds are not meeting consumer's expectations that by regularly paying their premiums and excesses that they will not face out of pocket charges. This expectation was articulated by a consumer in the following way:

> *Was 18yo and took my own HCF policy after being on parents - no gap in time. Had laparoscopy in hospital for a cyst on ovary and was denied based on pre-existing condition! despite my parents have cover for me for 18 years! At 18yp I had to pay for the surgery and accommodation fees - I was so disgusted I cancelled it immediately! I only*

[11] Consumers Health Forum of Australia. Consumer comment from CHF Private Health Insurance Survey report. 2015
[12] Private Health Insurance Ombudsman. State of the Health Funds Report 2016. 2017

> *took up health insurance for tax reasons a few years ago. I will cancel it if it rises in price again as I no longer earn enough to worry about tax*[13]

Hospital related out of pocket costs are increasing

Where out of pocket costs do exist, they are both considerable and increasing. The APRA Private Health Insurance Quarterly Statistics report the average out of pocket cost per episode or service to currently be $318 per hospital service and $47.69 per general treatment service, an increase of 4.3% over the 12 months to March 2017[14]. Over the quarter to March 2017 benefits paid by insurers per episode of hospital treatment decreased by 5.9% on average. These figures are concerning as they are often unexpected by consumers who are familiar with other models of insurance in which, having paid their premiums and excesses, their costs are covered. Even when consumers expect and try to estimate their out of pocket costs, they face considerable hurdles for finding out this information.

> *But I am constantly amazed at how much we pay on top of our premiums. e.g. $400 for ENT surgeon for operation on top of Medicare, $350 to Endodontist for root canal after getting rebate of only $34 from BUPA. Paid his anaesthetist $700 and will only get $160 back. Now I need a contact lenses cost $600 and rebate is prob* [sic] *only $150. Impossible to manage on a tight budget*[15]

Changes to reduce gaps

Considerable changes are possible, and necessary, to reduce these gaps. We are concerned that if consumers can predict that they will face significant out of pocket costs for hospital treatment when using PHI, they may choose to use the public system. This means that, despite their investment through premiums and the government's investment, no pressure is being taken off the public hospital system.

Low rates of coverage within general treatment products

While this submission focuses on hospital insurance, a note about general treatment is worthwhile in this area. Australians with chronic health conditions face considerable out of pocket costs in general, and those who have private health insurance are not being adequately supported by either the government or their health funds. The percentage of general treatment charges covered for consumers in NSW in 2015-16 varied from 39.1% (CDH) to 74.2% (GU Corporate)[16]. CHOICE's recent survey of consumers with private health insurance[17] shows that rebates for extras coverage have remained 'frozen' are concerning, as this is despite premiums

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[13] Consumers Health Forum of Australia. Consumer comment from CHF Private Health Insurance Survey report. 2015

[14] Australian Prudential Regulation Authority. Private Health Insurance Quarterly Statistics March 2017. 2017

[15] Consumers Health Forum of Australia. Consumer comment from CHF Private Health Insurance Survey report. 2015

[16] Australian Prudential Regulation Authority. Private Health Insurance Quarterly Statistics March 2017. 2017.

[17] CHOICE. Making Private Health Insurance Simpler: Results frmo CHOICE's national survey. Sydney; 2017.

increasing at 4-5% per year, and the federal government recently lifting its own Medicare freeze.

Contracting arrangements

'No gap' or 'known gap' arrangements

One way in which insurers have attempted to clarify or reduce these instances for consumers is by the development and promotion of 'no gap' or 'known gap' schemes. The PHIO's reporting about these schemes highlights that even where these schemes exist it is no guarantee that a particular doctor will choose to use the fund's gap scheme[18]. While the proportion of medical services with no gap or where a known gap payment was made is high across all funds – ranging from 84.5% (GMHBA) to 98.2% (Doctors' Health) in NSW in 2015-16, improvement is still possible in these policies. This has been illustrated to CHF in the following comment:

> *I had a 15-year policy with Medibank Private which I thought was "Top Cover" but when the daughter needed braces and an operation, no cover. $16,000 out of pocket despite the $3500 per year payments. Policies change and cover degrades we were not aware. Changed providers*[19]

Of concern to consumers regarding these arrangements is their perception that the providers who choose to participate in known or no gap policies are those, rightly or wrongly, who are perceived to not provide the highest quality care. While verification of this is not possible because of the lack of publicly available data about individual practitioner's health and safety records, the perception is concerning in and of itself. CHF has consistently called for greater transparency of both practitioner's fees and their safety and quality records via an independent, authoritative list or lists. These concerns articulated by consumers provide further evidence of the need for such measures

> *Cannot afford it as I can only afford the no gap specialists and these are not always the best option so the health fund rule what doctor and what hospital*[17]

Potential negative impacts of contracting arrangements

Consumers should not be too heavily penalised for choosing providers with whom their insurer does not hold a contract. One of our members, the Haemophilia Foundation of Australia has illustrated the potential negative impact of contracting arrangements for allied health professionals, such as dentists. People living with haemophilia need to access specialist professionals within these fields. We are concerned that the price differentials that arise from consumers not using insurer's preferred provider arrangements provide a disincentive for consumers to access these professionals, through making non-specialist providers more cost effective to see. People with ongoing health conditions already face considerable ongoing medical expenses, and being in any way incentivised through their private health insurance arrangements *not* to see the specialist health practitioners they optimally need to manage

[18] Private Health Insurance Ombudsman. State of the Health Funds Report 2016. 2017
[19] Consumers Health Forum of Australia. Consumer comment from CHF Private Health Insurance Survey report. 2015

their care will, over time, be only further disadvantaged by a system that is not working for them.

> *HCF's new approach to physiotherapy group classes seeks to punish providers who are not operating within the agreed protocols, but instead punishes patients and honest providers. This discourages proactive involvement*[17]

> *The funds should give the same rebate for a service irrespective of the provider. Failure to do so is price fixing with preferred providers*[17]

Because of these reasons, CHF opposes any changes to contracting arrangements which further restrict consumer's ability to choose providers. Other consumers who we are concerned for include rural and regional consumers who may be disadvantaged due to not being able to easily access preferred providers or contracted hospitals. One way in which this may be overcome is through insurers being required to have a minimum number of contracts in each regional area.

If the second-tier default benefit were to be removed this would disadvantage all consumers. Private hospitals need to be able to stay open in rural and regional areas – removing the benefit would reduce their viability, which would reduce the value rural consumers get from their insurance.

Transparency about contracting arrangements

Where contracting arrangements exist, greater transparency is needed about these contracts and easier access by consumers when they are purchasing and using PHI about the status of contracts. As discussed in the information provision section below (page 16), one way in which this is complicated by insurers is their practices of hiding this information behind login pages for members, which puts an extra barrier for consumers being able to check on line and have confidence the information is up to date.

Out of pocket costs in the broader health system

CHF has done extensive work previously on the issues of out of pocket costs for Australian healthcare consumers. We have provided submissions to the Senate Standing Committee on Community Affairs inquiry into out of pocket costs in Australian Healthcare. Our comments draw on this previous work. Existing levels of consumer out of pocket payments already comprise over 20% of total healthcare expenditure in Australia[20], making consumers the largest non-government source of funding of health goods and services. One area in scope for the terms of reference for this inquiry is the role of medical pricing schedules, such as the MBS and the AMA suggested schedule of fees. The complexities posed by this and PHI were illustrated to CHF by this comment by a consumer

[20] Jeyaratnam, E., Jackson-Webb, F. Infographic: comparing international health systems: https://theconversation.com/infographic-comparing-international-health-systems-30784, accessed 28/07/2017. 2014

> *Informed that they do not / cannot cover some gap payments OR that they do not cover that item OR that there is no rebate payable on that item IMPOSSIBLE for average people to know these things up front*[21]

Currently there are no maximums as to what doctors can charge for their services. The Medicare Benefits Schedule (MBS) effectively sets a price floor for practitioners and for insurers, however no consideration is regularly given to whether these costs are reasonable and fair, particularly relative to each other. We would support further scrutiny of this and related mechanisms.

In the absence of this, the main regulating factor for pricing schedules is the market, through the Australian Medical Association Fee schedule and those of medical colleges such as the Royal Australasian College of Surgeons (RACS). However, there is no compulsion for individual practitioners to charge fees in line with these recommendations. As discussed by the representative from the RACS at the June 5 hearing of this Committee, the colleges are professional, not industrial bodies, and as a result are very limited in any of their powers of enforcement. Regulatory bodies and regulation in this space is challenging and infrequent. Doctors who practice as private practitioners are regarded as carrying on a business and are therefore subject to the provisions of the Competition and Consumer Act 2010 which is enforced by the ACCC[22]. The advice provided to practitioners by the ACCC regarding the act is useful, however we are doubtful of how often or how thoroughly it is enforced. In particular, the directive to:

> *if you don't know what the cost of a treatment will be, give an estimate including all relevant information and explain the limitations of the estimate*[23]

may be able to be more frequently enforced.

As we recognise that regulatory options are limited, and likely to remain so due the need to prioritise regulating other aspects of the health system, we suggest that it is time health professionals to be required to list their fees publicly to ensure that consumers can make better informed choices and avoid the 'bill shock' of unexpectedly high fees. An example of the degree to which these fees can vary is described in a 2017 Medical Journal of Australia article, in which 2015 Medicare claims data for an initial outpatient appointment with a consultant physician was analysed[24]. The study found that:

> *The difference in average out-of-pocket costs between the least and most expensive practitioners was $100 or more for eight out of 11 specialties – cardiology, endocrinology, gastroenterology, haematology, immunology/allergy, neurology, respiratory medicine and rheumatology*[21].

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[21] Consumers Health Forum of Australia. Consumer comment from CHF Private Health Insurance Survey report. 2015
[22] Australian Competition and Consumer Commission. Medical Professionals. 2017
[23] Consumers Health Forum of Australia. Consumer comment from CHF Private Health Insurance Survey report. 2015
[24] Freed GL, Allen AR. Variation in outpatient consultant physician fees in Australia by specialty and state and territory. Med J Aust. 2017;206(4):176–80

This study supported findings from the 2014 Surgical Variance Report for Orthopaedic Procedures by the RACS and Medibank which also found that "there was no correlation between the size of the fee paid and the quality of the surgery"[25].

These findings and the limitations on current fee schedules shown by them, articulate that consumers face a random maze of costs for which there is no transparent explanation or justification. Given the degree to which the cost of medical specialists' services are paid for by the taxpayer through Medicare and private citizens through out-of-pocket expenses, we suggest that their fees and performance measures should be easily accessible to the community at large. One way in which this could be achieved is through the establishment of an authoritative and independent website containing this information would be an appropriate platform.

Another key reform would be the adoption of a single quote from the leading specialist, which includes quotes from all medical professionals in the team for that episode of care. The surgeon picks the team and so it shouldn't be unreasonable to suggest that his/her practice management should take responsibility for getting the quotes. This should not be the consumer's responsibility as they do not have sufficient knowledge to know exactly who is in the team and how to access quotes from them. We often receive complaints from consumers about high out of pockets on fees which , after closer examination, are caused by the multiple gaps from people that the consumer did not even know were in the team. This is an issue both of transparency and ensuring proper financial consent dealt with later in this submission.

Product design

Term of reference C: Private health insurance product design including product exclusions and benefit levels, including rebate consistency and public disclosure requirements

CHF is a strong advocate for the redesign of PHI policies and strengthening of several the current underpinning principles. We have pursued this agenda through previous submissions on the topic and our representation in the Private Health Ministerial Advisory Committee. In the following section, we address each of these areas in detail.

Community rating

Community rating is one of the key underpinning principles of the Australian PHI system. This important principle allows consumers to access the same level of care regardless of their health status. CHF strongly supports community rating and would oppose any moves to change it or the current practice of it. Our strong belief in it is one of the reasons that we see a need for change in the current design of PHI products. The proliferation of products with exclusions and restrictions, as well as the impact of government incentives and barriers to update (e.g. Lifetime Health Cover), have resulted in some consumers individually risk rating.

[25] Colyer S. Fees: let patients shop around for value. MJA InSight. 2017;(8)

The move to a set of standard products (e.g. Gold/Silver/Bronze) and a higher level of minimum product, may lead consumers to be less likely to do this risk rating.

> ** Policies must be more transparent, rebates that consumers receive back for services claimed should be easily accessible, and any exclusions, monetary and lifetime limits published. * The number and type of policies should be cut substantially to eight categories of contributors, a move which should bring the number of products down to manageable numbers. * Policy changes should be notified before they come into effect. * There should be standard definitions for general, major and complex dental services and all funds should be forced to use a model policy to ensure uniformity of offerings. * Rebates should be published by the funds for at least the 20 most regularly-used dental services[26].*

Re-design of the Complying Health Insurance Product (CHIP)

This redesign needs to start with a reform of the lowest level of cover eligible for government rebates. Currently, the lowest level of cover that is eligible for these incentives, the 'Complying Health Insurance Product' (CHIP), is not sufficient to provide value to consumers. This insufficiency is shown through the high number of products which provide very low value through a wide range of exclusions and restrictions on coverage.

Key principles that should underpin a re-design of the CHIP are services which are evidence based and in relatively widespread use by the medical community. The CHIP should have no restrictions within clearly defined treatment categories and have standard excess arrangements. Strengthening this base level will prevent Australians from falling victim to low value policies which fail to meet essential health needs. It will make comparisons between products easier through having a basic standard product against which the financial costs and potential value of other policies and services and so make it easier to use comparator websites when making the decision.

Re-design of broader PHI products

Progressing from the lowest level, consideration should be given to the proliferation of products which include myriad restrictions within treatment categories and exclusions. To some consumers they serve as merely a tax avoidance product, while others purchase them believing that they will be functional health products. Our views on tax avoidance products are addressed in the section examining the tax incentives for PHI below. In this section, we are primarily concerned about consumers who purchase their products based on what is the best price, and do not understand what they have opted out of in terms of coverage and then find, when they need it, that they are not covered. This concern has been strengthened by recent evidence from the Australian Competition and Consumer Commission (ACCC)[27] which has shown that, in response to increased cost pressures, consumers are choosing to take out

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[26] Consumers Health Forum of Australia. Consumer comment from CHF Private Health Insurance Survey report. 2015
[27] Australian Competition & Consumer Commission. Private health insurance report 2015-16 https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2015-16, accessed 21 July 2017. 2017

policies with more exclusions and that consumers with top value coverage are choosing to downgrade. It was also the main area of complaints to the PHIO in the last financial year[28].

Reform to product tiers, such as the three tiers, 'Gold/Silver/Bronze' proposal suggested by the previous health minister should focus on creating products which with no restrictions within treatment categories and exclusions which are appropriate from the perspectives of both public health needs and cost. Changes such as these will allow consumers to more easily compare products and have greater confidence that they will be able to use their product when they choose to.

Excesses and co-payments

CHF is concerned that high excesses or co-payments may contribute to people not using their private health insurance. If consumers take out products with high excesses they are unlikely to be able to use them when they need to, which would defeat the point of them having it because they would use the public system. We support the current levels of allowable excesses. If increases to these are to be considered, such as in the form of indexation, this needs to be in discrete, fixed increments. Having excesses that go up in percentage points will increase confusion and further reduce consumer's use of products.

> *Opted to use public system for two elective procedures with over 12 months waiting time for one procedure, in order to avoid the out-of-pocket costs of private care.*[29]
>
> *The gap is a big problem. The scheduled fee as determined by the govt is a laugh. It beats no relation to the actual cost charged. 75% of the scheduled fee leaves you heaps out of pocket despite highest health cover*[27]

Re-design of general treatment products

Our work to date and comments in much of this submission focus on hospital insurance – while we are supportive of general treatment products being re-designed or categorised adequate attention needs to be paid to this. However, if hospital coverage was to be simplified and general treatment wasn't that would increase confusion for consumers.

One area which needs attention around general treatment is non-evidence based therapies. We believe that insurers should remain able to cover non- evidence based 'natural therapies', however these therapies should not be eligible for tax-payer funded coverage (the Rebate). We take this position as treatments covered by the MBS and PBS are subjected to rigorous testing for effectiveness whilst natural therapies are not. There is a move to get rid of low value interventions through the MBS review and as the focus of the Choosing Wisely Australia campaign to better focus health resources where they do most good.

The Department of Health conducted a review of the Australian Government Rebate on Private Health Insurance for natural therapies to ensure private health insurance covers clinically

[28] Private Health Insurance Ombudsman. State of the Health Funds Report 2016. 2017
[29] Consumers Health Forum of Australia. Consumer comment from CHF Private Health Insurance Survey report. 2015

proven treatments. The report was released in 2015 and stated "Overall, there was not reliable, high-quality evidence available to allow assessment of the clinical effectiveness of any of the natural therapies for any health conditions." They would not meet the benchmarks set for interventions funded under PBS and MBS

We are not aware that there have been any publicly announced moves to strip the rebate of benefits for natural therapy, although we know from the publicly released documents that this was discussed in the Private Health Ministerial Advisory Committee[30]. In the past, we have been supportive of such a move, and would continue to be should a decision be made, as per this comment:

> *Consumers should be given evidence-based treatment and service options in their private health insurance packages. I believe the inclusion of "extras" like homeopathy are not essential and may be part of the higher cost of private health insurance. There are private health insurance products, like the Doctors Health Fund, which only cover evidence-based and essential services, and they seem to keep their prices low.*[31]

Information provision

Consumers find PHI challenging and hard to navigate. This was illustrated in a recent survey by CHOICE of consumers with PHI found that 44% of consumers find it difficult to compare policies, compared to only 28% of policy holders who find it easy[32]. The main reasons cited for this include: difficultly comparing policies side by side (69%), the information from insurers not being set out consistently (53%) and not all policies being available for comparison (45%). All of these reasons would be addressed, to differing extents, by improved information provision. Changes in this area will help consumers through ensuring that they understand what they are purchasing when they buy or transfer to a new health insurance product and can make informed decisions. It is important to remember that improved information provision is not the silver bullet to fix the problems with value and complexity of PHI. It is a necessary but not sufficient condition of reform.

We recognise that this is an ongoing challenge and one that is not easily solved. One of the key challenges in this area is that simply providing access to information does not necessarily mean that a consumer will read the information, understand it and act on it. For online and over the phone information provision, these impediments may be overcome through the use of prompts to check consumer understanding and comprehension.

Information provision at the point of purchase

The first point at which information provision needs to be improved is at the point of purchase or policy switch. The increasing prevalence of comparator websites and results of the recent

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[30] Department of Health. Summary of the fourth meeting of the Private Health Ministerial Advisory Committee, 1 February 2017, http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac-meeting-4, accessed 21 July 2017. 2017
[31] Consumers Health Forum of Australia. Consumer comment from CHF Private Health Insurance Survey report. 2015
[32] CHOICE. Making Private Health Insurance Simpler: Results frmo CHOICE's national survey. Sydney; 2017

CHOICE survey show that comparing policies is a confusing area for consumers. This confusion could be addressed through greater consideration being given to the way that comparator websites are publicised and used. For example, as currently being investigated by the PHIO, the raw data which makes up the Standard Information Sheet (the SIS) should be maintained on data.gov.au to allow these comparator websites to improve the recommendations that these groups can make. We also believe that the role of the PHIO should be strengthened as described in the 'role of regulating bodies' section below.

The Standard Information Sheet (the SIS)

Following the use of comparator websites to access potential policies, consumers then try to compare policies against each other. This raises the issue of the SIS. We support the improvement of the current SIS but not any moves to reduce it to simply a minimum dataset. We would not. We would support insurers having to have a link to privatehealth.gov.au for consumers to compare products.

Key elements of the current SIS, or an improved version, are:

- Basic details about the product: both the official product name and any other names by which it is referred to by the insurer, the name of the insurer
- The premium level – this should be able to be individualised to a consumer's requirements. However, a note should be provided about what the base premium, with no additional rebates or Lifetime Health Cover loading etc. applied to allow consumers to compare their product against other products on the market and to help them understand what may happen to their premium if their circumstances change
- A description of the cover level, using standard clinical definitions (see below)
- Waiting periods for services covered if relevant to the consumer – both those required by legislation and any additional benefit limitation periods imposed by the insurer
- Excesses, co-payment and gaps including any waiving of these for groups such as children
- A reminder to check with insurer about other costs that can be insured
- A reminder that they can compare products at privatehealth.gov.au
- A broad statement about any out of pocket costs, including the existence of contracting arrangements and a reminder to check with the health insurer before going to hospital

Information provision about a consumers' PHI status

Without a greater level of knowledge about the elements of PHI, however, improvements to the SIS will not be of great assistance. Broadly, this could be achieved through consideration of private health insurance being included as part of NPS Medicine Wise's 'Choosing Wisely' campaign, prompting consumers to think of five questions they could ask of insurers and health service providers either at point of policy purchase/review or prior to hospital admission.

Consumer's awareness of the tax incentives and their Lifetime Health Cover could be increased through the inclusion of this information and a reminder to check in the yearly premium increase notices. While we recognise that insurers cannot, and should not, provide advice about an individual's tax status, a yearly reminder may reduce consumer's tax liabilities and increase their awareness of how much they are paying for their PHI. Any changes to

regulation about the media through which insurance information is provided should protect consumer's right to choose how this information is provided. We support moves to make the regulation technologically neutral, however consumers should always be able to opt for this information to be provided in a way that suits them, not what suits the insurer. The default option should remain via post. No additional charges should be applied if consumers choose to have this information provided via post.

Information provision at the point of use

At the point of use, hospitals and medical practitioners have a role to play in the provision of appropriate information. For example, hospitals and medical professionals should be encouraged to produce a single bill for consumers for hospital stays and procedures. This single quote and bill would help consumers understand the costs involved in their procedure and help increase health literacy through helping consumers engage with their treatment more readily. Insurers can assist this with through improving the information provided to hospital and practitioners about their products. Providing information directly to these groups, instead of requiring consumers to bring information to them, will reduce the burden on consumers.

Informed financial consent procedures are currently not well understood by consumers and there is inadequacy and inconsistency in their application across the board. Specifically, any reforms should consider the often significant stress that consumers and their carers/families are under when they need to grant this. Succinct summaries of key information should be easily provided. Often insurers hide this under a log-in page on their website, which is unrealistic in times of stress. Many consumers will understand that they are members of a fund, but not remember their member number at times of stress. Making this information searchable without a log in would improve access and allow consumers to get better value from their insurance.

Standard clinical definitions

Currently, the terms used by insurers to describe the medical procedures and areas which they do and do not cover vary considerably. An inability to accurately compare terms increases confusion for consumers, is an impediment to consumers moving between policies and contributes to consumers believing they are covered for a treatment and later finding out they are not. This is an area of confusion for consumers which CHF believes would be an 'easy win' for the industry to overcome. During the 2016 election campaign the government committed to:

- Developing standard definitions for medical procedures across all insurers so that consumers can compare policies more easily;
- Ensuring that insurers use plain English and disclose policy information in a consumer-friendly way; and
- Ensuring the current gateway www.privatehealth.gov.au reflects these improvements and allows consumers to more easily compare policies and access information.

We are strongly supportive of these reforms and look forward to continuing to participate in work on this issue.

Cover for mental health conditions (psychiatric cover)

Every year, one in five Australians experiences a mental health condition. Young people aged 15-24 years old are among the most effected, and suicide is the biggest killer of young Australians. Despite this, PHI coverage for psychiatric conditions is extremely poor, and current regulations allow this to be the case. Under current legislation, insurers are required to pay benefits for every episode of hospital treatment covering psychiatric care, and formal waiting periods for psychiatric care are restricted to 2 months. However, these protections offer little more than a smoke screen of reassurances which mask the woeful coverage of private hospital treatment for psychiatric conditions. Health funds often restrict the amount of cover provided in policies by[33]:

- Limiting the number of days, a person can access day programs a year
- Only covering a limited number of ECT treatments per year, usually 10
- Imposing a benefit limitation period so that consumers are forced to wait longer than the statutory two month waiting period

Other issues for health fund members who require access to psychiatric care include:

- Many consumers have difficult in accessing accurate and complete information about their policies
- Health funds cover day admission programs, however there is minimal awareness as to what kind of day programs, how many sessions and how to access these programs
- Limited ability to compare policies as they pertain to psychiatric care.

Consumer’s health data

Term of reference D: The use and sharing of membership and related health data

Regarding the sharing of data by and within the private health insurance industry, there are instances where this is necessary, such as for membership details to be transferred between insurers. This sharing is key to the portability requirement which we strongly support. We do not believe that any changes should be made to this – the current legislative protections around portability and mandated waiting periods within PHI are adequate and sufficient for consumers to be protected.

More broadly, we do not support any changes which would allow insurers to obtain a consumer’s health records without their knowledge or consent. Full and case-by-case consent should be required and provided by consumers where they can be identified. The complexities of consumers understanding what and how they have provided consent for, however, are myriad. As highlighted by the RACGP in their submission to the Parliamentary Joint Committee on Corporations and Financial Services Inquiry into the Life Insurance Industry[34], both consumers and GPs are put in challenging positions when insurers ask consumers to sign permission for the insurer to have access to their medical records. Consumers are frequently not aware of what they are signing, or feel unable to refuse access, and GP’s are not

[33] McMahon J. Health insurance and psychiatry - covered or not? Health Voices. 2017;April 2017
[34] Royal Australian College of General Practitioners. RACGP Submission – Inquiry into the Life Insurance Industry http://www.racgp.org.au/yourracgp/news/reports/20170607insurance/, accessed 21 July 2017. 2017

comfortable handing over records. In many instances, when the GP explains in detail to the consumer what they have signed over, the consumer withdraws their consent.

Of specific concern to CHF would be any move to allow insurers to access online health records. While we are otherwise supportive of the greater roll out and implementation of My Health Record we strongly believe that insurers should not be able to access the MyHealth record – even if consumers want to give them access. They are not a service provider and allowing them access would establish a dangerous precedent. However, we would consider that de-identified insurance data could be linked to government e-health records. This may potentially be valuable to consumers, healthcare researchers, and governments in auditing and designing better services, policies, and tracking costs to the healthcare system.

Membership rates and government incentives

Terms of reference E and I: The take-up rates of private health insurance, including as they relate to the Medicare levy surcharge and Lifetime Health Cover loading and the current government incentives for private health

Please note that we have combined terms of reference D and I for the purposes of our response, as we believe they need to be considered together. Additionally, these issues should be examined considering product design; as described above we believe that consumers feel that current products on the market offer poor value for money, and so therefore may not want to waste money on products that they won't use to their full benefit.

Addressing perceptions of poor value

Broadly, we believe that the decreasing rates of PHI membership are reflective of the poor value that consumers are getting from their insurance products, particularly in the context of other cost of living pressures increasing. Unlike other commentators in the current discussion we do not feel that these decreasing rates are inherently a problem.

One way in which these decreasing perceptions of value might be addressed would be through a robust public interest test which measures economic benefits of PHI and the benefits to the health of the population, such as through a Productivity Commission Inquiry. Given the large cost to both individual consumers and to the Australian government a measure should be developed, tested and data regularly collected. This data should feed into ongoing discussion and reform of the PHI system.

Lifetime Health Cover (LHC)

The Lifetime Health Cover (LHC) policy needs a re-examination with a look to changing how it is implemented. Increasing the cost to consumers based on their age is a distortion of the market and a dilution of the community rating principle. While it had the intended impact when it was introduced of increasing the rates of uptake of PHI by people on their 31st birthday, decreasing rates of uptake in this group show that this impact has not been retained. While research on the impact of LHC has not been undertaken, we are particularly concerned about the impact on vulnerable groups within the community, such as those on low incomes.

While changes to this would be complex and require careful consideration to ensure that consumers who are currently subject to LHC are not further disadvantaged, potential changes may include increasing the age at which it comes into effect, or changing the number of years that it applies for.

There is not good understanding of LHC and the advertising campaigns from the insurers leading up to 30 June each year is not sufficient to address this knowledge gap. There needs to be more public education from the PHIO about LHC including:

- Making it clearer that the extra cost to their premiums goes to the insurer, not the government
- Explaining that the additional 2% is cumulative so the longer a consumer puts off taking out PHI the greater the penalty.

The Rebate

The private health insurance rebate was introduced to increase coverage with the intent that this would take pressure off the public health system. It would make private treatment more affordable and give people more choice about where they have treatment. To achieve that policy goal CHF believes that the private health insurance rebate needs to be targeted to policies that provide better value for health consumers in terms of covering them for the health services they use. This would deliver better value for taxpayers as it could decrease demand for public services and free up resources for use by the non-insured population.

Increases to the value of the rebate will increase consumers' perceptions of the product being value for money without increasing the actual value and thereby any impact on the health system. Additionally, the removal of even more money from the health system will put further strain on an already strained budget.

Consistency of standards and informed financial consent

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

Improving informed financial consent procedures are an important way that consumers will be able to gain more value from their PHI. Our comments on this issue can be seen on page 16 with our other comments about improved information provision for consumers.

CHF is a strong advocate for greater price disclosure and cost transparency throughout the health cost chain. We would support moves which would see health providers making their costs more public and would like to see insurers making more transparent the details of their contracting arrangements with hospitals. We applaud the recent improvements made to privatehealth.gov.au to include contracting arrangements.

We do not oppose the practice of insurers contracting with hospitals, but are supportive of the maintenance of the second-tier default benefit arrangements. Consumers should not be disadvantaged in cases where their insurer does not have a contract with a hospital, particularly in light of the complexity of these contracting arrangements.

Right care at the right time in the right place

Term of reference G: Medical services delivery methods, including health care in homes and other models

The increasing prevalence of chronic illnesses in the Australian community and the rapid rate of change through medical technologies mean that change to medical service delivery methods are critical. How these models are funded must logically keep pace with these changes. These changes may include insurers providing enhanced clinical care programs to members with chronic illnesses, such as those provided by a range of insurers currently. However, we place two strong caveats on this support: that the current prohibitions on insurers funding GP and other primary care consultations where a Medicare rebate is available should remain and that these changes must be led by evidence based health care, not an imperative to reduce costs.

The changes made to the Private Health Insurance Act in 2007[35] to allow insurers to provide programs under the Broader Health Cover' (BHC) provisions are broadly appropriate. Our comments below incorporate many of those that we made when the legislation was first introduced in 2006, as they remain relevant.

Out-of-hospital care must be at the same standard as hospital care

Consumers have advised CHF that the most important consideration for them in receiving out of- hospital care is that the services provided are at least an equal standard of care, and result in equal or better health outcomes than those offered in a hospital. CHF members are concerned that the increased complexity of these initiatives will ultimately lead to increased costs – and the strain that will place on the health system and health consumers may lead to poorer overall health outcomes in the community.

Programs and services included in health insurance products must be evidence-based, appropriate to health consumer needs and deliver high quality health outcomes for consumers. Consumers believe that a balance of expenditure between preventive and hospital-substitute programs is necessary.

Many consumers reported to CHF that safety is a key issue for both staff and consumers. They also advised that services need to be evidence based and of equivalent safety and quality to those provided in the hospital setting. Health consumers want to know that there are 'back up' services if thing go wrong.

[35] Biggs A. Chronic disease management: the role of private health insurance. Canberra: Australia; 2013

CHF supports the minimum requirements for home care that the health care service provider must be licensed or registered to provide health care service under the relevant state or territory law. However, being registered, or a member of a professional association, does not guarantee the safety and quality of the way the service is provided.

Choice of when and how care is provided

Consumer choice is critical to many consumers. Consumers reported to CHF that they want the right to choose whether to have treatment in the hospital or at home, based on their health and broader support needs. They also want to be fully informed about the costs, the type of service being offered, and the kind of medical and health care assistance that they may expect if they agree to be treated out-of-hospital. The consumer needs upfront information and assurance of back-up services, should help be required.

An important, yet often overlooked, factor in the decision to accept out-of-hospital services is the impact on family members and carers who may need to provide more intensive care around the episode of treatment. It is critical that patients, and their carers/families, are provided with access to support and resources needed for good health care around the clock. If necessary, a hospital bed must be provided if the home situation is not the best option to patient care, considering the opinions of the patient, carer, family members or health care professional, through appropriate consultation. Even after a choice has been selected, the immediate availability of a hospital bed must be guaranteed if the patient's circumstances change.

Consumers are looking for standard protocols that outline the services and products clearly, including arrangements for referral, discharge, accreditation, and consumer agreement to services. They expect the same level of privacy as a hospital service. An easily accessed consumer complaints mechanism, supported by independent monitoring and review of service delivery, is also expected.

PHI should not be allowed to fund primary care

CHF is concerned that, should private health insurers be allowed to fund primary care services such as GP consultations, then universal access to healthcare would be undermined. While we support the mixed model of public and private healthcare, reports of consumers with PHI being given preferential treatment in public hospitals suggests that were this change allowed, consumers without PHI would face increased costs and longer waiting times for essential primary healthcare services and treatments. Such situations are also evidenced by the contracting arrangements which have occurred in dental and optical care. The Australian Dental Association has detailed the impacts of these arrangements in their submissions to the ACCC[36] and has said that

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[36] Australian Dental Associsation. ACCC Submission on Prviate Health Insurance. 2017

> *This interference in the patient/health practitioner relationship effectively removes consumers' choice of provider, and disrupts consumers' continuity of care as well as substantially lessening competition*

While CHF does not oppose these arrangements, we believe that they provide an unsettling precedent for what may occur should PHI be able to fund primary healthcare and specialist consultations.

The role of regulating bodies

Term of reference Hii: The role and function of the Australian Prudential Regulation Authority (APRA) in regulating private health insurers and Hii: The role and function of Department of Health and the Private Health Insurance Ombudsman in regulating private health insurers and private hospital operators;

Regulating bodies play an important role in ensuring consumers interests and needs are protected and clearly explained to them. As discussed above, consumers' awareness of the details of the PHI industry and how it is regulated is minimal. Given this, the role of regulating bodies in protecting consumers' interests is vital. In particular, we do not support any deregulation of the premium setting process, as mentioned in as an option in the public minutes of the 1 February Private Health Ministerial Advisory Committee. Given the large sums of public investment in PHI, any moves to let the industry set its own premium increases would be inappropriate. The current process already lacks transparency and makes consumers the end product of closed doors discussions. Any further changes to this are likely to disadvantage consumers considerably. If a robust public interest test is developed (see page 21) the results of this test should be used to inform the premium setting process and to make it more transparent. Our specific comments about the current regulating bodies are as follows:

We support the current role of the Department of Health as a steward for and source of policy advice about PHI. If the government is to continue approving premium increases, then the Department of Health should continue their role in this. CHF had expressed some concerns around abolition of the Private Health Insurance Advisory Council (PHIAC) and Private Health Insurance Ombudsman (PHIO) when they moved to APRA and the Commonwealth Ombudsman respectively. One of the reasons for this was that the splintering of regulatory powers could be seen to be inefficient unless there was a very clear transition of roles, clarity about who has responsibility for what and, importantly, no diminution of the functions particularly in light of current ongoing debates about the value of PHI and its place in the health system. Splintering such as this could be very confusing to consumers.

Regarding the Australian Prudential Regulation Authority (APRA), while we have been pleased with its operation and function to date, reported rises in APRA costs in July 2017 calls into question the efficiency dividends intended from the integration of PHIAC into APRA. We are also concerned at the industry suggestion that, as these increased costs are borne by the health insurance funds, that there is a risk they will be passed on to consumers in higher premiums.

The Private Health Insurance Ombudsman (the PHIO) plays a critical role through educating consumers about private health insurance, dealing with complaints and publishing system wide data. While we initially opposed the dissolution of the Private Health Insurance Advisory Council (PHIAC) and the merging of the ombudsman's role into the Commonwealth Ombudsman's office, to date we have been pleased with the operation of the PHIO. We are especially pleased that the PHI Ombudsman retained the capacity to undertake own-motion investigations. The increase in the overall consumer complaints to the PHIO over the last three financial years shows the importance of its role and how much consumers value it[1] as a complaints and complaints resolution pathway.

CHF would support increases to the resources provided to the PHIO for privatehealth.gov.au. Specifically, we suggest that greater resources are put into the promotion of the only independent comparison website and further development of the search tool on the website. The recent improvements made to the website are commendable, however the search tool still lacks the ability for consumers to apply any tax rebates or incentives to the premium they will be charged. Improvements also need to be made around the way that policies from restricted health funds are shown in the results sections – policies that are only available to particular population groups, such those offered by Defence Health to partners of currently serving members of the Australian Defence Force, do not currently appear when using the search tools.

> *Procedure approved by insurer prior to undertaking it. However, after procedure, Medicare refused to pay their portion as it was in a private hospital and I am a (British) reciprocal Medicare card holder. Insurer thus refused to pay even though it was their negligence in obtaining the requisite information. I engaged the Ombudsman who initially was passive in their intervention. Not until I pointed to the PHIO and the insurance company that it stands against reason and legality to sell me a policy and collect high premiums if/when they determine that I cannot claim from it. The process was unnecessarily long but I pursued it and forced both the PHIO and the insurer to do what was reasonable and pay up. What they paid was still very much a small fraction of my OOP cost which in turn defeats the whole purpose of insurance. SHAM system[37].*

Whilst not a regulator of the industry the ACCC has a significant role in protecting consumers in the PHI market. The requirement for the ACCC to report to the Senate on "any anti-competitive practices by health insurers or providers which reduce the extent of health cover for consumers and increase their out-of- pocket medical and other expenses"[38] is critically important and show's this agency's role. The importance of the ACCC's role is exemplified in its role in investigating and prosecuting PHI funds, such as the cases against Medibank and NIB, through which it provides important consumer protection. The recent reports of the ACCC have focused on information provision and how need to address the asymmetry of knowledge

[37] Consumers Health Forum of Australia. Consumer comment from CHF Private Health Insurance Survey report. 2015
[38] Australian Competition & Consumer Commission. Private health insurance reports: https://www.accc.gov.au/publications/private-health-insurance-reports, accessed 21 July 2017. 2017

and information to give consumers more power and knowledge to make choices about products.

Relevant legislative and regulatory instruments

Term of reference J: the operation of relevant legislative and regulatory instruments

Prostheses list

CHF has provided a submission to the Senate Inquiry into Price Regulation associated with the Prostheses List Framework. Our key positions regarding the Prostheses List are as follows.

We welcomed the announcement in October 2016 of reductions of the price of some items on the prostheses list. If these cuts lead to a lower level of premium increase in the next round of premium increases then consumers will benefit. However, to get longer term and more sustainable reductions in premiums the government needs to take a broader, more systemic approach with a robust price disclosure regime across all medical devices. We are also concerned that, other than some commitments in the media, insurers are under no obligation to pass on the savings gained through the recent cuts to consumers.

Above all on this issue we do not support any changes that will shift the costs of prostheses or prostheses-related services onto consumers. Of concern to us would be any moves to change existing 'no gap' provisions in ways that would amend them to apply only to the device, with costs for support services being passed on.

We are also strong advocates for evidence based medicine. This could be strengthened in the current case through the regular removal of prostheses which are not clinically supported from the list.

Appendix A: CHF Private Health Insurance Consumer Survey report

Private Health Insurance Consumer Survey

Results and Discussion

January 2016

Introduction

Australia has a public-private health system. Private health insurance (PHI) is a critical component of the Australian health care system: it is intended to assist with the costs of care in the private system, to support choice of private provider and to help take the pressure off public hospitals.

As just over half of all Australians are covered by some form of private health insurance[39], it is timely to consider whether consumers have the confidence that their policies are robust and will afford them access to critical treatments should the need arise. And as all taxpayers contribute to the Rebate, even though they may not be insured themselves, it is important to ask whether their contributions are being used to the greatest benefit of the health system at large.

The Government announced a review into private health insurance on 28 October 2015. In order to help inform the government's review into private health insurance, the Consumers Health Forum of Australia (CHF) launched the online survey on 6 November 2015, and it ran until 27 November 2015. CHF promoted the survey through its member organisations, publications and social media platforms. It was also highlighted in a number of other stakeholder newsletters and subscription media outlets.

CHF made its formal submission to the government's review on 14 December 2015. The full submission can be accessed from CHF's website[40]. The findings, discussion, and

[39] According to the Australian Prudential Regulation Authority's preliminary data for the quarter ending September 2015, 47.3 per cent of Australians are covered by hospital treatment plans, and 55.8 per cent by general treatment plans – 50.9 per cent if ambulance only plans are excluded. *Private Health Insurance Membership and Coverage*, November 2015.
[40] *CHF Submission to the Review on Private Health Insurance: December 2015*. https://www.chf.org.au/pdfs/chf/CHF-PHI-Review-Submission-FINAL.pdf

recommendations in this report should be viewed as a companion to the full submission, which discusses CHF's views in detail. While some of the recommendations in this report mirror those in our submission, we have limited them to the results of the survey.

The survey received 573 responses. The profile of survey respondents is discussed in detail in the report, but in general, respondents tended to be older than the general population and with higher incomes. The survey respondents were also overwhelmingly holders of private health insurance, thus making it impossible to draw meaningful comparisons to the experiences and opinions of non-insurance holders. Survey respondents were also slightly higher users of the health system than the general population.

The government also conducted a consumer survey as part of the review from 8 November 2015 to 7 December 2015 and received over 40,000 responses[41]. However, at the time of this report's publication, the government had not detailed the survey's results in order for CHF to draw comparisons.

The survey

The key findings of the survey are:

- Most respondents were driven to take out private health insurance because of a lack of confidence in the public system's ability to provide timely, coordinated care.
- The leading reasons why respondents had private health insurance were to have better access to elective procedures, have control over their choice of provider, and avoid out of pocket costs.
- While holders of private health insurance were satisfied that their policies provided them with control over their providers (60 per cent) and having timely access to elective procedures (64 per cent), they were less satisfied that their policies adequately covered their health needs (43 per cent) and kept their out-of-pocket costs low (30 per cent).
- Only a slim majority of policy holders (51 per cent) were confident that they understood what their policy covers, even though almost half (48 per cent) have had their policies for 11 years or longer. More than one-in-five respondents (24 per cent) reported having had a claim denied by their health insurer.
- Overall satisfaction of respondents with insurance of their policies was 38 per cent.

The key takeaway from the survey is that while people are choosing to take out private health insurance for apparently practical reasons, they do not appear to be receiving overall value for having insurance in the absence of a medical need. Even then, their coverage for necessary procedures was not always comprehensive, resulting in higher consumer costs. This lack of overall value appeared to be a significant burden on households.

On the whole, respondents reported the average annual cost of their policies was $3,377 per year, varying between $1,938 for individual policies and $4,337 for family policies. Considered on top of other out-of-pocket expenses, for respondents with insurance who also reported out-of-pocket expenses, the average cost of their policies was $3,294 with an additional, average,

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[41] According to the Department of Health's page for the "Private Health Insurance Consultation 2015-16." http://www.health.gov.au/internet/main/publishing.nsf/Content/phiconsultations2015-16, updated 5 December 2015.

annual out-of-pocket expenditure of $2,035. Among these persons, 46 per cent reported a combined expenditure above the national average of medical care and health expenses, as reported by the Australian Bureau of Statistics (ABS)[42], with almost one-in-five (18 per cent) having a combined expenditure of 10 per cent or higher.

The implications of the lack of value of private health insurance for consumers are far reaching. Consumers desire having private health insurance as a way to avoid increasing wait times in the public system – which is also a key government interest – and having control over their choice of care provider, but are not happy about the lack of cost controls. Although respondents were supportive of the Rebate (65 per cent), many felt it was too low to cover the cost of health insurance (35 per cent).

Results and Discussion

Utilisation of Private Health Insurance

The survey respondents were overwhelmingly currently covered by health insurance (87 per cent, *Table 1*) – much higher than the general population – or previously had insurance (6 per cent). The proportion of respondents without private health insurance and who did not previously have private health insurance (7 per cent) was too small to make significant extrapolations about the opinions of non-insured Australians. As such, our analysis of the survey is confined to those respondents who reported currently having or being covered by private health insurance, unless otherwise indicated.

Table 1

Do you have private health insurance?

Response	%
Yes - Policy Holder	76%
Yes - Covered by Insurance	10%
No - Previously Insured	6%
No	7%
Don't Know	*

Based on 540 responses

Overwhelmingly, respondents with private health insurance had a Combined Cover policy (85 per cent), with 11 percent having Hospital Cover only, and the remainder General Cover. The policies were almost evenly distributed across individual plans (34 per cent), families (33 per cent) and couples (32 per cent).

[42] According to the “Household Expenditure Survey, Australia: Summary of Results, 2009-10,” its most recent survey, “Medical care and health expenses” made up 5.3 per cent of Australians’ household expenditures.

Almost three-fourths of respondents with insurance reported having had some form of insurance coverage for 16 or more years, with another 10 per cent having coverage for 11 to 15 years (*Table 2*). Overall, just less than half (48 per cent) of respondents with private health insurance reported having their current policies for 11 years or more, with almost one-in-three (29 per cent) having had their existing policies for more than 20 years (*Appendix, Charts 1 and 2*).

Table 2
How long have you had any form of private health insurance?

More than 20 years	63%
16-20 years	11%
11-15 years	10%
6-10 years	9%
2-5 years	5%
Less than 2 years	2%

Based on 457 responses

These statistics strongly suggest that persons with private health insurance fall victim to a "set and forget" frame of mind, despite possible changes to their life circumstances that may affect the value of their coverage. While a high percentage of respondents indicated they understood what their policies did and did not cover (42 per cent responding to either "4" or "5" on a Likert scale), the degree of confidence varied based on how long the respondent had been an insurance holder (*Table 3*).

Respondents who have had some form of health insurance for more than 20 years were more than twice as likely to say they knew what their insurance covered (58 per cent) than respondents with some form of health insurance for 5 years or less (24 per cent). This may be a reflection that the more direct experience consumers have with the insurance system; the better able they are to understand their coverage.

Table 3
How well would you say you understand what your insurance does and does not cover?

	Not well at all 1	2	3	4	*Very well* 5	Don't know
All respondents	7%	15%	25%	29%	23%	1%
Respondents having insurance for...						
More than 20 years	7%	11%	22%	32%	26%	1%
11-20 years	5%	31%	23%	23%	17%	0%
6-10 years	8%	21%	36%	21%	15%	0%
5 years or less	7%	34%	28%	14%	10%	7%

Based on 456 responses

As nearly three-fourths of respondents (73 per cent) indicated that they had needed to lodge a claim with their provider at some point in the last year, and more than one-in-five (24 per cent) said they'd ever had a claim denied, consumers with insurance appear to have ample opportunity to learn the ins-and-outs of their policies over time.

The reasons most commonly cited by respondents for taking out private health insurance (*Appendix*, *Chart 3*) were to:

- Have quicker access to elective procedures (77 per cent)
- Have more control over the providers they could see (69 per cent)
- Avoid possible financial costs in the absence of insurance (68 per cent)
- Avoiding over-reliance on the public system (64 per cent).

Regarding the point about reliance on the public system, the survey revealed strong concerns among all respondents – those with and without private health insurance – about the ability of the public system to meet demand. A majority (54 per cent responding to either "4" or "5" on a Likert scale) disagreed that the public system is able to offer timely access for health care. Just less (48 per cent) disagreed that it has sufficient medical professionals to meet demand, with an equal proportion disagreeing that it is able to coordinate services for chronic or complex needs. The only apparent support for the public system among respondents was in its ability to provide affordable health care, a position which 47 per cent of respondents agreed with.

Value of private health insurance

As the government pays billions of dollars each year through the Rebate to support the insurance industry, it is vital that the products are viewed by consumers as having value in the delivery of health care for the expense of insurance.

Among all respondents with insurance, they reported an average, annual cost of their policies at $3,377 per year. The costs varied by policies, with individual plans costing an average $1,936, couples plans costing $3,955, and family plans $4,337.

For respondents who reported both the annual costs of their insurance and out-of-pocket expenses, the averages were $3,294 and $2,035, respectively. The average Australian, however, pays $1,075 per year in out-of-pocket health costs[43], meaning persons with private health insurance are paying significantly more than those who do not. This is consistent with previous research undertaken by CHF which found that persons with private health insurance are more likely to pay more in out of pocket expenses than those without[44].

These figures come despite the fact, as discussed in the previous section, that more than two-thirds of people sought private health insurance in order to avoid a financial burden.

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[43] The Senate Community Affairs References Committee Report, *Out-of-pocket costs in Australian healthcare*. August 2014.
[44] In our report on our survey into out-of-pocket costs, *Health Consumer Out-of-Pocket Costs Survey: Results and Analysis*, 38 per cent of respondents without private health insurance had annual out-of-pocket costs in excess of $1,000. For respondents with insurance, that percentage rose to 56 per cent.

Of the respondents who reported the costs of their insurance, out-of-pocket expenses, and gross household income, three-in-five (40 per cent) reported that the combination of their insurance and out-of-pocket expenses were six per cent or more of their household income. Almost one-in-five (19 per cent) reported that their combined health costs represented 10 per cent or more of their household income (*Table 4*).

Table 4

Combined insurance premiums and out-of-pocket expenses as a percentage of household income

10% or more	"Very High"	19%
8.0-9.9%	"High"	8%
6.0-7.9%	"Above Average"	13%
4.0-5.9%	"Average"	19%
2.0-3.9%	"Below Average"	25%
Less than 2.0%	"Low"	16%

Based on 407 responses

The survey responses do not appear to indicate that the higher out of pocket costs for persons with private health insurance are due to greater use of the health system.

Table 5

What's your best guess as to how many times you visited a GP in the last year?

NHPA Category	Respondents	Australians	Difference
Very High (20+)	8.6%	3.8%	4.8%
Frequent (12-19)	9.5%	8.7%	0.8%
Above Average (6-11)	22.2%	22.8%	-0.6%
Occasional (4-5)	22.9%	15.8%	7.1%
Low (1-3)	34.1%	33.6%	0.5%
Zero	2.6%	15.3%	-12.7%

Based on 552 responses

On the whole, the survey respondents were more frequent users of the health system than the general population, with 97 per cent of respondents having seen a GP in the last year versus 85 per cent of Australians[45]. However, the frequency of visits still hovered around the national average, with only 40 per cent of respondents seeing a GP six or more times in the last year versus 35 per cent of the general population (*Table 5*).

While the government offers a tax Rebate to assist with the affordability of health insurance, it does not appear that this is providing any meaningful assistance to consumers who are struggling with health affordability. In their comments on the survey, many respondents indicated that a major financial burden was the gap in specialist fees that their insurance does not cover.

[45] According to a report by the National Health Performance Authority, *Healthy Communities: Frequent GP attenders and their use of health services in 2012–13*. March 2015.

Although a large majority of respondents support the government's Rebate policy (65 per cent overall, 71 per cent of policy-holders) only one-third (32 per cent) believed the level of Rebate to be adequate, with 36 per cent believing it's too low. Among respondents whose combined health costs were 10 per cent or more of their gross household income, a majority (54 per cent) believed the Rebate level to be too low (*Table 6*).

Table 6

In general, how do you feel about the levels of rebates offered by the government?

	Too low	About right	Too high	Don't know
All respondents	36%	32%	17%	15%
Respondents with household health expenses of...				
10% or more	54%	35%	5%	6%
8.0-9.9%	29%	44%	9%	18%
6.0-7.9%	32%	40%	17%	11%
4.0-5.9%	34%	39%	12%	14%
2.0-3.9%	41%	29%	20%	10%
Less than 2.0%	24%	36%	27%	12%

Based on 540 responses

Yet while the government offers the Rebate to assist with insurance affordability, it also penalises Australians who don't have health insurance through two mechanisms – the Lifetime Health Cover rating and the Medicare Levy Surcharge. Those measures were introduced by the government at a time when overall uptake of health insurance in Australia was at historic lows in order to compel uptake of policies.

While 49 per cent of respondents with health insurance said they wanted to avoid a higher Lifetime Health Cover, only 35 per cent were worried about being penalised by the Medicare Levy Surcharge.

When asked about their satisfaction with their insurance policies' ability to keep costs manageable, less than one-in-three indicated satisfaction (30 per cent responding to either "4" or "5" on a Likert scale), with 43 per cent indicating dissatisfaction (*Table 7*).

While majorities indicated satisfaction that their insurance provided them with better access to hospitals for elective procedures (64 per cent) and offered them control over the providers they wished to see (60 per cent), just over two-in-five (43 per cent) said they were satisfied that their insurance covered treatments for their specific health conditions.

The combination of high costs of coverage and lower satisfaction in insurers' ability to meet consumers' needs appeared to be the key factors behind respondents' overall satisfaction with their insurance. Despite the previously mentioned satisfaction with access to care, only 38 per cent of respondents with health insurance indicated overall satisfaction with their policies, despite the otherwise high marks for access to hospitals and providers. Moreover, it did not appear that respondents were satisfied that their insurance was keeping up with their health needs.

Table 7

How satisfied are you that your current policy…

	Not at all 1	2	3	4	Very 5	Don't know
Gives you control over the providers you see?	8%	11%	16%	28%	32%	5%
Provides you with better access to hospitals?	6%	7%	15%	32%	31%	8%
Adequately covers treatments your health conditions?	13%	18%	22%	26%	17%	4%
Keeps the costs of your health care manageable?	19%	24%	25%	19%	11%	2%
Based on 456 responses						
Overall	7%	21%	31%	26%	12%	3%
Based on 454 responses						

Policy Considerations and Recommendations

The Government has a responsibility to ensure that the public health system is sustainable. Yet in recent years, more attention has been given to whether the health insurance market is solvent.

As the government is involved in the health insurance market by way of the Rebate and regulation of premium increases, it has the responsibility to ensure that taxpayer dollars are not going towards a system that both lacks transparency and places an undue burden on consumers to purchase a health plan that meets essential health needs.

The proliferation of insurance policies has made it increasingly difficult for consumers to shop for an appropriate insurance policy and understand just what their policies cover. Given the scope of the market, it is incumbent on Government to be an active regulator by identifying and eliminating policies that do not provide value to consumers.

It also has the responsibility to set the policy frameworks to ensure that consumers are able to have timely access to information about the costs of insurance – not just the premiums on the face of the policies, but what other fees and relevant performance information might be applicable by specialists and other health practitioners in order for consumers, in consultation with their GPs, to make informed choices.

In light of the issues revealed by our survey, CHF makes the following recommendations for the future of the Australian health insurance market. As mentioned previously, we discuss these and other recommendations in greater detail in our full submission to the review, which is available from our website.

Nationally standard health insurance product (myCover)

CHF believes that there ought to be a legislated, national standard for basic or default hospital coverage (*myCover*) that would be required by all health funds to offer to consumers. The suite

of myCover packages should be tailored to accommodate different stages of the life course. The services covered under this basic package ought to be evidence-based and in relatively widespread use by the medical community. It should have minimal exclusions, standard excess arrangements and be fit for purpose.

Having such a standard package would prevent Australians from falling victim to "junk policies" that fail to meet essential health needs. It would allow Australians shopping for health insurance to have a basic standard against which they could compare the financial costs and potential value of other policies and services and so make it easier to use comparator websites when making the decision.

Rebate reform

CHF calls for the Rebate to be redesigned to only apply to hospital products that meet as a minimum the myCover standard for hospital cover as recommended above. Furthermore, the Rebate ought to be indexed to the costs of providing care under the package.

Regarding General Cover policies, CHF believes that, if a rebate continues to apply, it should be tied to treatments and procedures with an evidence base and shown to have clinical benefits. CHF also believes that the Government could consider other innovative policy options such as moving away from offering Rebate incentives and, instead, encourage people to self-insure for the costs of private allied health and dental services, such as a health savings account.

In place of offering the Rebate broadly for General Cover policies, the Government could offer matching contributions or provide flexible reimbursements for certain, evidence-based procedures and preventive measures. Additionally, there may be incentives to support to consumers and insurers that participate in preventive health and hospital avoidance programs. These could also include certain, targeted chronic disease prevention and management programs.

Insurers ought to be permitted to develop and market policies that can compete with the health savings account, and consumers would be free to select such policies based on their own needs and preferences. However, such policies should exist in a purely competitive environment and not be supported by Government rebates or other subsidies.

Transparency of premiums

Survey respondents repeatedly made comments about the impact of premium increases against the overall value of their insurance. Many cited ever-rising premiums as a possible reason for eventually dropping their insurance coverage. CHF calls for amendments to the *Private Health Insurance Act of 2007* to require health insurers to make more transparent and explicit their rationales for increasing premiums when notifying their customers. Additionally, insurers should be transparent about the reasons why some customers' premiums have increased at a higher rate than the health fund and national averages. Moreover, we call for a cap on the rate that premiums may rise on health insurance packages in a given year while retaining eligibility for the Rebate.

Consumer information and decision-making

When shopping for private health insurance, most respondents (51 per cent) reported turning to insurer-provided information, whether printed or electronic. This was followed closely by the use of insurance comparison sites (40 per cent) and then recommendations by family and friends (35 per cent). Other respondents reported "going with the flow" and using the providers of their parents and employers, and several indicated that they had held their policies for so long that they could not remember which sources of information had been available.

One constant among the sources of information, however, was that few found the process easy. Only 27 per cent of respondents indicated that the process of shopping for health insurance was easy, versus 42 per cent who found it difficult (with 24 per cent indicating the highest level of difficulty).

Overcoming the chronic information asymmetry in the marketplace is a critical area of reform that must be addressed in this Review. The current health insurance marketplace is a morass of confusion for consumers, repeatedly reinforced through several surveys, reports, and complaints to agencies such as the Australian Competition and Consumer Commission and ourselves. The proliferation of policies and the manner in which they may change can leave many consumers unsure of what they are and are not covered for until they present at hospital.

CHF calls for legislated reforms to improve informed financial consent at the time a consumer purchases health insurance, and at any stage that their premiums may change. Such reforms ought to include a mandate for the use of plain language in explaining the policy's coverage and costs. Similarly, there should be regulatory requirements for funds to publicise information held about specialists' fees, performance and waiting times. Many health funds have already taken it on themselves to provide information to their customers in this manner. CHF believes that legislating such requirements would not provide an undue administrative burden for compliance and is the only way to ensure consistent, industry-wide information and disclosure practices.

Appendix

Chart 1

Percent of Repondents with PHI and Time Under Current Policy

Time with any Insurance (Years) \ Time Under Current Policy (Years)	20+	16-20	11-15	6-10	2-5	< 2
20+	29%	4%	4%	9%	10%	8%
16-20		4%	1%	2%	2%	2%
11-15			6%	1%	1%	2%
6-10				4%	2%	2%
2-5					4%	1%
< 2						2%

Based on 457 Responses

Chart 2

Repondents' Time Under Current Policy vs. Lifetime of Coverage

Time Under Current Policy (Years) \ Length of all Insurance Coverage (Years)	20+	16-20	11-15	6-10	2-5	< 2
20+	46%	6%	6%	14%	16%	12%
16-20		35%	8%	14%	22%	22%
11-15			60%	6%	13%	21%
6-10				46%	26%	28%
2-5					87%	13%
< 2						100%

Based on 457 Responses

Appendix

Chart 3

How strong were these factors for you in choosing to purchase private health insurance?

	Not at all 1	2	3	4	*Very* 5	Don't know	1 & 2	4 & 5	Diff.
I wanted to have quicker access to elective procedures	7%	5%	7%	19%	58%	4%	12%	77%	65%
I wanted more control over the providers I see	9%	7%	11%	21%	48%	3%	16%	69%	53%
I was concerned about financial costs of care without insurance	8%	10%	11%	18%	50%	3%	18%	68%	50%
I was concerned about relying on the public hospital system	11%	11%	12%	20%	43%	3%	22%	64%	42%
I wanted to avoid paying a high Lifetime Health Cover later	22%	11%	12%	15%	34%	6%	33%	49%	16%
I wanted better coverage for existing health conditions	26%	13%	13%	14%	30%	4%	39%	44%	5%
I wanted to avoid the Medicare Levy Surcharge	34%	13%	14%	10%	25%	4%	47%	35%	-12%

Based on 466 responses

Appendix B: Health Voices

Health insurance: a question of value

Leanne Wells, Chief Executive Officer of the Consumers Health Forum of Australia

Private health insurance represents an increasingly disturbing paradox in Australia. While it now finances the majority of surgical procedures, and private hospital admissions for those with mental illness, there is a greater number of uninsured people for whom such services are only available at great cost or after long delays.

The multi-billion dollar subsidies for health insurance which were supposed to ease pressure on public hospitals have failed to stem longer waiting times for elective surgery in public hospitals or to meet the public need for services for many chronic conditions including mental illness.

The notion that private health insurance would drive efficiency and add other value to our system turns out to be a hollow promise for many consumers.

The articles in this edition of Health Voices show there are profound questions about the value and equity of private insurance in Australia's mixed public-private health system.

At a time when the expense and worth of health insurance represents a huge issue for consumers, the 20 authors in this Health Voices provide a range of insights on this subject rarely seen in one publication.

Significantly, our authors include Jeff Harmer, the person at the centre of efforts to improve health insurance.

Dr Harmer chairs the Private Health Ministerial Advisory Committee which is inquiring into health insurance. His views echo the comments of many others on this issue: health insurance is complex, confusing and increasingly too costly for many people.

The Committee is still to report, but Dr Harmer's message is sobering. The Committee, Dr Harmer writes, recognises that the Government has limited options for regulation in this area. Despite this, he says the Committee is keen to look at opportunities for industry participants – doctors, insurers and hospitals – to work together to provide better value for consumers.

Hope that a new era of unity in the interests of consumers may emerge among doctors, funds and hospitals in the private sector seems to be the best, if ambitious, hope for the future of health insurance, judging by the tenor of most articles for this edition.

Many of the authors representing consumers and analysts, challenge the value of health cover in terms of both financial return and certainty of outcome and even in terms of its economic and social worth to Australia.

The supporters of private health on the other hand point to its role in reducing demand for public hospital care particularly for elective surgery, and of maintaining the sustainability of Australia's health system.

The Consumers Health Forum recently opened an online checklist and survey to coincide with the 1 April premium changes. As our policy officer, Rebecca Randall, found in analysing responses, consumers who responded are highly sceptical of the value of private health insurance. They are aware of insurers' large profit margins and cite this as a reason why they feel that they are paying unnecessarily high premiums. Despite the tax incentives to have private health insurance, a number of participants said that they would prefer to pay higher taxes and contribute to the public health system in this way rather than paying for a product they feel was not of value to them or to others.

The Private Health Insurance Ombudsman Richard Glenn list three common reasons why people take out health insurance: to ensure private hospital care and choice of doctors; to have cover for services not covered by Medicare like allied health services; and because of the various surcharges and incentives to take out private cover.

Arguments for and against the value of Australia's private health insurance (PHI) system are many and varied but often negative.

To present the issues in some order, I will reflect on authors' contributions by grouping them according to their communities of interest: consumers, health funds/providers and analysts.

Consumers

For consumer leaders like Christine Walker of the Chronic Illness Alliance, whose members depend heavily on the health system "The benefits of PHI are limited for people with chronic illnesses, who often have low incomes and face out-of-pocket costs." She says the effect of the health insurance arrangements, instead of reducing pressure on the public system "is to produce greater inequality in the health system". Given the continued rise in premiums, the investment by Government in the rebate "will become largely wasted".

Lesley Brydon of Painaustralia says that while health insurance may cover expensive surgery, there is a real gap when it comes to covering evidence-based best practice treatment for people with chronic conditions needing therapy from allied health professionals. She says there are so many exclusions and inadequate PHI benefits which overlook the value of prevention and allied health services that these costs to patients often far outweigh the benefits of the tax rebate.

Arthritis Australia's Ainslie Cahill says: "In particular, the government's private health insurance rebate, which is evidently not achieving its objective of making health insurance more affordable, needs to be urgently reviewed."

On that aspect, Matt Levey from CHOICE describes PHI as "a very strange market; one where some customers are grudgingly pushed into products they don't want let alone understand, subsidised by the entire community through rebates. Insurance providers regularly point out the amount of regulation that constrains their industry. But when demand for your product is

guaranteed through a combination of legislated carrots and sticks, it is fair to ask what the community should expect in return."

A group which says the current discriminatory cover for psychiatric care is well below what the community should expect, fears further erosion in health fund benefits. Janne McMahon of the Private Mental Health Consumer Carer Network says suggestions that the present mandatory cover for psychiatric care might be restricted to high cost policies would "dramatically reduce patient access to vital psychiatric services".

Older Australians, who are more likely to hold health insurance because of their vulnerability and concern about public hospital waiting lists, are another group who are worried by the higher premiums and the out-of-pocket costs they face if they do have private care. Susan McGrath of COTA says that given the enormous public investment, PHI needs to deliver better health outcomes for the nation overall and for older health consumers.

David Butt of the National Rural Health Alliance says that given the meagre private health services in the country and rising cost of private insurance, many rural people must be considering whether to keep their insurance. "Without a drive to innovate in private health service delivery outside the major cities, we will see increasingly smaller levels of uptake of insurance." Without change, regional and remote Australia will rely increasingly on Federal and State governments to address the ever widening level of disadvantage in access to health services and its impact on health outcomes.

Health Funds/Providers

Rachel David, who heads Private Healthcare Australia, representing health funds, says however that surveys show over 80 per cent of the Australians with private health insurance value the product and want to keep it. PHI pays for nearly two thirds of essential non-emergency surgery in Australia, 90 per cent of day admissions for mental health care, 70 per cent of joint replacements and 60 per cent of chemotherapy. Ms David says there is scope to address the sustainability of healthcare through sensible policy correction. The PHI reform process must deliver real change to improve affordability and value of private cover. "There's no alternative."

Matthew Koce of the NFP community sector funds organisation, says that if affordability pressure is to be relieved, "consumers need to be empowered to make better informed choices…Giving consumers access to the information they need to take a more active role in their own healthcare will result in greater competition and better outcomes, while also placing downward pressure on medical costs".

Health fund policies come under severe fire from Michael Roff of the Australian Private Hospitals Association. "Few consumer products are as complicated and difficult for the purchaser to understand as a private health insurance policy." He writes that it is often private hospital staff who are left in the unfortunate position of having to explain to prospective patients that their policy does not cover the surgery and they must choose between either high out of pocket costs or joining the public hospital waiting list.

Dr Lawrie Malisano from the Royal Australasian College of Surgeons warns the long term viability of private health in Australia will decline if insurance premiums continue to rise above CPI and wages growth. His College has criticised the “extortionate” fees that bear little relationship to performance charged by some surgeons. The College supports measures to reduce complexity and improve consumer information about health insurance coverage. A consistent approach to the use of rigorous quality indicators for performance of surgeons would also be of significant benefit, Dr Malisano said.

Alison Verhoeven of the Australian Healthcare and Hospitals Association details the complex funding arrangements between public and private hospitals. To criticism of privately insured patients using public hospitals, she says the cost to the health funds is less than what they spend on overall administration. She urges caution over any moves to limit private patients in public hospitals given impact on funding and difficulties retaining clinicians in public hospitals.

The Royal Australian and NZ College of Psychiatrists questions whether it is “morally justifiable” for insurance companies not to cover such a large percentage of the burden of disease represented by those with mental illness. College President, Professor Malcolm Hopwood says that despite the fact that mental illness represents 24 per cent of the burden of disease if substance use disorders are included, fewer than half of all major health fund policies cover the cost of admission into a private psychiatric facility. The College is advocating that the Government consider health funds’ psychiatric cover in the private health review.

Dentists also argue that health funds deal unfairly with them and their patients. Dr Hugo Sachs, President of the Australian Dental Association, says consumers have paid out $6.2 billion more in general or extras policy premiums than what they received back from health funds over the past five financial years. Dr Sachs says the health funds are also using discriminatory rebate regimes to make their contracted dentists appear more attractive than dentists who are not contracted to them, placing the latters’ practices in jeopardy.

Health fund sweetheart arrangements with health practitioners are also a concern for Allied Health Professions Australia’s executive director Lin Oke. She says health providers are increasingly faced with the choice of securing their customer base by entering into preferred provider agreements with insurers or losing customers to preferred providers who attract higher rebates. “Those with preferred provider agreements are under significant pressure to keep costs low which conflicts with their ability to provide high quality care.”

Analysts

Private health insurance is unfair, wasteful and a grave threat to Medicare. That’s the verdict of distinguished former business leader and public servant, John Menadue. Rebates and tax incentives pump an estimated $11 billion every year into health insurance, bolstering an inefficient and unfair system that is weakening Medicare’s power to control costs. Mr Menadue says the former Health Minister, Sussan Ley, had herself said “Australians are paying too much for health insurance that does not deliver them much value.” The Government had continued to support huge subsidies for health funds which did not have the

market power to restrain costs, resulting in premiums soaring at more than double the inflation rate throughout this century, Mr Menadue says.

Health financing analyst Ian McAuley, writes there are strong efficiency arguments for ending Government subsidies of health insurance. The savings could be reinvested in Medicare which is significantly more cost effective than health funds whose administrative costs are significantly higher. If tax rises were needed to boost public hospitals, the people who dropped health insurance would make very significant savings by not having to pay, the "high cost privatised tax" of PHI premiums.

Without significant change, the omens for health insurance are discouraging. Health economist Terence Cheng says that if the current trend in downgrading of policies by many people continues, it may potentially worsen the problem of increasing premium costs, as healthier consumers (i.e younger) scale back their insurance, resulting in a remaining pool of 'less healthy' consumers with greater health care needs.

For the Consumers Health Forum that provides a disturbing signal for the likely future of health insurance: an unhealthy prospect for those who need care most.

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CHF is represented on PHMAC through our Chair, Tony Lawson. Tony believes that while there are many challenges for consumers in understanding and managing private health insurance (PHI) policies, he is encouraged by the commitment shown by the Federal Government in attempting to transform PHI. Tony also points to the high level of co-operation and willingness of all the key stakeholders to achieve much needed and overdue change to PHI. On behalf of CHF, Tony has been advocating for changes which will bring significant improvements to PHI for the benefit of consumers. The key issues Tony has been pursuing cover a range of matters including;

- Greater simplicity in the range of policies
- More easily understood information, common language and common definitions
- Improved communication to consumers by insurers on the coverage they have as they reach particular life milestones and as their needs change
- Less out of pocket expenses
- Reduction in exclusions
- Greater coverage of mental health
- Improved coverage for the rural and remote population

And most importantly of all, greater value for consumers.

Seeking better value for consumers

Jeff Harmer AO, Chair of the Private Health Ministerial Advisory Committee

Australia has a mixed public and private model of health care funding and service delivery, and private health insurance plays a major role. It offers members greater choice in the provision

of treatment and covers some services not included under Medicare arrangements. Over half the population holds some form of private health insurance.

The Australian Government's 2015 private health insurance consultations revealed widespread community and industry concern around the complexity of private health insurance and consumers' access to easily understandable information about what their policy will and will not cover. The consultations found that the way product information is presented is a particular source of confusion for consumers. There is significant variability in the terminology insurers use to describe what's covered, and this makes it difficult for consumers to understand and compare policies.

There has been growth in the number of low priced products on the market, including policies that only cover treatment in a public hospital or exclude a majority of services. Some consumers may see value in these products as they do allow access to treatment with their doctor of choice as a private patient in a public hospital. However, consumer groups and providers have suggested that increasing numbers of consumers are purchasing products without a proper understanding of what's covered. When they require hospital treatment these consumers are surprised to find they are not covered and/or face considerable out-of-pocket costs.

It's also clear that consumers are increasingly concerned with the affordability of private health insurance as premiums continue to rise.

Increasing health costs and growth in the number of services delivered are leading to higher premiums. It's becoming clearer that increasing numbers of consumers are finding it difficult to meet these costs.

Together, these issues are leading consumers to question the value of private health insurance. Private health insurance membership growth and overall membership levels are now in decline. Hospital insurance population coverage has declined over the last six quarters, from 47.4 per cent in June 2015 to 46.6 per cent in December 2016.

Private Health Ministerial Advisory Committee

The Government established the Private Health Ministerial Advisory Committee in late-2016. This Committee includes members representing consumers (including the Consumers Health Forum), insurers, private hospitals and healthcare providers.

We have a key role in advising the Minister on the Government's reform agenda. The main areas to be considered by the Committee include: simplifying private health insurance products; improving the quality and transparency of information provided to consumers; and taking costs out of the system to ease pressure on premium rises.

Product design

Reforms to product design aim to simplify private health insurance by developing easily-understood categories of cover, such as Gold, Silver and Bronze. These changes will help

consumers compare products more easily and better understand what they are (and are not) covered for. The Committee is well progressed in its consideration of this issue.

Working Groups

The Committee has established working groups to assist on a number of policy areas, including: improving the quality and transparency of information provided to consumers; developing standard clinical definitions to describe services that are covered by private health insurance; and possible reforms to hospital contracting and private health insurance default benefit arrangements.

The Committee is also looking at how to deliver better value for Australians living in rural and remote areas. A workshop held in late-2016 brought together key groups, including consumers, doctors, hospitals and insurers, to discuss these issues. Committee members are doing further work to finalise options to improve value for rural and remote consumers.

Out-of-pocket costs

The Committee has considered the issue of consumer out-of-pocket costs, with a focus on medical gaps.

Large medical out-of-pockets are a major issue undermining consumer confidence in private health insurance.

Consumers are unhappy about the size of many medical gaps, and the fact that these gaps are often unexpected. The Committee recognises that the Government has limited options for regulation in this area. Despite this, we are keen to look at opportunities for industry participants – doctors, insurers and hospitals – to work together to address this important issue and provide better value for consumers.

Next steps

The Committee is still developing reform options and is yet to finalise any positions. The Committee is advisory in nature, so any recommendations are not binding on Government.

The Committee is keen to maintain an open dialogue with consumers and the private health sector. We are committed to being as transparent as possible while we develop our advice to government. Our website contains meeting summaries outlining the major issues discussed at all Committee and Working Group meetings.

Low value, confusing and time consuming – findings from CHF's 2017 Awareness campaign

Rebecca Randall, Policy Officer at the Consumers Health Forum of Australia

Year on year CHF consistently hears about the confusion that PHI causes, the considerable out of pocket costs it generates and the impact of rising premiums. We set out this year to document these experiences with PHI through a four-step checklist and survey, see chf.org.au/healthy-cover. The responses to the survey were indicative of the concerns that we frequently hear from consumers – that private health insurance is low value, confusing and time consuming.

To date we have used the results in our submission to the ACCC's report to the senate and to inform our work on PHMAC. The survey will remain open for the foreseeable future to allow us to see if concerns and issues change over time or in response to policy and premium price changes.

Low value

Consumers are highly sceptical of the value of private health insurance. They are aware of insurers' large profit margins and cite this as a reason that they feel that they are paying unnecessarily high premiums. Despite the tax incentives to have private health insurance, a number of participants expressed that they would prefer to pay higher taxes and contribute to the public health system in this way rather than paying for a product they feel was not of value to them or others.

Gap fees featured frequently in the survey responses as an area of frustration. Consumers conveyed that, having already paid their health insurance premium, they should not be asked to pay out of pocket costs at the point of service. This appears to be particularly relevant for extras, or general, cover. However, this bias may be due to the greater frequency with which consumers use extras cover. This appears to be particularly true for consumers who are more frequent users of services. One such survey respondent said:

> *You have to pay $260 per month for private health and when you attend an appointment with a Dentist or physio etc.. you still have to pay the gap fees . So $260 per month plus 70 bucks Gap fees, plus remedial massage per hr $80 bucks that's total of $ 410 for that month for one person alone. Total scam*

The reasoning behind insurers covering set ranges of services in their policies is an area of confusion for consumers. Consumers indicated that they think that having to pay for services that they do not use contributes to premiums being higher than necessary. While CHF believes that while it should be mandatory for hospital insurance policies to cover a minimum and broad set of areas, as hospital insurance as 'insurance' in the traditional sense of the word, we suggest that insurers should either explain the reason that they offer such a wide range of services in their extra's policies or consider reducing these.

Confusing

Consumers use a range of ways to find information about their health insurance but the majority of consumers only use one source of information. Approximately one third of respondents to our survey used each of the government website, a specific insurer's website, and a comparator website. This finding shows the importance of each of these sources being

accurate, up to date and honest about the limitations of the information they display. While we do not believe that each of these sources need to be, or should, be completely comprehensive as they serve different purposes and target different audiences, we strongly believe that they should acknowledge their limitations.

More than half of respondents were able to complete the actions they wished to do using available information. This suggests that consumers are able to access the information they need when they choose to search for it.

A strong theme arising from the comments was that complexity of policies makes comparing and moving between policies a significant challenge. Consumers report that they find the process of comparing policies time consuming and difficult. When they are able devote sufficient time and effort to compare policies they often find they are able to purchase a comparable product for a considerably lower price. One consumer told us:

I did this a few months ago and appear to have saved up to around $1700 / year although refunds could be a little less on some items. It was a very complicated process especially for older people who have a relationship with the old insurer and pre-existing conditions

Another consumer concisely captured the implications of misleading information being conveyed. Our data cannot determine whether these practices are deliberately misleading or merely accidental, however in either case this practice is problematic.

Health insurance websites are so complicated it is difficult to work out often what the benefit will be. For two things recently I called first and then later found the advice they provided was not consistent with the benefit they would pay – that is to say no benefit.

Consumers also expressed that they have difficulty understanding the practice of insurers paying differential amounts for different medical item numbers, particularly for extras insurance. For example, when going to the dentist consumers don't differentiate between each of the steps or actions taken by their dentist which are then charged as separate items. Despite this, insurers are in the practice of limiting the amount they will rebate per item in each year, not the overall amount paid for a dental service. As above, while CHF does not necessarily disagree with this practice we feel that insurers are not adequately explaining how and why the rebates paid are limited per item. Both insurers and practitioners could work to change this practice by equipping consumers with tools to better understand the range of items included in a consultation or service and how they are differentially charged. This would empower consumers to get better value from their insurance and to better be able to compare insurance policies when they wish to change insurance coverage.

Time consuming

When consumers do compare policies and attempt to switch, they find this very time consuming. This is particularly true for extras policies, to which insurers frequently apply a range of specific sub limits. Respondents generated an ideal comparator site wish list, which they would like to be able to use to compare policies to each other. The items on this wish list included:

- A tool that allows them to compare the rebate they will receive for specific conditions or consultations.
- To be able to search for health funds and policies which cover specific health needs. Current comparator websites rank policies based on the number or range of policies they cover, not the specific conditions or issues they cover
- An explanation of government imposed rebates or extra costs, such as the lifetime health cover levy, and an ability to see how these apply to the premium they will pay
- A website or tool that doesn't follow up with unwanted phone calls or emails. The practices of comparator websites, such as iselect which follow up consumers with calls or emails were mentioned as being frustrating and annoying to consumers

The Ombudsman's guide to private cover

Richard Glenn, Acting Commonwealth and Private Health Insurance Ombudsman

Australian consumers are faced with many choices when selecting a health insurance policy. With over 180 hospital and over 110 general treatment (extras) policies available for a single person in Victoria, and similar figures in other states and territories, consumers often contact our office seeking more information so they can make an informed choice[1].

Private health insurance is optional and all people have different needs, so no single solution can apply to every consumer. What our office encourages is that consumers should make themselves informed of the various factors that may impact on their decision to purchase, change, or cancel their insurance.

Why should consumers choose private health insurance?

Although there isn't any one reason why every Australian must or should take out private health insurance, these are common factors that most people take into consideration when making their decision:

Access to private hospitals and choice of doctor – Treatment as a public patient is free of charge under Medicare. However, the most urgent treatments and emergencies are prioritised over less urgent or elective procedures. Private hospital insurance allows consumers to avoid public hospital waiting lists and book into private hospitals, with a doctor of their choice.

Cover for services not covered by Medicare – The public system covers services such as medical consultations and prescription medicines covered under the Pharmaceutical Benefits Scheme. For items that are not included on the public system, such as dental care, optical items, physiotherapy, non-PBS pharmaceuticals, podiatry and other ancillary services, consumers can purchase general treatment insurance. In some states and territories, ambulance cover is also available.

Government surcharges and incentives – The Government's three major surcharges and incentive schemes are often significant factors for consumers when deciding whether to join or stay in private health insurance:

- *Medicare Levy Surcharge*: If a person's income exceeds the Surcharge threshold ($90,000 for individuals or $180,000 for couples/families in 2016-17) and they do not hold an appropriate level of hospital cover, they are liable to pay the Surcharge of between 1 to 1.5% in income tax.
- *Lifetime Health Cover*: Private hospital insurance premiums remain cheaper if purchased by the 1 July following one's 31st birthday. If this deadline is missed, the cost of joining hospital cover increases for each further year one is without hospital insurance. (Some exemptions may also apply for new migrants, Australians returning from overseas and former Australian Defence Force members.)
- *Government Rebate*: Most Australians with private health insurance receive a rebate from the Australian Government to help cover the cost of their premiums. The rebate is age- and income-tested. Currently, anyone who is registered with Medicare and earning under $140,001 as a single or $280,001 as a couple in 2016-17 is eligible for a rebate.

Selecting a Policy

These are the questions we encourage every consumer to ask when they are selecting a policy:

What's covered on my hospital policy?

Generally the cheapest policies cover fewer services. Consumers should check the service exclusions and restrictions carefully – it's important to weigh up the potential risk of not being covered for certain services against the savings in premium. The Ombudsman suggests that consumers should consider taking out the highest level of hospital cover they can afford, and choosing a higher excess to reduce the premiums rather than electing to have restrictions or exclusions.

What's covered on my general treatment policy?

Consumers should consider how much they are likely to claim in benefits each year. Some policies may include higher benefits or limits, but also require a higher premium and include a wider range of items, some of which may not be required.

How long do I have to wait before I am covered?

Waiting periods apply whenever commencing or upgrading a hospital policy: 12 months for pre-existing conditions and obstetrics (pregnancy), and 2 months for psychiatric treatment, palliative care and rehabilitation.

For general treatment, waiting periods vary from 2 months for items such as general dental and physiotherapy, and up to 12 to 24 months or more for major dental and health appliances.

If transferring from one policy or health fund to another, consumers won't have to re-serve hospital waiting periods again provided there is no gap in cover. Most health funds apply similar rules for general treatment. (Waiting periods still apply for any additional benefits for which they weren't previously covered.)

Are my local hospitals and providers recognised by the health fund?

Most health funds have a wide range of 'agreement hospitals', but it's important to confirm if a fund has agreements with one's local private hospitals, as consumers incur extra expenses if they are admitted to a non-agreement hospital. For general treatment services, health providers need to be registered with the fund for benefits to be paid.

Maintaining and reviewing a health insurance policy

Many people have a 'set and forget' attitude to their health insurance. When they need to make a claim, they may find their policy doesn't provide the cover they expected. To prevent these issues, these are the Ombudsman's tips to consumers:

- **Check your policy documents** after purchase or after making a change – If there has been an error or you have changed your mind, raise this with your fund within the 30 day cooling off period so it can be corrected.
- **Review your cover regularly** – Your health fund is required to send you a Standard Information Statement (SIS) every year. Think about whether your policy continues to meet your needs.
- **Stay informed about your cover** – Read all the information sent by your fund. Important information, such as changes or reductions to benefits, will be sent in a personalised letter.
- **Confirm your benefits** – Contact your fund, doctor and hospital before hospitalisation to check your cover and what expenses you may need to pay yourself. For general treatment benefits, ask your fund and provider for a quote before treatment commences.
- **Keep your policy up to date** – Tell your fund if you change address, add a partner, have a child, or any other circumstance which might affect your cover. Always check your payments and direct debits to ensure your premiums are up to date.

Health insurance complaints and advice

If problems arise that consumers can't resolve directly with their health fund or provider, our office is available to handle complaints. Complaints can be about private health funds, brokers, hospitals, doctors, dentists and other practitioners, as long as it relates to private health insurance. Complaints can be submitted at Ombudsman.gov.au or on 1300 362 072.

For general information and advice, the Ombudsman's websites Ombudsman.gov.au and Privatehealth.gov.au provide a range of information, tools, and factsheets about private health insurance.

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[1] Figure based on Privatehealth.gov.au figures in February 2017 for a single person in Victoria; this figure eliminated closed policies and policies from restricted funds and corporate policies, but includes different excess levels & co-payments.

Private Health Insurance: a conundrum for people with chronic illnesses

Christine Walker: CEO of the Chronic Illness Alliance Australia

Jason* is in his 40s and has multiple sclerosis. He has always had private health insurance (PHI) and was relieved he kept it up, following his diagnosis. His wife is working and consequently he receives only a part disability support pension. Their total income is less than half of what it would be had he been able to keep up his employment. They have two adolescent children engaged in the usual activities that come with that age: sports, social events and after-hours school activities. Jason considers private health insurance is really important for all the family. Jason pays $5000 a year in premiums. Making the regular payments means juggling money to pay other bills and going without some items.

Beatrice* (55) had a colonoscopy and bowel cancer was detected. She is to have surgery and possibly follow up radiotherapy. She knows she will be off work for at least six weeks and maybe longer. She is relieved she has plenty of sick-leave. Her husband is relieved that they took out PHI when the PHI rebate first came in. Now they can use it to access a high quality hospital with good private rooms and have the surgeon of their choice. A neighbor suggested that care in a public hospital might be as good and the surgery safer, but he thinks that in this situation it is too urgent to wait, and only 'the best will do for Bea'.

Mary* (73) is a widow and has a musculoskeletal condition, Type 2 diabetes and epilepsy. She has basic PHI which she keeps 'just in case'. She has recently had several visits to the local hospital ED and was admitted once after a seizure, as a public patient. She is on a Centrelink pension and worries that one day older people like herself will have trouble accessing public hospitals or the government might introduce copayments.

Ralph* (67) has retired and has a generous pension and is financially 'savvy' so takes advantage of the PHI rebate. He has PHI at the highest level and being well off considers that he should maintain it to leave public hospitals for those who really need them. He sees a specialist cardiologist privately and does not like the gap he has to meet.

These scenarios are all quite common to people with chronic illnesses with PHI. They represent the motivations for taking out and maintaining PHI. Much of the motivation relates to uncertainty generated by both health policy changes and fiscal changes. In some instances they are related to misperceptions of the public health system. Mary has heard stories about how older people are clogging up the hospital system. Anxiety about his family's future and not being taken care of by the health system underlies Jason's rationale for maintaining PHI, even though he does not use it for his own MS care. In Beatrice's case there is also the perception that private care is better quality than public care and that it will optimise her chances of recovery. Ralph's motives are both altruistic and related to maintaining his financial independence. However, not using the public system does not necessarily make it more accessible to less well-off people.

We can see that uncertainly created by health policy becomes a nexus with individuals' values, health-related anxiety, the future of their families and their incomes. This is further exploited by promotions to encourage people to 'save' money by taking advantage of the PHI rebate. For many, investment in PHI over many years suggests it would be foolish to abandon it. In some instances it might be said that continuing to hold PHI in the face of burgeoning out-of-pocket costs simply adds to people's anxieties.

However, these actions don't always provide people with chronic illnesses with any great advantages. As we can see from the scenarios some people don't use their PHI because of the gap payments. Many people with chronic illnesses access public hospital outpatients departments for the coordinated specialist care they require from specialist teams, such as physiotherapy, rehab and social work: it provides them with a 'one-stop' shop and they learn fairly quickly that declaring their PHI status might create more expense. At the same time using one's PHI to reduce pressure on the public system does not actually work as hospital usage has continued to rise in both sectors: with private hospitals providing care for people unwilling to wait, wanting elective surgery or short-term acute care and public hospitals being accessed by those with chronic illnesses, complex conditions and requiring critical and emergency care. Some of these people (but not all) will have PHI but may not use it in public hospitals.

Instead of reducing pressure on the public system the effect is to produce greater inequality in the health system.

The perception that private hospital care is better quality is rarely held by people with serious or rare chronic illnesses. Many do not have the means to access services privately (such as people with epilepsy whose incomes are substantially below poverty levels); while for others the standards of care in public hospitals are world standard, as for example with haemophilia and cystic fibrosis. For those people with chronic illnesses who have the means to hold PHI there are some benefits, for example some insurers can offer telephone coaching to assist with self-management and dealing with depression, while others offer limited access to dental services. Some services offered by PHI are innovative and directed at preventive care. These might be considered by the government for purchase to provide to all Australians.

Conclusion

The benefits of PHI are limited for people with chronic illnesses, who often have low incomes and face out-of-pocket costs. At the time of writing, premiums have just risen by nearly 5 per cent leading many people to forecast they will drop PHI entirely. This suggests that the investment by Government into the rebate will become largely wasted. It also suggests that those people still well and on reasonable incomes will have to forego any preventive health programs.

**These names have been changed for the purposes of anonymity.*

Private health insurance: what's in it for people with chronic conditions?

Lesley Brydon: Chief Executive Officer of Pain Australia

he rise in private health insurance premiums from 1 April will put more pressure on people with chronic conditions prompting us to ask—does private health insurance offer value to this cash-strapped segment of the market, or does the cost outweigh the benefit? And do insurers adequately cover the services that someone with a chronic condition — often more than one — really needs?

The financial pressures are already severe for most people with chronic conditions. They are often forced into early retirement (40 percent of forced retirements are due to back problems and arthritis) and subsequently experience a significant reduction in income.

In other cases, they work reduced hours, or may be excluded from the workforce altogether. While some may be eligible for a Disability Support Pension, others are supported by a spouse or partner, or with savings accumulated over their working life. Living in fear of the alternative, many pay a premium price for their illness in more ways than one.

Our hospitals and broader health system are facing a crisis. The recent Australian Medical Association Public Hospital Report Card shows the national median wait time for elective surgery has increased over the past decade, from 27 days in 2001-02 to 35 days in 2014-15. This does not include the wait time between referral and getting an appointment with the specialist.

This situation is a key motivator. People with chronic conditions requiring surgery find reassurance in private health cover to help with the cost of specialised medical procedures with a known provider and hospital stays on-demand. In a recent Painaustralia survey, one consumer said her nerve stimulation device, at a total cost of $150,000, left her out-of-pocket just $15,000 thanks to rebates.

Unfortunately this is where the good news ends. Most respondents to our survey observed that while private health insurance is largely focused on medical or surgical interventions, best-practice treatment of chronic conditions has moved on.

We now understand that the biggest benefit to health and wellbeing, and the greatest improvement in function, is achieved through multi-modal assessment and treatment and sustained by ongoing supported self-management strategies including diet, exercise and stress management. Group and peer support programs are also valued ways to empower consumers to self-manage their chronic conditions.

For chronic pain conditions, which affect one in five and one in three over the age of 65, medication is not effective. While surgery has a role in the more advanced stages of conditions like osteoarthritis, a multidisciplinary approach, using a range of therapies from mainstream as well as complementary medicine, is most helpful to a majority of people.

So there is a real gap between evidence-based best-practice treatment and what consumers can actually access. Despite paying their dues, people with chronic conditions still cannot afford to see an allied health professional on a regular basis because of inadequate rebates.

One consumer told Painaustralia that even on the top level of cover, she is paying $20,000 a year in out-of-pocket costs (excluding surgeries) because rebates for extras and allied health are hopelessly inadequate.

Others say there are very few pain management services offered through their insurer, and Medicare does not fund pain management programs, although they are available for those with work-related inssues through Workcover.

Health practitioners responding to our survey agree. Most report their clients reach their yearly allocation for allied health care within the first four to six months, despite needing treatments long-term.

There is an overall view that rebates for allied health or alternative therapies are provided without matching the needs of the consumer with the skills of the practitioner.

Someone with chronic musculoskeletal pain, for example, will benefit most from a therapist trained in pain management who is able to educate and support the patient with self-management strategies, not simply provide hands-on therapy.

There was concern that people with chronic pain who have private insurance are more likely to see multiple specialist providers and have more unnecessary investigations or invasive procedures than those in the public system.

It was suggested that funds might consider limiting rebates to services provided by practitioners with advanced qualifications or accreditation in pain management.

Painaustralia is a strong advocate for more programs like the Osteoarthritis Management Program at Hunters Hill Private Hospital — which can be accessed by eligible patients with private health insurance at no cost to the patient — and the Healthy Weight for Life™ knee osteoarthritis program—an innovative program delivered to patients anywhere in Australia with private health insurance.

These evidence-based management programs present a cost-effective way of staving off disability, expensive surgery and associated costs to the hospital system; they might also be adapted to address the massive public health issues posed by conditions such as chronic pain and obesity.

Fear of the unknown compels people with chronic conditions to pay up big for insurance for surgical procedures and hospital stays, even when they can’t really afford it, with many too frightened and uncertain to make any drastic changes, or even properly investigate the alternatives. (The CHF has released a tool to help people choose the right cover for them, it’s worth a look: chf.org.au/healthy-cover)

There are so many exclusions and poorly considered rebates which overlook the value of prevention and allied health services that the costs often far outweigh the benefits of the tax rebate.

For those in retirement of course, the rebate is meaningless.

Clearly any mass exodus from private health insurance could tip an overworked public health system over the edge. If we really want consumer-centred health care and a healthy society, we need private health insurers to offer policy options with rebates that align with best-practice health prevention and management strategies. Anything less doesn't make sense, for the individual, the community or for the long-term viability of the private health insurance industry.

Private health insurance – is it delivering good value?

Ainslie Cahill, CEO of Arthritis Australia

Private health insurance is an important pillar of Australia's health system, but increasingly there is doubt about whether it delivers good value for consumers, or even whether it meets their needs.

Premium rises continue to outpace inflation and with many policies now costing thousands of dollars a year, health insurance is becoming less and less affordable. Yet while PHI premiums continue their steep rise, the benefits of health insurance for consumers are reducing.

In particular protection against high out-of-pocket health costs is by no means assured.

Rising premiums, together with government policies to support the uptake of private health insurance have seen a proliferation of lower cost policies offering reduced cover. 'Junk' policies, policies that provide cover only for services in public hospitals and policies with exclusions and excesses are now common. Unfortunately they mean that people may not be covered at all for procedures they may require, or the benefits they receive fall well short of expenses and expectations. Thirty percent of policies now have important exclusions such as joint replacements or cardiac treatment.

The complexity of the private health insurance market, where thousands of products are available offering various combinations of benefits, exclusions, excesses and preferred provider arrangements, can make it hard for consumers to find the right cover for their needs, especially when their future health needs are unknown. Too often, people don't know if a policy is good value for money until they try to use it.

Then there is the increasing gap between the scheduled Medicare fee and the fees actually charged by providers, which private health insurance is unable to cover. Often the extent of the out-of-pocket costs is unknown or difficult to determine, as you need to contact your insurer, the hospital and the various health care practitioners involved in your care to find out. Preferred provider arrangements may mitigate this risk to some extent by providing no gap or

known gap services, but this is reliant on your provider of choice having an agreement with your insurance fund.

Too many people with arthritis who have joint replacement surgery in the private system report that despite Medicare and private health insurance they face thousands of dollars in out-of-pocket costs for their procedure.

Finally for people living with chronic conditions like arthritis, private health insurance does little to help with the high and ongoing costs of managing their condition such as medications or the cost of specialist appointments outside of hospital. Caps and limits on the benefits paid for allied health services also limit the utility of ancillary cover for accessing multidisciplinary care in the private sector. This issue is keenly felt by people with arthritis, where most care is provided in the private sector.

On the other hand, private health insurance does offer consumers timely access to elective surgery. For people with arthritis needing expensive joint replacement surgery, who face long waiting times in the public sector, this is a significant benefit. The median waiting time for these procedures in the public system is 196 days, but in some states waiting times are close to a year. In the private sector, joint replacements can often be done within a couple of weeks. While this is a major benefit at an individual level, at the health system level it raises major questions about the equity of a system which allows those who can afford it to jump the queue and receive services ahead of those who cannot afford to pay, but may have greater need.

If premiums continue to rise at recent rates, we will soon come to a tipping point where more and more people abandon private health insurance. This will increase pressure on the public system and amplify the inequity between those who can afford to pay for private care and those who cannot.

What is needed is an overhaul of private health insurance arrangements in Australia, both at the industry and the government policy level.

In particular, the government's private health insurance rebate, which is evidently not achieving its objective of making health insurance more affordable, needs to be urgently reviewed.

Other measures that should be implemented are those which will:

- Support the provision of clearer, more easily understood information about private health insurance policies, to make it easier for consumers to understand what is and is not covered by their policy and to compare products to find one that best suits their needs.
- Improve transparency and access to information about provider fees for health services, including out-of-pocket costs.
- Develop standardised packages of health cover designed to meet the needs of different types of consumers. This should include packages for people with chronic conditions that support team care arrangements and provide improved benefits for medications, specialist care and allied health.

- Improving management of people with chronic conditions in the community will reduce costs for insurers by reducing demand for expensive hospital procedures such as joint replacements.
- Limit the health insurance rebate to only those policies which provide reasonable value and which support evidence based interventions. The government would not support certain unproven natural therapies through Medicare, so why should it subsidise them through its private health insurance rebate?
- Reform prostheses pricing arrangements to reduce the costs of prostheses in the private sector, which are substantially higher than prices paid in the public sector. Consumers deserve a health system which delivers equitable, accessible and affordable health care. It is time for the role and operation of private health insurance to be reviewed to ensure it is helping, not hindering the achievement of this goal.

How to counter the walled garden of health insurance

Matt Levey, Director of Content, Campaigns and Communications at CHOCIE

Private health insurance has become a perfect storm for Australian consumers. Premiums have increased an average of 54.6 per cent since 2009, well ahead of CPI. According to CHOICE's national Consumer Pulse survey, it is the hardest market for people to find the product that best suits them. This toxic combination of surging prices and complexity is leading many Australians to downgrade or drop their cover completely.

Health insurance is also a sector where everything is connected to everything else. Like a magician pulling endless handkerchiefs from a hat, issues around premium increases quickly lead to questions around strained hospital funding, growing out-of-pocket costs for patients, remuneration for healthcare professionals, and inevitably, tensions around the role of private provision of healthcare.

Value for money… for who?

It is worth reminding ourselves of the first principle – how do we provide the community with equitable access to quality healthcare? Recognising that every Australian already has health cover through Medicare, we require those on higher incomes to contribute more.

As a result, Private Health Insurance is a very strange market; one where some customers are grudgingly pushed into products they don't want let alone understand, subsidised by the entire community through rebates.

Insurance providers regularly point out the amount of regulation that constrains their industry. But when demand for your product is guaranteed through a combination of legislated carrots and sticks, it is fair to ask what the community should expect in return.

CHOICE thinks at the very least, the community should expect products that increase equitable access to quality healthcare, in theory by reducing pressure on the public healthcare system. A good start would be removing subsidies for 'junk' insurance. We define these as:

- Private hospital policies that only provide cover for a very small number of procedures such as accidents, wisdom teeth removal, appendix surgery, knee investigations and reconstructions.
- Private hospital cover for accident and ambulance only.
- Public hospital policies that only provide cover in a public hospital – while you can choose your own doctor you'll have to join public hospital waiting lists.

If a hospital insurance policy does nothing more than provide accident coverage (in which case you'd be taken to the closest emergency department), covers a small handful of procedures, or simply your choice of doctor in a public hospital, then it fails the community value test.

One response to claims of 'junk insurance' is to say we need fit, healthy Australians to buy health insurance they won't use to subsidise those with higher risk profiles. To some extent, this is the reality of the community rating principle and the risk equalisation that supports it.

But there is a difference between selling people policies they are unlikely to use (this is how insurance works) and cover that they simply can't use without entering the public system (this is 'junk'). There must be a more efficient and direct way to support risk equalisation than spending millions subsidising and marketing health insurance policies that are little more than tax breaks undermining perceptions of value.

CHOICE supports calls from Consumers Health Forum that only value-for-money policies should be eligible for the rebate. The same criteria should be considered for policies that exempt consumers from the Medicare Levy Surcharge. The aim should be structural reform that simplifies policies, and gives both consumers and the community genuine value.

Do I need health insurance?

In January this year, CHOICE launched a new online tool, 'Do I need health insurance'? In a market dominated by insurers and commercial comparison sites, all with a vested interest in selling insurance no matter what, we're aiming to fill an information gap. So far over 50,000 Australians have used our tool to navigate their options.

Much more should be done to improve information for Australians considering taking up or changing health insurance.

This does not necessarily mean more information, but instead redesigning mandatory requirements through consumer-led testing. For example:

- Most people will not read or understand a lengthy list of detailed exclusions from a policy before they buy it – but they might pay attention to a single sentence saying a policy covers less than 1 per cent of treatments in a hospital.
- It should be much easier to find exactly what procedures are covered under a policy, accessible when it's needed, and comparable to other policies.

- Let's test providing premium statements that highlight the amount a policy has increased in dollar and percentage terms, how much cheaper or more expensive it is than comparable policies, with a link to shop around for a better deal in a comprehensive, unbiased comparison.

We must maintain a baseline of standardised, comparable information about policies, provided regularly to all customers. Some people will read this information. Many will ignore it, just as they do in other markets. But increasingly the real potential of standardised product information is in the third parties who can provide it to consumers in more personalised ways.

Current commercial comparison sites are not transparent or comprehensive. Many use their websites as funnels into call centres, where 'comparison' gives way to sales. Government-run alternatives often suffer from a poor user experience and negligible marketing budgets. It's not as if the government is in the business of giving away meerkat dolls.

But in a digital world, this is an argument for making comparison better, rather than leaving consumers stuck in walled gardens of their own providers. Giving people easy and trusted access to their own data – for example, how they used their existing extras cover over the last year, pre-loaded into the comparison tool of their choice – could make genuine inroads into complexity.

This is one small part of a bigger picture. The most perfect information in the world won't necessarily make health insurance any more affordable, especially when it's tied to so many cost drivers in the wider healthcare system. But if we are going to insist that health insurers play the role of privatised tax collectors, then we at least need to make sure the community benefits, and that consumers benefit from products they can understand and use confidently.

Health insurance and psychiatry – covered or not?

Janne McMahon OAM – Chair and Chief Executive Officer of the Private Mental Health Consumer Carer Network (Australia) Ltd.

In these increasingly difficult financial times, more Australians with private health insurance are questioning whether to stay or leave as the premiums increase annually with questions such as 'is it worth the cost?', 'would I be better off in the public health system?' or 'am I getting the benefits?'.

My organisation, the Private Mental Health Consumer Carer Network (Australia) (hereafter Network) represents Australians who have private health insurance and who receive their treatment and care from private hospital settings for their mental illnesses so we believe we are in a good position to speak about health insurance and psychiatry.

In order to understand the extent of the private psychiatric hospital sector to which this article relates, it is important to provide some basic statistics. There are:

- 68 private hospitals providing specialist psychiatric care
- 3,200 beds
- 36,000 people accessing these services every year

Private hospitals treat patients with the full range of psychiatric conditions: depression and affective disorders, psychotic disorders, PTSD, anxiety disorders, alcohol and substance abuse, eating disorders and personality disorders.

The Network is very concerned as to what we understand are the increasingly discriminatory practices by health funds to psychiatry cover which affects people now and in the longer term. In our opinion, it would seem that the larger companies are intent on removing psychiatry cover from their products. This is an appalling position given that the statistics above show that this affects 36,000 Australians. We know this would not happen in illnesses such as cancer, cardiology, orthopaedics etc.

We are also concerned about the possible categorisation of health fund policies into Gold, Silver or Bronze with psychiatric cover being flagged for inclusion in only the Gold or highest level of cover. If this becomes the adopted Government policy, it will remove the mandatory cover as currently exists under legislation and dramatically reduce patient access to vital psychiatric services.

Current regulations ensure that health funds are obliged to pay at least a minimum level of benefits for mental health services. Even though restricted cover for psychiatry can leave consumers with an out-of-pocket cost, the assurance that some level of cover will be provided and that consumers can switch cover with a waiting period of only 2 months means that consumers with private health insurance are able to access timely care.

Many people with mental illness have limited funds, for example those on Disability Support Pensions. They go without in order to pay their health fund premiums to ensure timely access to private psychiatric hospitals. For some people it comes as a surprise to learn that their fund does not fully cover psychiatric admission. This then necessitates referral to the public system or face a large gap payment. So any alternative funding model to cover private patients in public hospitals as might be the case with other specialities, could be very problematic for people with mental illness given the already overstretched public mental health system.

Health funds limit the level of benefits provided in numerous ways, some of which are of serious concern.

Some health funds are declining to recognise and fund evidence-based programs such as day programs and hospital outreach programs that provide the interventions necessary to avoid more expensive overnight care.

Current re-insurance arrangements for private health insurance mean that there is a disincentive for health funds to fund innovative community care modalities. This gap in current government policy translates into services not being available for the privately insured patient. Innovative programs could ensure continuity of care and provide an essential adjunct to reliance on inpatient and psychiatrist led services particularly for those patients already in therapeutic relationships.

When consumers are referred for admission to a private psychiatric hospital it is not uncommon for them to find that they are not fully covered because their fund does not

contract with the hospital in question or because the insurer has declined to recognise a particular program. Health funds often restrict the amount of cover provided in some policies by:

- Limiting the number of days a person can access day programs in a year
- Only covering a limited number of ECT treatments per year, usually 10 treatments.
- Imposing a benefit limitation period so that a consumer is forced to wait longer than the statutory two month waiting period.

Other issues for health fund members requiring access to private psychiatric hospital services include:

- Many consumers have difficulty in accessing accurate and complete information about their policies.
- For some people who have private health insurance it comes as a surprise to learn that their insurance does not cover psychiatric admission. This then necessitates referral to the public system (if available), or acceptance of a large gap payment.
- Health funds cover day admission programs however there is confusion by consumers as to what kind of day programs and the number of sessions covered under their policies.
- Consumers have limited ability to compare policies particularly as they pertain to psychiatric care.

There is a clear need for better information and communication by health funds to consumers about whether they are covered for psychiatric care and the extent of inclusions and exclusions on their policies. It would seem that there is insufficient transparency and consistency regarding the features of health fund policies for psychiatric care to enable consumer to make informed decisions.

We are also aware that the Private Health Insurance Ombudsman pays particular regard to correct and prudent information. We regularly refer our members to the Government's website of: www.privatehealth.gov.au which provides good, independent information about health insurer policies.

So in terms of health insurance cover for psychiatry, there are lots of things to be wary of. Make sure you know what your policy covers, the extent of your cover, what are your exclusions, excesses and any other issues which might affect you if you need private psychiatric hospital services for your mental illness or disorder.

Private Mental Health Consumer Carer Network (Australia) Ltd is at www.pmhccn.com.au

Older consumers and the private health insurance dilemma

Susan McGrath, National Policy Manager for COTA Australia

Maintaining private health cover in later life, on a fixed income, can be a costly proposition. Yet at 30 June 2015 52 per cent of people over the age of 65 had private health insurance (PHI)

compared with 56 per cent of the population overall, even though we have Medicare; a universal health care system. How is this explained?

In 2011 research by the National Senior's Productive Ageing Centre showed the main reasons older people gave for maintaining PHI were:

- security or protection or peace of mind (those over 50 were twice as likely to list this as those under 50);
- choice of doctor;
- treatment as a private patient;
- and/or skipping the public hospital waiting list.

The same research also found that the main reason for people over 50 not purchasing health insurance was affordability. This barrier has compounded over time by a rise in premium rates well above the CPI growth.

These findings tallied with what we at COTA have heard from members and the older general public over time. Nonetheless we tested these propositions again recently by asking our members to give us their views on PHI, prompting them with a few questions around value for money, motivations for having/not having PHI, and scope of PHI.

Most of the members from whom we heard had some level of PHI. However, many questioned its value given the high cost of premiums compared to the benefits received in return. Out-of-pocket expenses were a great concern. A number of members reported very good experiences using the public hospital system, leading them to further question the value of PHI.

Despite this, most members maintained their PHI coverage to avoid lengthy waiting lists in the public health system and to have the doctor of their choice. Some of the longest waiting lists apply to procedures that are most relevant to older people, such as joint replacements.

The jury remained out on the issue of Extras cover. It was valued by some of our respondents as it allowed them to maintain optimal health by providing access to a range of allied health services, particularly optical and dental care. Others felt that Extras cover was of little value.

The cost of PHI and the rate of premium increases was the most commonly expressed concern, particularly for those who are reliant on the Age Pension. Many were concerned they may not be able to afford PHI in the future given the premium increases, especially if there is a reduction in the PHI Rebate. While some members noted that using PHI preferred providers increased the benefits paid, the preferred provider was not necessarily the provider of the member's choice.

The challenge of shopping around for PHI was also highlighted as it is increasingly complex and difficult to compare the benefits of products offered. One member highlighted the importance of considering subtle differences in benefits, for example coverage for 'ambulance in emergencies only' does not include a range of situations for older people where an ambulance may be needed but is not considered an emergency.

This recent consumer input has further strengthened COTA's PHI advocacy stance on the key issues of affordability, value for money and consumer information.

At a broader political level, COTA is also often involved in the policy debate about the role of government-supported PHI in a mixed public/private healthcare system. For example, there are a number of government 'carrots and sticks' in place to encourage Australians to take out and maintain PHI on a life-long basis. Those 'carrots and sticks' are expensive and their value is a contentious issue. In 2013 the Grattan Institute estimated that abolishing the government Private Health Insurance Rebate would save around $3 billion. COTA argues that this enormous public investment in PHI needs to deliver better health outcomes for the nation overall and for our constituency of older health consumers.

Like CHF, COTA participates in the Private Health Ministerial Advisory Committee, and is represented by COTA Australia Chief Executive, Ian Yates AM .

Private health insurance in rural and remote Australia

David Butt, CEO of the National Rural Health Alliance

There are 1.3 million people living in outer regional and remote communities in Australia who are cross-subsidising the cost of private health insurance for people in metropolitan and inner regional Australia.

These are the people who pay for private health insurance but get very little back for what they pay. But by adding to the private insurance pool they help keep down the cost of insurance for metropolitan Australia.

The remaining 1.5 million people living in outer regional and remote Australia don't bother.

Almost seven million people live outside Australia's major cities and just over 60 per cent of those seven million people live in the inner regional centres. The remaining 40 per cent live in outer regional and remote communities.

The people who live outside Australia's major cities generally experience poorer health outcomes than those living in the major cities.

They earn about 15 per cent less than those in major cities and generally die earlier too – and the further they live from a major city, the worse their health outcomes when they are ill.

Of those who live in Inner regional communities, 49.9 per cent do not have private health insurance, increasing to 52.3 per cent in outer regional and remote communities

And why should they when the most recent data for 2012-2013 from the Australian Institute of Health and Welfare shows that access to private hospitals outside the major cities is extremely limited, and approaching zero access once you reach outer regional communities[1]? Additionally, we know that access to allied health providers – whose services may be included under 'extras cover' – is also very poor.

With the latest private health insurance price rise on 1 April 2017, whether to continue holding private health insurance must be a question many residents of regional and remote communities are considering. Does private health insurance represent good value outside of major cities? Why should country people pay to keep down the cost of private health insurance for people in the cities?

In their 2005 "For debate" article in the Medical Journal of Australia, Lokuge, Denniss and Faunce presented evidence that led them to conclude that:

- The key barriers to take up of private health insurance in regional Australia (by which they mean Inner and Outer regional and Remote and Very remote locations) were affordability and choice;
- Regional Australia has lower levels of private health membership due to the limited availability of private inpatient facilities; and
- There are structural failures in private health insurance as a vehicle for federal health financing that disadvantage regional Australians[2].

Certainly between 2005 and the 2012-13 there has been little change in the access of people from rural and remote Australia to private hospital care. The Australian Institute of Health and Welfare published 2012-13 data on the number of private hospitals by location and hospital type and overwhelmingly, private hospitals are located in the major cities. That report found:

> "Use of private hospitals in 2012–13 was highest for those residing in major cities (175 separations per 1,000 persons) and lowest for those residing in Very remote areas (67 separations per 1,000 persons)."

In rural and remote Australia, consumers would need to consider two key issues when determining if private health insurance is right for them – cost and value. With regard to cost, people living in rural and remote Australia are often less well off than those in the city and also face higher costs of living. This makes buying additional extras much more difficult, and also makes decisions on how to direct any additional disposable income more difficult.

In terms of value, many people in rural and remote Australia do not see the value in private health insurance. The value of private health insurance comes from being able to access a 'private service' with choice of doctor. In rural and remote areas, private hospitals are generally not available unless people are prepared to travel often significant distances, which is disruptive both socially and economically. In addition, there is often little choice of doctor – in rural areas there may be only one or a limited number of doctors and as such the idea of choice is meaningless. Further, there is dubious value in extras cover – there may be few if any providers in the local area thus making the product not usable in many rural and remote communities.

The one area of potential value in private health insurance for rural and remote residents is in being able to be treated as a private patient in a public hospital (albeit choice of doctor can still be quite limited). In this context, recent suggestions to remove the entitlement to be treated as a private patient in a public hospital would result in even further disadvantage for people who are already disadvantaged in the private health insurance arena.

The Alliance has been involved with the Private Health Ministerial Advisory Committee and its work to improve the value of private health insurance in rural and remote Australia. It is important to note that feedback from rural and remote consumers, communities and the workforce that serves them is to focus on improving the value of the product rather than reducing the cost. This offers an opportunity to consider how to make private health insurance products more attractive to people living in rural and remote Australia.

To become a product that is attractive to a greater number of people living in regional and remote Australia, private health insurance needs to deliver improved access outside the major cities and inner regional locations to a greater range of services. This may mean looking at how to support greater access to:

- rehabilitation services;
- mental health facilities and support services;
- oral health;
- mixed sub-acute and non-acute services;
- prevention and early intervention; and
- travel and accommodation when a patient needs to relocate for treatment.

Supporting such access may mean developing different models of service delivery for private health services outside the major cities and introducing modified private health insurance products for people living in rural and remote Australia.

Without a drive to innovate in private health service delivery outside the major cities, we will see increasingly smaller levels of uptake of insurance. Should there be a failure to innovate, the ongoing funding of health services in regional and remote Australia will rely on Federal and State governments at increasing cost to address the ever widening level of disadvantage in access to health services and the impact of that disadvantage on health outcomes.

1 AIHW – Australian hospital statistics
2012–13 – Table 2.2
2 MJA – For Debate – Private Health Insurance and regional Australia

Changes urgently needed to address inflation and inefficiencies

Dr Rachel David, CEO of Private Healthcare Australia

Australia's mixed private – public health system is highly regarded by the Australian community. The private and public sectors are intrinsically interconnected and private health insurance is embedded in Australian culture. Repeated large surveys (IPSOS 2015-17) show over 80 per cent of Australians with private health insurance value the product and want to keep it.

Private health insurance is a critical element of Australia's health care system. PHI pays for close to two thirds of essential non-emergency surgery in Australia, 90 per cent of day admissions for mental health care and 50 per cent of all mental health admissions, 70 per

cent of joint replacements, 60 per cent of chemotherapy and 88 per cent of retinal procedures take place in the private health sector. In addition, under ancillary (extras) cover, health funds pay out more than $2.5 billion for dental care, more than the Federal Government and 90 per cent of dental health services provided to low and middle income earners are subsidised by health funds.

Our mixed public-private health system is well-regarded in terms of clinical outcomes. We enjoy the fourth highest life-expectancy in the world and are among the best in terms of other outcomes like infant mortality.

There is concern among Australians however around the issue of health system sustainability. In Australia 44 per cent of people believe the mixed public and private health system will not be around in 15 years, and 52 per cent of people are not confident the public hospital system will be around in its current form in 15 years. This unease is driven by the fact that inflation of health input costs has risen at a rate much higher than CPI over the last decade, which in turn increases pressure on premiums and therefore household budgets.

Australian health funds are committed to working with the Government to improve the sustainability and affordability of the private health sector and to continue to reduce upward pressure on premiums. Premiums increase due to inflation of input costs, including hospital accommodation, medical devices, medical specialist gaps and allied health costs. This year the Government announced an average premium increase of 4.84 per cent, the lowest increase in a decade, reflecting the commitment of the industry to delivering affordable healthcare. The sector has done this by passing savings from the Government's PHI reform process back to members, and by introducing efficiencies.

The premium increase is necessary to ensure health funds stay ahead of rising health costs and that fund members continue to get value for their investment. Funds paid a record $19 billion in benefits in 2015-16 which will increase to $20 billion in 2016-17. Of every dollar of premium income, 86.1c is returned to members as benefits, a rate which exceeds that paid by other insurance sectors.

More than 13.5 million Australians have private health insurance and almost half of them have an annual income of less than $50,000. They are hard-working Australians who value their private health cover and their right to choose when and where they have medical care. Of Australians with private health insurance, 84 per cent value the product, want to keep it and make considerable sacrifices to do so but are concerned about affordability. (IPSOS)

While Australians value their private health insurance, market research has repeatedly shown premium affordability is the main reason deterring people from taking out PHI, and premium increases are the main driver of dropouts and downgrades from existing levels of cover.

Private Healthcare Australia believes that policy change is urgently needed. Some of the regulatory measures that apply to the private health sector are no longer relevant and have inflated costs and decreased the efficiency and transparency of the sector. By eliminating waste in healthcare and revisiting outdated legislation that is reducing market transparency and competition, we can put downward pressure on premiums and consumer out-of-pocket costs.

While the sector understands the climate is not right for the introduction of sweeping or fundamental reform of Australia's health system, there is scope to address the sustainability of healthcare through sensible policy correction.

The PHI industry has identified practical and achievable policy adjustments that will ensure the sustainability of the Australian health system in to the future and has made a number of recommendations to Government ahead of the 2017-18 Federal Budget.

The value of the PHI rebate has been eroded in recent years as a result of regulatory changes aimed at controlling Government outlays. Not only is net expenditure on the rebate declining, if health inflation continues at the current rate, the value of the rebate as a percentage of the premium will be 16 per cent in a decade.

In the interests of affordability for low and middle income earners no further changes should be made to the rebate on PHI premiums for either hospital or 'extras'.

Currently the Government regulates the benefits health funds pay when an implantable medical device or 'prosthesis' is used in a procedure. The effect of benefit-fixing has meant that private health fund members now pay two to five times what public hospitals, and those in comparable economies pay for medical devices. This is reflected in premium increases. The Government made some progress but reform of prostheses list price-setting by the Commonwealth must progress rapidly in 2017-18.

Public hospital cost shifting or transferring the costs of incurred service to health funds in Australia is in the order of $1 billion dollars per annum. This accounts for about 6 per cent of premiums. PHI policyholders are subsidising the costs of public hospitals, despite having already contributed to these through their taxes. Public hospital cost-shifting to health funds adds more to premium costs than the average year's premium increase.

PHA supports the Government's MBS Review as every dollar of waste and every episode of inappropriate practice threatens the sustainability of private health.

The Federal Government should also review legislation preventing private health insurance from covering medical services that are provided out-of-hospital and covered by Medicare. This has the potential to reduce unnecessary hospitalisations for people needing minor procedures and those with chronic health conditions, a key factor in keeping premiums down.

Healthcare reform is not an easy undertaking and in the current political environment there will be pressures from stakeholders across the country. There will be winners and losers but the Government's PHI Reform process must deliver real change to improve the affordability and value of private health cover. There's no alternative.

Every Australian who pulls out of private health insurance will have to rely on the public hospital system and those who remain will have to pay higher premiums. If PHI levels fell to around pre-2000 levels, Australia would need at least 8 per cent more public hospital beds, plus more for population growth. (IPSOS)

Private health insurance takes the pressure off the public hospital system and ultimately benefits all Australians.

Private Healthcare Australia *is the Australian private health insurance industry's peak body, representing 19 registered health funds and collectively 96 per cent of people covered by private health insurance. These funds provide healthcare benefits for more than 12.8 million Australians.*

Driving better health outcomes and improved affordability: a consumer-empowered health system for the 21st Century

Matthew Koce, CEO of hirmaa

Australia has a unique health system that comprises a mix of public and private providers, which together deliver outstanding outcomes and value for money for patents across the country.

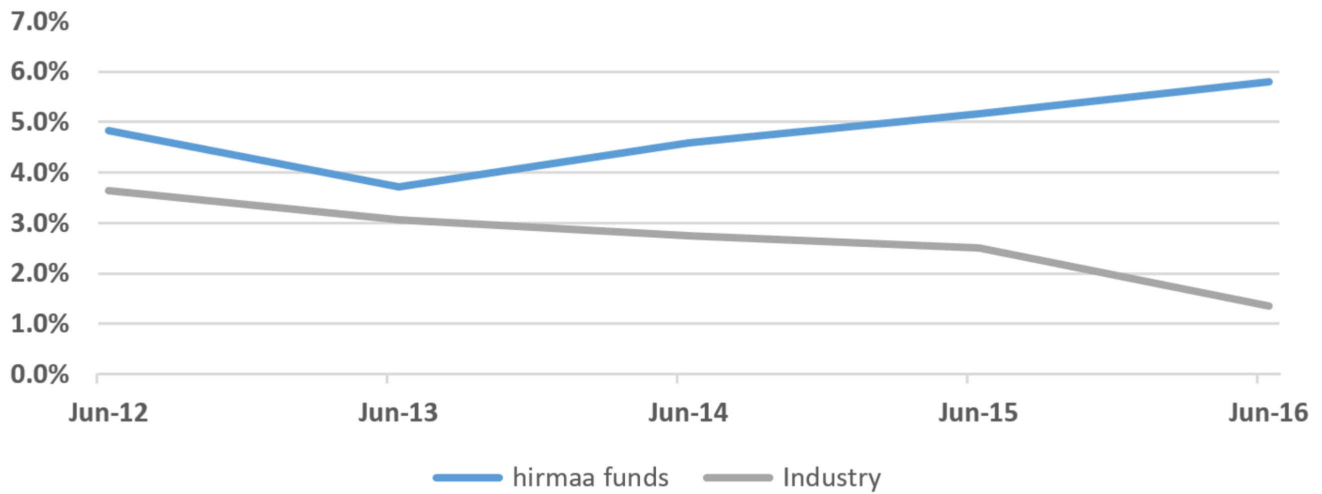
Private health insurance is a vital component of Australia's health mix and an important contributor to the country's health outcomes.

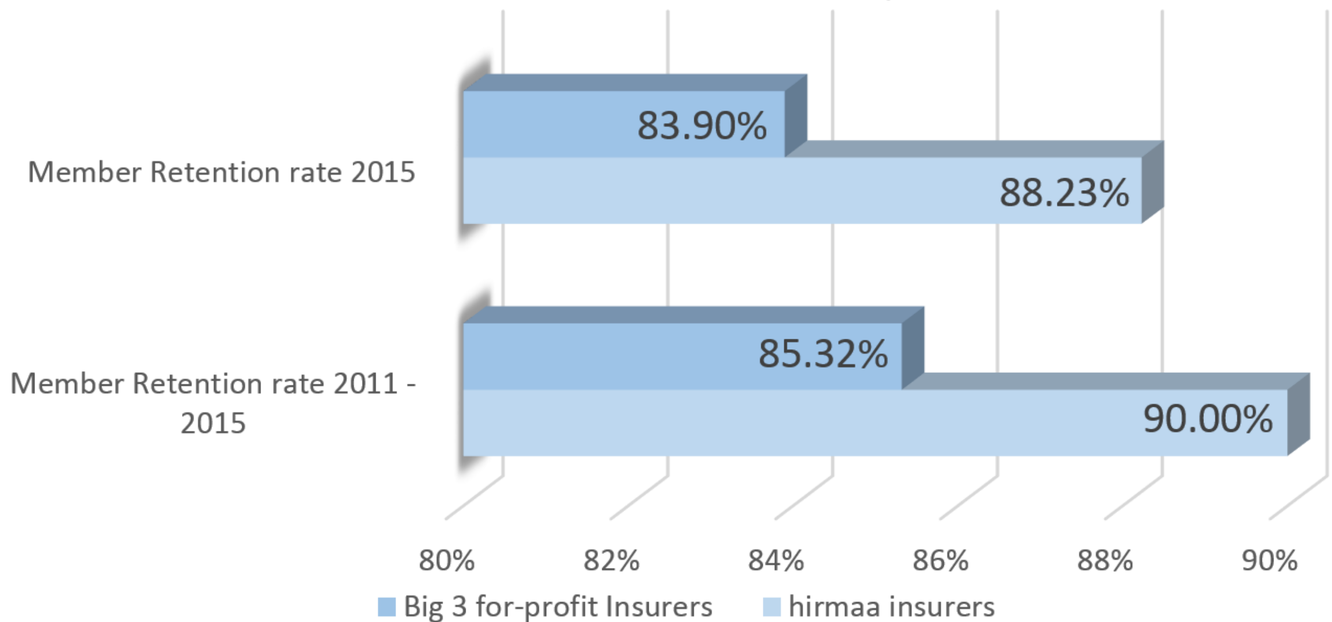
Health spending in Australia accounts for 10 per cent of GPD, which is slightly above the OECD median and delivers superior health outcomes, particularly in areas such as life expectancy.

Around 13.5 million Australians choose to have private health insurance, which provides immediate access to high quality care. In the 2015-16 financial year alone, insurers paid nearly $19billion in benefits to consumers. That is $19billion that would otherwise be picked up by taxpayers. Covering thousands of procedures, including two out of every three elective surgeries, a thriving private health sector is critical to keeping pressure off the already overstretched public hospital system, where waiting lists can run into the years.

There are currently 37 registered private health insurers across Australia ranging from the large ASX listed and overseas owned for-profits to the small regional not-for-profit and mutual funds. As the peak body for 21 not-for-profit, member owned and community based health insurers, hirmaa is keen to ensure the continuation of a diverse and competitive health insurance sector that offers real choice for consumers.

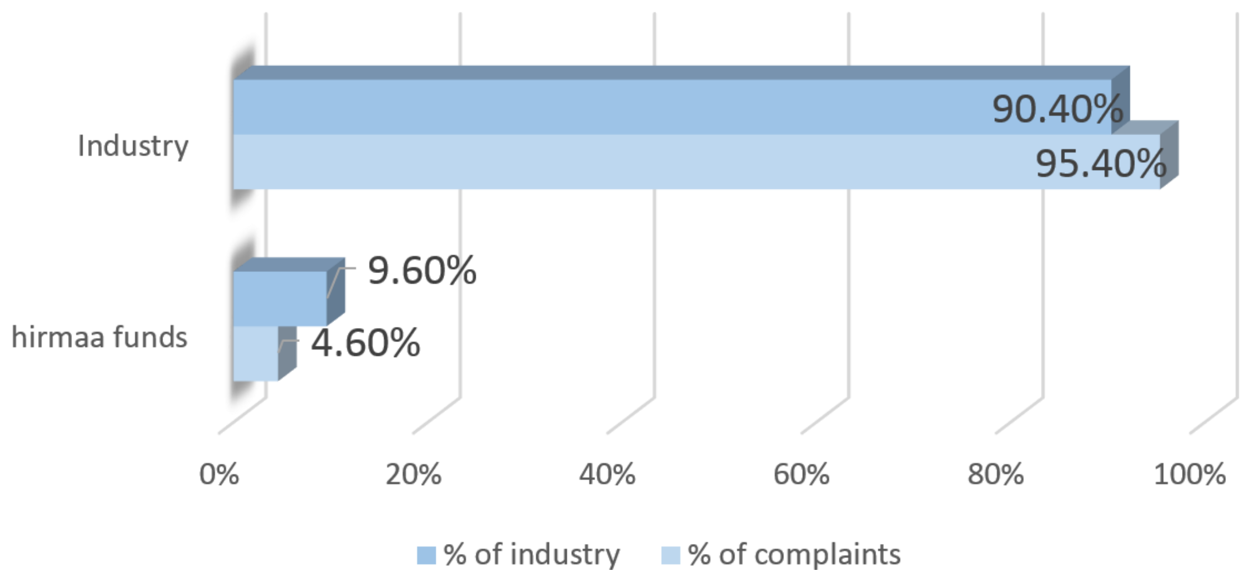
Existing solely to serve their membership, not shareholders, hirmaa funds are growing much faster than the industry average, enjoy significantly higher retention rates and return around 90 per cent of all premiums back to policyholders as benefits.





The consumer ethos and focus of hirmaa funds is reflected in the findings of independently conducted surveys and reports by the Private Health Insurance Ombudsman (PHIO). For eleven consecutive years, hirmaa funds have participated in an independently run annual customer satisfaction survey. The latest survey received responses from more than 21,800 policy-holders with a staggering 97 per cent of respondents registering that they are satisfied with their health fund membership. These surveys provide hirmaa funds with an important tool for continual improvement and benchmarking and provide a further demonstration of their ongoing long term commitment to meeting the changing needs and expectations of consumers.

The strong customer service performance of the hirmaa funds is also reflected in PHIO statistics, which show that while hirmaa member funds represented 9.6 per cent of the private health insurance market in 2016, they attracted only 4.6 per cent of annual complaints, well below their market share. To put this into further context, the 4,416 complaints received in total by the Private Health Insurance Ombudsman in 2016 represented just 0.03% of all those Australians with private health insurance.



While hirmaa funds continue to grow strongly and are valued by consumers, there is growing concern around the ongoing affordability of private health insurance.

The fact that health insurance premiums are growing faster than inflation is undeniable. Primarily driven by growth in chronic disease and escalating costs of treatment with the introduction of new technology, premiums and participation are further impacted by the declining health insurance rebate, which is falling by around 1 percent each year, and high cost of living pressures and low wages growth.

Consequently the percentage of Australians holding cover declined for the first time in 15 years during the December 2016 quarter. If this declining trend were to continue, it could have a severe impact on the public health system.

As passive entities in the health supply chain, who rightly stand outside the patient doctor relationship, health insurers have very little control over the cost of the medical services for which they are required to pay. As such, insurance premiums have followed the movement of health costs, which are increasing much faster than inflation.

If affordability pressure is to be relieved, consumers need to be empowered to make better informed choices across the entire health service supply chain.

Giving consumers access to the information they need to take a more active role in their own healthcare will result in greater competition and better outcomes, while also placing downward pressure on medical costs. It is absurd that while consumers can search for a hotel online through a trip advisor service, neither they nor their GP can search for a hospital or surgeon online, basing their selection on sound authoritative performance data.

Private health insurers are subjected to extensive transparency and accountability including publicly available and published data on complaints, premiums, benefits paid, management expenses, capital assets, member retention and policyholder growth. All of this information can be freely accessed by consumers, the media, consumer groups, comparators and industry bodies. This transparency provides a very comprehensive platform upon which consumers can select their health fund but this is as far as the publicly available transparency extends. It does not extend into the hospitals and medical specialists who are the real drivers of health inflation.

There is no justifiable reason why such a high level of transparency and accountability cannot be extended across the entire health system. Why should consumers and their general practitioners not have access to information on re-admission and complication rates and out of pocket costs associated with medical specialists and hospitals in the public and private systems?

The appalling failure by governments over many years to effectively regulate prostheses pricing provides an outstanding case study of why transparency and accountability are so central to a well-run health system.

Under existing arrangements, private health insurers are required to pay a minimum benefit for prostheses as set by the Government through the Prostheses List. These benefits are significantly higher that what is paid by public hospitals and can be up to 300 per cent more expensive than the prices charged in comparable overseas countries, such as France.

The effect of the prostheses list is such that the difference between what consumers paid for prostheses in private settings in 2013-14 versus what would have been the case if public sector rates had been used was approximately $720 million. hirmaa projects that this will increase to over $1 billion in 2018-19 based on current trends, representing an average additional cost of $181 to the holder of a hospital insurance policy.

A complete lack of transparency around prostheses has resulted in the payment of undisclosed and secretive rebates or kickbacks between some large private hospital networks and the large multinational prostheses companies with some prostheses companies describing Australia as so lucrative that is a 'Treasure Island' and that being on the Prostheses List is a licence to print money.

If we are serious about placing downwards pressure on premiums it is essential that the principles of transparency and accountability, which apply so heavily to health insurers, be applied across the entire health service provider chain including doctors and hospitals.

The member-centric ethos of hirmaa member funds will ensure that any savings achieved through improved efficiencies and performance within the health service provider chain are

returned to policy holders through reduced premiums, a fact that will be readily verifiable to the consumer, and the Federal Government, through existing publicly available disclosure provisions. Indeed, private health insurance premiums are subject to assessment by APRA and the Department of Health, and require the direct approval of the Minister for Health.

A sustainable and affordable private health system maximises choice and complements Australia's public health system. In order to ensure that the interests of the Australian consumer are best represented it is essential that consumer focused organisations such as the Consumer Health Forum and hirmaa work together through these complex issues.

Does it have to be this way?

Michael Roff, Chief Executive Officer of the Australian Private Hospitals Association

Few consumer products are as complicated and difficult for the purchaser to understand as a private health insurance policy.

With confusing and inconsistent medical terminology, complex rules, waiting periods, exclusions, restrictions, benefit limitations, excesses and co-payments – private health insurance policies seem designed to addle rather than assist. It's little wonder that consumers find it difficult to compare policies, adopting a set and forget mentality towards their insurance. But does it have to be this way?

One of the key issues is the growth in so-called "junk" policies, which exclude cover for a range of different services. Between 2007 and 2016, the proportion of health insurance policies with exclusions jumped from 7 per cent to almost 39 per cent. Health funds argue exclusions are a valid way for members to reduce their premiums as they don't have to pay to cover services they don't need.

There are several problems with this argument. Firstly, exclusionary products undermine community rating (the principle where all members pay the same premium regardless of age or health status). While the young and healthy might choose to exclude cardiac surgery or joint replacements, the elderly and infirm can't take that risk, so they are forced to take out a more expensive product – this is not how community rating is supposed to work.

However, the bigger problem is that very few consumers are able to adequately self-assess their own risk of requiring particular hospital services, meaning millions of people are probably holding health cover that does not meet their needs. Indeed, research conducted by the APHA shows that 39 per cent of Australians with health cover don't know if their policy has any exclusions. Of those who do know they have exclusions, almost a third could not name the services that were not covered.

Private hospitals recognise and understand the challenges for consumers. As the interface between the insurance company and the consumer, hospital staff are often in the unfortunate position of having to inform patients their insurance policy will not cover them for a required procedure. These are difficult conversations. The patient is told they can go ahead with the

procedure in the private hospital and face large out-of-pocket costs, or try their luck in the public system with the inherent uncertainty that entails.

This must change, and the work being progressed by the Private Health Ministerial Advisory Committee has the potential to deliver big wins for consumers. For example, developing a common list of clinical definitions will make it easier for consumers to know what their policy covers.

Did you know that different health funds describe cover for cataract and eye lens procedures in 15 different ways? If one policy says it covers you for lens procedures, is this the same as a different policy that has cover for major eye procedures? We need one set of common definitions that all funds must use.

Similarly, the development of a product categories (Gold, Silver, Bronze) where everyone understands what each category does and doesn't cover will make product comparison a much simpler task.

Another area of work involves the information provided to consumers by health insurers. APHA has long advocated that health funds should regularly provide members with information about what is not covered in their policy, with recommendations to review their cover as they move through different life stages. This should overcome the "set and forget" regime where somebody in their 20s takes out a policy with a cardiac exclusion, only to suffer a cardiac episode in their 40s and "discover" they are not covered.

All of this will help deliver better value health insurance that is easier to understand, but another key issue that needs to be addressed is affordability. Premiums are increasing above CPI year after year, but why is this happening?

Between 2010 and 2016 hospital benefits paid out by health funds increased from $6.1 billion to $9.6 billion. Health funds point to figures like this to assert 'hospital costs are out of control', but a look behind the headline numbers tells a different story.

Over the same period, the number of people insured increased by 1.4 million. More people covered means more people claiming and this accounted for 25.4 per cent of the increased payout.

Growing utilisation also had a big impact. We know that people use more health services as they age, and the insured population is actually older than the general population. In the six years to 2016 the number of hospital episodes per 1000 people insured increased by 20 per cent, accounting for another 40.2 per cent of the benefits paid out by funds.

Private hospital costs have increased, driven largely by increases in nursing wages (staffing accounts for around 60 per cent of the private hospital cost base). But the increase in the average benefit per episode paid to private hospitals has been less than 3 per cent per annum for the last 10 years.

One area of health fund expenditure that continues to grow, 10 per cent in the last year alone, is payments to public hospitals. Public hospitals are actively chasing private patient revenue,

almost 20 per cent of all patients in public hospitals are private, while public patients are left to languish on waiting lists.

This is now costing the health funds $1.1 billion a year, not to mention the cost shift to the Commonwealth (who pick up 75 per cent of the MBS costs for private patients in public hospitals) and to the consumers who are often left with out of pocket costs, all to access a public hospital bed which every Australian is entitled to do free of charge.

Ending this practice could deliver a reduction in health fund premiums of more than 10 per cent.
While means-testing the health insurance rebate was a sensible policy change, affordability has been adversely impacted by changes to indexation of the rebate which has seen the real value of the rebate erode over time. This issue will become worse unless the Government reverts to the original policy settings.

While there are a range of challenges for consumers in managing private health insurance policies there appears to be the political will, and the right people around the table, to see some genuine change in this area. APHA fully supports all moves to make private health insurance policies that are simple, easy to understand and truly meet consumers' needs.

Surgeons seek less complexity, more transparency in health care

Lawrie Malisano, First Vice President of the Australian Orthopaedic Association and a Council Member of the Royal Australasian College of Surgeons

The Royal Australasian College of Surgeons (RACS) is aware of the increasing costs associated with providing health services in Australia, including surgery, and the significant challenge this poses to the government and the health sector. The system is under pressure due to a range of factors including the burden of chronic disease; demographic changes; workforce distribution; and increasing costs associated with technological advances. In 2014-2015 Australia's health expenditure was $161.6 billion, with the share of GDP represented by health reaching 10 per cent for the first time. At the same time, an increasing number of Australians are cancelling or reducing their private health insurance cover, citing value for money and concern about the complexity of private health insurance as key factors influencing their decision making.

The role of private health providers in the delivery of surgical services in Australia is significant and RACS recognises the important contribution of the private sector in the financing and delivery of health services under the Medicare framework. In 2013-2014, public hospitals provided approximately 29 elective admissions involving surgery per 1,000 population and private hospitals provided approximately 57 per 1,000 (figures from the AIHW here). A significant shift away from the private sector would increase pressure on governments to provide those services and likely increase waiting times for elective surgery to the

disadvantage of patients. The long term viability of the private health model in Australia will also decline if health insurance premiums continue to rise above CPI and wages growth. The industry weighted average premium increase in 2017 is 4.84 per cent, with the cumulative average increase in premiums totalling 33.47 percent since 2012.

In addition to high annual premiums, reports about high out of pocket costs being incurred by patients continue and will likely influence the uptake and retention of private health insurance in the future. Attempts to deliver low-level private health insurance policies have done little to reduce the burden on public funding or reduce out of pocket costs. Exclusionary policies often offer little or no value to consumers and leave patients vulnerable to significant out of pocket or upfront costs, which has the potential to influence their decision making around treatment options. We advocate that these policies be discontinued and would support initiatives that improved transparency and assisted consumers in gaining a better understanding of rebates associated with their policy.

Discussions about out of pocket costs are often associated with the fees charged by hospitals and medical practitioners.

RACS has taken the position that extortionate fees, or where fees are manifestly excessive, bear little if any relationship to the utilisation of skills, time or resources, and are exploitative and unethical.

A series of documents has been developed that outline our position including Excessive Fees, Informed Consent and Informed Financial Consent. RACS has also prepared a patient information sheet which advocates that patients take an active role in discussions with their surgeon about all available treatment options; that patients are given full disclosure and transparency of fees as early as possible in the patient-doctor relationship; and that concerned patients should seek second opinions on recommended treatments and fees.

At a systemic level, purchasing or contracting arrangements between private health insurers and hospitals can significantly impact upon out of pocket costs or cost variation, and continue to remain opaque to patients and medical practitioners. For example, prosthesis prices in the Australian private hospital setting are amongst the highest in the world, with estimates indicating that prosthesis benefit payments comprise 14 per cent of total reimbursements by private health insurers – totalling $1.9 billion in 2014-15. RACS encourages greater transparency in relation to the disclosure of any negotiated conditions which may affect clinical decision making by doctors and patients.

Beyond discussions about the role of private health insurance in the Australian healthcare sector, there are a number of other initiatives underway that can support patients in making more informed decisions about their healthcare and improve affordability. RACS has been actively involved in the Choosing Wisely Australia campaign, which aims to help healthcare providers and consumers start conversations about improving the quality of healthcare by eliminating unnecessary and sometimes harmful tests, treatments, and procedures. We have also worked collaboratively with Medibank to establish a series of Surgical Variance Reports, which aim to address the paucity of available information to surgeons on indicators such as the median length of patient stay, rates of readmission or admission to an intensive care unit

(ICU), and prices charged for services, for different procedures within their speciality, and particularly in the private sector. The data in these reports do not define best practice, however it is hoped that by highlighting variation in practice, we will be able to improve clinical outcomes and patient care.

RACS supports the principle of universal and sustainable healthcare provision across all communities in Australia and acknowledges the important contribution the private sector makes in the financing and delivery of health services under the Medicare framework. We support measures aimed at reducing complexity and improving consumer information about private health insurance coverage and which give consumers more transparency in private health insurance packages and interactions with health care providers. Strategies to reduce growing out of pocket costs including exclusionary policies that offer little or no value to consumers must be addressed. A consistent approach to the use of quality indicators for performance that are supported by a rigorous evidence base and subject to regular review would also be of significant benefit to the ongoing quality improvement of the healthcare sector.

Private patients in public hospitals: the story in detail

Alison Verhoeven, Chief Executive of the Australian Healthcare and Hospitals Association

Private health insurance policies are complex and do not readily support comparisons, accurate assessments of costs and, in some cases, may include possible misrepresentations of products and their value.[1]

While health costs keep rising by more than inflation the ease with which the Commonwealth approves insurance premium increases does nothing to exert downward pressure on those costs.[2]

Private insurers[3] and private hospitals[4] have stated that public hospitals treating private patients is largely to blame for premium increases, but their arguments ignore key data and do not consider the mixed public-private nature of Australia's health system.

Hospitals funding reflects our mixed public-private system

About 90 per cent of care in public hospitals and 32 per cent of care in private hospitals is funded by governments.[5]

The number of separations that were funded by governments in public and private hospitals combined increased by an average of 2.7 per cent 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 per cent.[6]

Between 2009–10 and 2013–14, after adjusting for inflation, total funding for public hospitals increased by an average of 4.2 per cent each year. However, the proportion of public hospital funding by the Australian Government decreased from 38 per cent to 37 per cent.[7]

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 10.3 per cent each year between 2010–11 and 2014–15. Since 2013–14, separations in private hospitals increased by 5.6 per cent for both those funded by governments, and those funded by private health insurance.[8]

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 per cent 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 per cent. In comparison, the average annual growth rate in state and territory government recurrent expenditure in public hospitals was 4.7 per cent over the same period.[9]

More public hospital separations are being funded by insurers—but there's more to the story

In 2014–15, the net benefits paid by private health insurers in public hospitals was $1.06 billion. This was a growth of 8.7 per cent over the previous year. In the same period, the net benefits paid by private health insurers in private hospitals was $7.974 billion, or growth of 6.4 per cent over the previous year.[10]

There were almost 5 million separations in public hospitals during 2014–15, and of these 14.1 per cent (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 per cent each year, or 4.4 percentage points over the period.[11] 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 per cent of bed days in June 2009, increasing to 12.4 per cent 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 per cent in June 2009 to 4.3 per cent in June 2016.[12]

Private health insurance used in public hospitals represents only 7.6% of private health insurance total expenditure. 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).[13]

What factors have driven growth of private health insurance use in public hospitals?

The Independent Hospital Pricing Authority's recent report on public hospital service utilisation by private patients[14] 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[15] 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 per cent were exclusionary policies. By June 2016, 37 per cent 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. Coinciding with this, the proportion of overall hospitals expenditure funded by private health insurers increased from 7.4 per cent in 2011–12 to 8.3 per cent in 2013–14.[16]

It's more than about who pays for what

Foundational principles of Australia's universal health care system is 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.

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 health care are complex – with public and private providers, public and private sources of funding, 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. This 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.

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Affordability, access and equity: the issue of private health insurance

Professor Malcom Hopwood, President of the Royal Australian and New Zealand College of Psychiatrists

The complexity, cost and lack of transparency in the private health insurance industry is making it increasingly difficult for vulnerable Australians to access the psychiatric care they need and deserve.

Despite the fact that mental illness represents one of the largest burdens of disease in Australia, 13 per cent of the non-fatal burden of disease and 24 per cent when you include substance use disorders, fewer than half of all private health policies from the major insurers cover the cost of admission into a private psychiatric facility.

Is it morally justifiable for insurance companies not to cover such a large percentage of the burden of disease?

Increasingly restrictive policies for psychiatric care mean that more and more people are finding that they are not covered for a range of psychiatric services. Many policies, in some cases even top level private health policies, do not offer cover for ongoing psychiatric services such as out of hospital care, outreach programs, day programs, checkups, consultations and electro-convulsive therapy.

There is no doubt that private health insurance is an important part of the health system in Australia and covers valuable services and care. We know that it affords people greater choice in the provision of treatment, coverage for services not covered by Medicare, and that it also offers shorter waiting times on some services. Importantly, by providing cover for private services the private health insurance industry does take the pressure off an over-burdened public system. As of December 2016, 46.6 per cent of the Australian population had private hospital insurance policies.

Currently there are 68 private psychiatric hospitals across Australia providing 3,200 specialised mental health beds. These services are accessed by 36,000 people each year with 63 per cent of overnight stays being for people aged 25-44.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is particularly concerned about the limited coverage for psychiatric care currently available under many private health insurance policies, the increasing out-of-pocket costs for consumers, and the lack of comparative information about what the policies actually cover.

The Private Health Insurance Act 2007 indicates that people are only required to serve a two month waiting period to be covered for psychiatric services, even if they have a pre-existing condition. The Act also says that all hospital policies must include a ‘minimum benefit’ for psychiatric care. The reality, however, is that the ‘minimum benefit’ often only provides limited coverage and consumers are left with significant out-of-pocket costs.

The lack of information available about what a person's policy actually covers is also of great concern and makes it difficult for people to make informed decisions. The RANZCP regularly receives feedback that many people have poor experiences in trying to get access to accurate and complete information about their private health insurance policies.

Limited information about policy exclusions such as pathology and radiology treatments, multiple psychiatric admissions and a limited number of electroconvulsive treatments (ECT) are just some of the areas we hear about. Some people have also discovered that their policy does not fully cover psychiatric admission to hospital and they have then been referred to the public system which we know is already overstretched. Others have been advised that the waiting period for psychiatric services is 12 months when it is, by law, actually 2 months.

Young people also have been given advice by health insurance companies that diminishes the importance of taking out psychiatric cover.

Another area requiring attention is the need for greater parity of care in the treatment of a person's physical and mental health needs. Patients who are admitted to a private psychiatric hospital for the treatment of a mental health disorder should be able to have their co-existing physical health needs treated at the same time, whenever possible.

There is extensive evidence that people with complex mental illness have higher rates of chronic physical illness compared to the general population. For example, a person with a serious mental illness is two to three times more likely to have diabetes, six times more likely to die from a cardiovascular disease, and generally more likely to die from almost all key chronic conditions.

On this basis, the experiences of people with private health insurance, who have combined mental and physical health needs, can be particularly detrimental. Many mental health consumers are already in a situation where they experience significant gaps between what is covered by their private health insurance policy and what they must actually pay in terms of their mental health care.

It is an artificial divide and contradictory for private health insurers to separate the costs of care for both physical and mental health. This situation is discriminatory for people with mental health conditions and reinforces the stigma that they can face on a daily basis.

Most importantly, this approach is detrimental to patients and society as a whole if patients actively avoid treatment for their physical health conditions due to the likelihood of significant out-of-pocket costs.

The RANZCP is advocating that the Government consider private health funds' psychiatric cover within the broader review of private health insurance with a view to improving transparency and understanding for consumers.

We also believe that it is crucial that educational tools are developed for consumers, carers, psychiatrists and health fund providers to raise public awareness of the risk factors associated with mental illness and the physical health needs of people with mental illness.

In recent years great strides have been made in destigmatizing mental illness and increasing the knowledge and understanding of the wider community. Unfortunately, at the same time, many private health insurance companies have restricted access to psychiatric services and made it more difficult for people to navigate the complexities of private health insurance and manage their mental illness.

Is your private health insurance worth it for dental care? Or is it Time2Switch?

Dr Hugo Sachs, President of the Australian Dental Association

Consumers are questioning the value of their private health insurance. I would like to give the Australian Dental Association's (ADA) perspective on private health insurance and out of pocket expenses.

When it comes to general treatment (extras) policies, the majority of rebates paid out to policy holders are for dental services claims – over 54 per cent on average. This is followed by optical at 15 per cent and physiotherapy at 9 per cent[1].

While the dental share might sound large, nationally private health insurance contributed 18 per cent of the $9.6 billion paid for dental services in Australia. Individuals still paid the most, via direct out-of-pocket expenses (57 per cent), followed by government programmes (24 per cent)[2].

What's happening here?

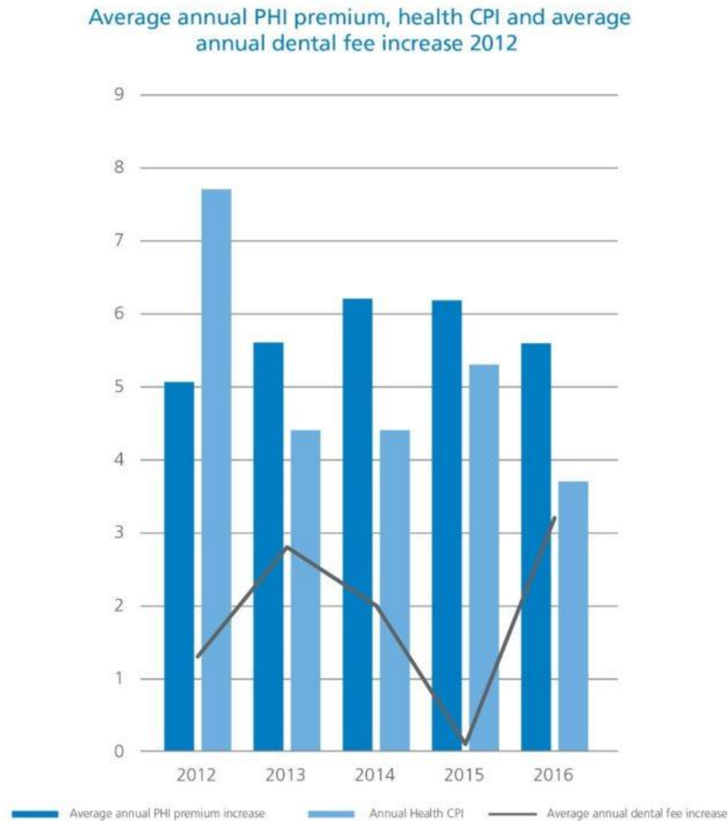
The main contributor to this trend is that private health insurers have not adequately increased rebates in step with the premium increases policy-holders pay every year.

Private health insurance consumers pay more in policy premiums than what they received back via benefits or rebates, to the tune of $6.2 billion over the last five financial years. Consumers receive less yet pay more.

Deflecting consumers' attention to healthcare providers' fees

There is another level consumers need to assess. Do the rebates they receive under their private health insurance policies perform a reasonable job at lowering out-of-pocket costs for health services?

The ADA conducts an annual fee survey of the average increase in dental fees. The chart below tracks these increases against the health CPI and the average annual private health insurance premium increases over the last five years.



Over the last five years, average dental fees have been lower than the annual health cost-of-living increase and private health insurance premium increases. With the exception of 2012, premium increases have been higher than the health cost-of-living index.

This analysis confirms the ADA's and CHOICE'S conclusion that rebates have failed to adequately reflect increases in the premiums consumers pay. By having stagnant rebates, the private health insurance industry has essentially been gouging money from consumers.

Not only has this been happening for many years, the private health insurance industry has deflected the blame and attention for consumers' increased out-of-pocket costs onto fees charged by health service providers, particularly dentists.

Discriminatory rebates and contracted provider arrangements

The ADA has received complaints that when a policy holder calls their private health insurer to obtain information about their rebates for their dental treatment, the insurer's call centre staff use this opportunity to assert to the policy holder that the dentist they are considering is 'too expensive'. The policy holder is then encouraged to consider one of the insurer's 'preferred providers' or 'network dentists' (in other words, healthcare providers contracted to the insurer).

The problem is that it may not be true that the original, non- contracted dentist's fees are higher than the contracted providers. In fact, private health insurers use discriminatory rebate regimes to make their contracted providers appear more attractive. A policy holder will receive a higher rebate if they attend a contracted provider than if they continued to see their original dentist. There is no level playing field for fair competition, as the original dentist's fees may

actually be lower than the contracted dentists but the consumer may no longer have dental treatment with this dentist.

Consumers understandably might ask, 'What is the problem with that, if I have lower out-of-pocket costs in the end?'. Discriminatory rebates and contracted provider arrangements are problematic on a number of levels:

First, discriminatory rebate regimes create two tiers of policy holders. Is it fair that the first policy holder is punished for exercising their choice to go to a particular non-contracted dentist? The first policy holder is effectively subsiding the other one to obtain a higher rebate, yet the former does not receive any immediate benefit. This is patently unfair.

Second, the continuity of care of the policy holder who chooses to see their non-contracted dentist is being interfered with by these practices. Continuity of care is crucial to ensure the best possible health outcomes for a patient. Any issues that may arise are most likely to be identified and treated appropriately rather than if a patient were to see a different practitioner each time. Discriminatory rebates and contracted provider arrangements are a direct attack on continuity of care, which is not in the best health interests of patients.

Third, insurers can cross subsidise the provision of these discriminatory rebates as a means to ultimately run out independent, smaller dental practices in a manner that does not improve the quality of dental care provided nor the range of healthcare providers available to consumers. It is reducing consumer choice and thus in the long term reduces competition.

The ADA's Time2Switch.com.au campaign

Problems with the private health insurance industry and their impact on patients are the reasons why the ADA has embarked on its Time2Switch campaign (time2switch.com.au).

Time2Switch provides the public with an independent, dental profession-developed comparator that assesses private health insurance policy's rebates for general dental, major dental, endodontic and orthodontics services. The ADA's Time2Switch website's comparator aims to simplify choices by assessing health fund dental rebates as a proportion of the average fee for the particular service, and how these rebates compare to other insurers' policies.

This website also helps consumers lodge a complaint to the Private Health Insurance Ombudsman about inadequate rebates in health insurance policies and the unfairness of discriminatory rebates. To date there have been almost 4,000 complaints made about private health insurance, particularly as it pertains to dental services, representing almost 84 per cent of complaints lodged to the Private Health Insurance Ombudsman for 2015-16 alone. The aim of the ADA's campaign is to:

1. Highlight to consumers the significant bias and anti-competitive practises of the private health insurance industry; and
2. To persuade the Australian Government to institute much needed reform so that consumers receive more value for money for their policy, and their choice of provider, and continuity of care, is not compromised.

We urge all consumers to consider whether it's Time2Switch.com.au

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The challenges of private health insurance for allied health in primary care

Lin Oke, Executive Officer at Allied Health Professions Australia

Australia spends considerable money on its health. In 2014-15, the Australian Government spent $66.2bn to fund the health system, almost $7bn of which went to fund private health insurance. With health costs growing rapidly, governments are increasingly seeking to curtail spending and this has driven a strong focus on supporting use of private health insurance.

The allied health sector is an essential part of our health system, providing crucial services for many Australians. Many of our biggest current health challenges, including the growth in chronic and complex conditions, mean consumers increasingly depend on allied health care. Yet government funding for allied health services represents only a fraction of overall spending meaning consumers often depend on paying for services themselves. As a result, many consumers use private health insurance to subsidise the allied health services they use. Many families rely on Extras cover to help cover allied health treatments such as physiotherapy or dietetics. Almost ten percent more Australians have Extras cover (55.7 percent) than hospital treatment insurance (47.1 percent) showing the importance consumers place on access to these services.

Private health insurance and the need for subsidised allied health care

Despite the popularity of Extras policies, private health insurance provides only limited and highly variable access to allied health services. Both consumer organisation Choice and the Grattan Institute have expressed concern about the function and value of these policies, noting that only hospital insurance functions as true insurance. Choice noted that Extras treatment insurance coverage can vary widely in the services that are covered and the way benefits are paid and may not necessarily provide value for many consumers.

Health insurance benefits paid out by health insurers for non-dental primary care services totalled less than 6 percent ($781 million) of payments from private. The large increase in complaints to the Private Health Insurance Ombudsman over the last two years, shows the significant gap between the needs and expectations of consumers and the insurance products available. The Australian Government has taken early steps to combat the failures of current insurance products with the establishment of the Private Health Ministerial Advisory Committee and an increased focus on improving product information and consistency between providers. Yet even if those reforms are successful, a range of issues still concern the allied health sector.

Impact of private health insurance funding of health services

Access to rebates for services has a significant impact in driving consumer choices about the types of health care they access. Where there are multiple options for dealing with a particular health condition, consumers are understandably more likely to choose the option funded by insurers.

Yet the way insurers determine which services to fund lacks transparency and may not be consistent across insurance providers and products.

A recent article published by allied health professionals from the University of Sydney noted significant inconsistency in funding for allied health services with nutritionists more likely than dietitians to be funded for nutrition services, physiotherapists more likely to be funded for hand splints and orthoses than occupational therapists and orthopaedic surgeons more likely than podiatric surgeons to be rebated for foot and ankle surgery.

Similarly, Arthritis Australia and Rheumatology Australia have presented research suggesting that at least 10 per cent of joint replacements in Australia are avoidable resulting in unnecessary spending of some $200 million each year. Their submission estimated that programs based around allied health services such as physiotherapy and occupational therapy could be provided to people with hip and knee osteoarthritis for around $750 per person preventing many joint replacement surgeries and their related costs (~ $25,000). Yet funding remains focused on medical interventions rather than preventative care.

Preferred provider relationships

Where allied health services are funded by private health insurers, those providers frequently find that they are impacted on by the insurers' ability to pay different benefits payments to different providers based on contractual arrangements. Insurers have recognised that they can increasingly control costs by entering into exclusive agreements with private providers or establishing their own health providers. Those providers attract higher benefits payments for consumers leading many to switch from one health service to another. The Australian Dental Association has accurately noted the strong likelihood of anticompetitive behaviour that can arise from such relationships and that the government has stepped in to reduce such behaviour in other industry areas.

Allied health providers are increasingly faced with the choice of securing their customer base by entering into preferred provider agreements with insurers or losing customers to preferred providers who attract higher rebates.

Those with preferred provider agreements are under significant pressure to keep costs low which conflicts with their ability to provide high quality care.

This raises significant questions about whether insurers should be able to freely choose which services to subsidise and how much, particularly as these products are generally at least partially funded by the public purse through health insurance rebates. The question becomes particularly pertinent when an insurer is both the recipient of premiums, the payer of benefits and the beneficiary of payments for services through ownership of health services.

Private health insurance and equitable access to allied health services

The goal of government funding must be to use public health dollars to ensure access to health services. Yet private insurance is disproportionately held by middle and high income earners. The ABS Health Survey noted people living in areas with relatively high socio-economic disadvantage have the lowest levels of private health insurance in Australia (33.4%), while people in low disadvantage areas had the highest levels (79.4%). The growth in chronic disease means consumers increasingly need allied health services, yet funding for these is inflexible and limited and has the lowest uptake by disadvantaged Australians.

Government funding of private health is also growing rapidly, outpacing spending growth in other areas.

The Grattan Institute has calculated that the government subsidy for private health insurance is expected to grow by 7 percent from 2015-16 to 2018-19. This compares with 3.2 percent growth in overall Commonwealth health spending and 6.7 percent growth in Commonwealth support for public hospitals.

Given finite public health funds, Australians must ask whether health insurance spending by the government is appropriate in place of increased funding of more equitable universal access programs such as the Medicare Benefits Schedule.

Determining the role of private health insurance

Private health insurance has the potential to provide important access to allied health services for many Australians but if governments are to continue funding insurance rebates then the community should rightly expect these products focus on health outcomes, not profit. That will require more consistency between insurance products and greater transparency concerning efficacy and costs. An increased focus on equity is also important to ensure that increased government funding for private insurance does not result in decreased public funding and a two tier health system.

The unfairness and waste of private health insurance

John Menadue AO

History is repeating itself.

Medicare was created by the Whitlam Government because of the abject failure of private health insurance or, as it was then called, voluntary health insurance.

As a result of the growth of PHI since 1999 under the Howard government, Medicare is now seriously threatened. Government subsidies for PHI will take us back to the pre-Whitlam and pre-Medicare era.

The Australian Government today knows that PHI is in real trouble. But for ideological reasons it wants to prop up what John Howard foisted on us in 1999. That is the reason for the current review. It is like putting lipstick on a pig.

There are 34 insurers with 40,000 variations of PHI policies available. Due to complexities and deliberate obfuscation, the public is confused over exclusions, inclusions and gap cover. It is an awful mess and it is not surprising that the public is increasingly sceptical. The former Minister for Health, Sussan Ley, told us:

> *"Everywhere I go, consumers health insurers, doctors and private hospitals tell me their needs are not being met by PHI….Australians are paying too much for health insurance that does not deliver them much value."*

It all takes me back to what Gough Whitlam said in 1969 about PHI.

> *"Voluntary health insurance was condemned in the Nimmo report for having become complex to the point of incomprehensibility, charging contributions beyond the means of many members of the community, paying less in benefits than the cost of medical and hospital services, causing serious and widespread hardship through the application of 'special account' regulations, appropriating too much of its own contribution income for operating expenses and accumulating excessive reserves."*

What he said then about voluntary/private health insurance is still true today of PHI. It is inefficient and unfair. It is eroding Medicare. And the CEO of NIB has warned us that that is what he wants to see, "to bring us back to the days before…Gough Whitlam introduced Medicare".

Yet inefficient and unfair private health insurance is underwritten in Australia through an enormous government subsidy.

Private health insurance is subsidised by Australian taxpayers at a cost of $11 billion a year. The motor industry never got a subsidy like this.

In 2015-16, that taxpayer subsidy was made up as follows:

- $6.565 billion, direct outlays in the budget for the rebate.
- $1.6 billion, tax-free income for those who got the rebate.
- $1 billion, estimate for the benefit of exemption of tax-payers from the Medibank Levy Surcharge.
- $2 billion, for the estimated cost to taxpayers of high costs associated with PHI and particularly unnecessary treatments.

That subsidy should be abolished and some of the money saved should be spent to include dental care as part of Medicare, at a cost of about $6 billion a year. Almost 40 per cent of Australians earning less than $75 000 a year cannot afford to see a dentist.

It is important to understand some history to realise the threat of PHI. We have been here before.

The ALP in the Senate in 1968 was responsible for establishing a Select Committee on

Medical and Hospital Costs. To head off this report, the McMahon Government appointed Justice Nimmo to conduct an inquiry into health insurance. Not surprisingly, both the Nimmo report and the Senate report condemned the inefficiency and waste of private health insurance that I have mentioned.

Those two reports laid the basis and the reasons for establishing Medicare.

PHI is a grave threat to Medicare but the ALP does not seem to care.

Let me summarise the failings and risks of PHI.

- It threatens our universal health system through seriously weakening the ability of Medicare as a single funder to control costs. We have seen the enormous damage that PHI has wrought in the US. We are steadily going down the same dangerous path. On present trends, we will have a divided healthcare system. One system will be for the wealthy with a safety net system for the indigent.
- PHI not only weakens Medicare, but in itself it does not have the market power to match the power of health providers who hold all the cards. In February this year in the Sydney Morning Herald, Dr Rachel David, the chief executive of Private Healthcare Australia said that "private health funds have no control over input costs, which include medical device benefits, hospital accommodation costs, allied health costs e.g. dental, medical specialist gap costs among others". Without perhaps realising it she put the case against PHI…its inability to control costs.
- It favours the wealthy who can jump the public hospital queue by going to private hospitals.
- It penalises country people who have limited access to private hospitals.
- It has administrative costs three times higher than Medicare.
- Since John Howard introduced the PHI subsidy in 1999, premiums payable on PHI have increased by over 150 per cent but the CPI has risen by 60 per cent.
- PHI has made it extremely difficult for public hospitals to retain specialists who are attracted to remuneration which is often at least three times higher in private practice and private hospitals. PHI has not taken the pressure off public hospitals.
- There are government-supported trials in Queensland to extend coverage of PHI to general practice.
- Medibank Private is pressing for PHI holders to get preference in public emergency departments.

If people want private health insurance that is their right. But why should taxpayers subsidise the PHI industry to corrupt and undermine a universal system that is available to all?

The vested interests in PHI never argue their case in public. They rely on private lobbying of ministers and officials.

PHI is like a Trojan horse to lead us away from world's best practice in health care, a single public payer with services provided by both private and public providers.

Doing without private health insurance

Ian McAuley,, Adjunct lecturer in public sector finance at the University of Canberra and a fellow of the Centre for Policy Development

Every year the Australian Competition and Consumer Commission reports on competition and consumer issues in private health insurance, and recent reports show increasing consumer dissatisfaction with PHI. Most complaints relate to unexpected charges when claims are made and confusion over terms and conditions.

Responses by consumer groups, including the Consumers Health Forum and Choice, include websites to help consumers make a more informed choice about health insurance, and advice urging consumers to think very carefully before taking up PHI. The Government has responded with a promise to require insurers to simplify product offerings, and the ACCC is taking legal action against Medibank over alleged misrepresentations of policies and changes in policies that were not reported to consumers.

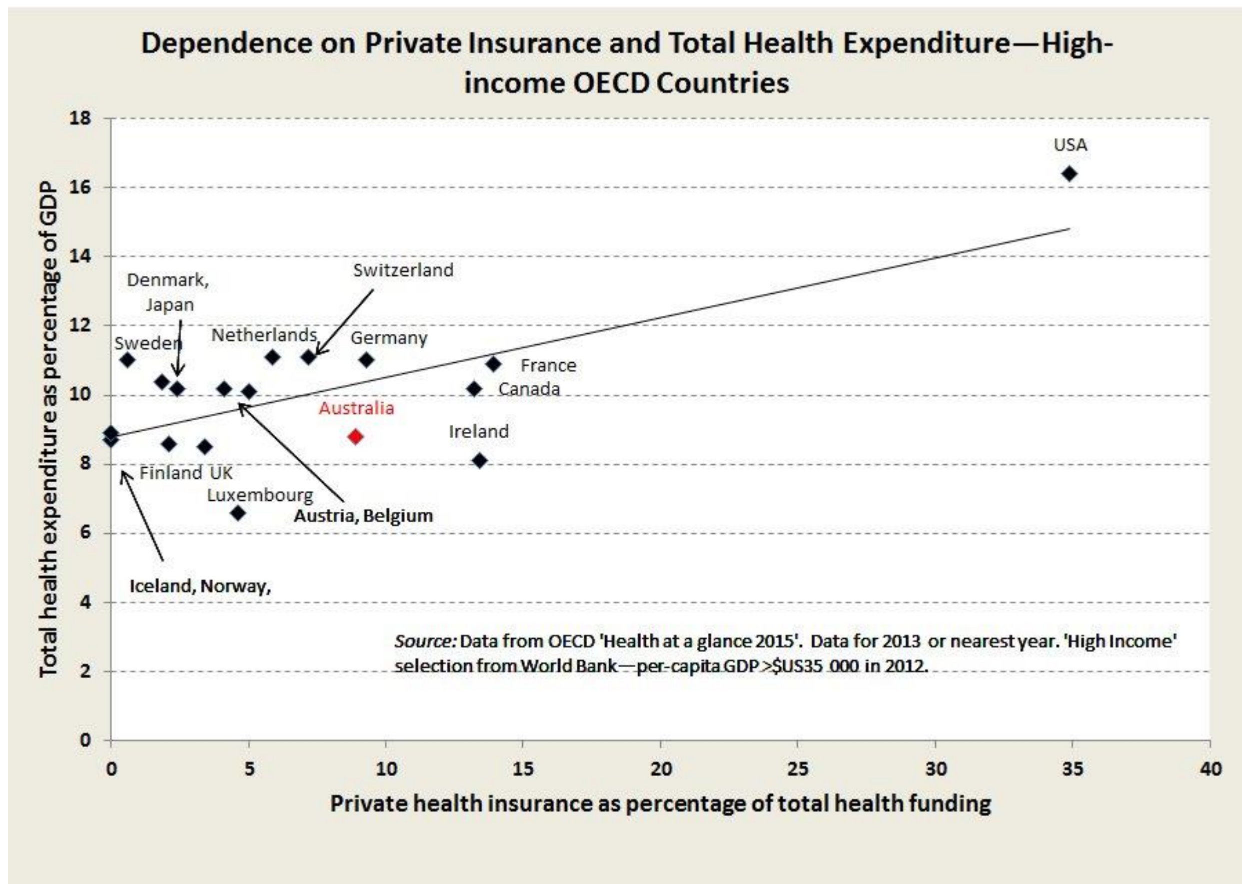
These responses are all in the context of making the market for PHI perform better – ensuring that consumers are better informed and that firms behave in accordance with the spirit and letter of competition law.

Can private health insurance be made to work?

But while these measures are commendable in themselves, they do not address the wider policy issue as to whether PHI, under any realistic policy settings, can serve a useful role in funding health care. Is there anything PHI can do that isn't done more efficiently and more equitably by a single national insurer, such as Medicare in Australia and similar schemes in Canada, the UK and the Nordic countries?

The evidence from comparing health financing schemes among prosperous "developed" countries is that the more countries rely on PHI to fund health care the more is the total cost of health care, without any improvement in health outcomes.

The relationship between use of PHI to fund health care and the total cost of health care is shown in the accompanying below.



The standout example is the USA, where health care accounts for 17 per cent of GDP, compared with 9 – 11 per cent of GDP in those countries with single insurers. In America reform has been about trying to make PHI work: Obama's Affordable Care Act improved coverage but has not controlled costs, and the new administration is struggling to design an alternative. Bernie Sanders, who called for a single national insurer, had it right: research by health economists suggests that a single insurer scheme could save Americans $US620 billion a year: that's around $US5000 a household.

Part of the problem lies in PHI's high bureaucratic cost. In Australia only 85 cents in the dollar passing through PHI makes its way to fund health care, compared with 95 cents when health care is funded through taxation and Medicare. Tough application of competition laws may ensure that insurers don't gouge excess profits from consumers, but there is no way a multitude of insurers, all with their own corporate structures and retail presences, and with their spending on promotion to tout for customers, can match the administrative efficiency of a single payer.

But by far the greatest problem faced by private insurers is their inability to control providers' charges. In an unusually frank disclosure to the media last year Dr Rachel David, chief executive of the PHI peak representative body, said "Health funds have no control over input costs". She went on to list hospital accommodation, medical devices and specialist gap payments as costs outside insurers' control. By contrast a single insurer can use its power in the market to act in the patient's (and the taxpayer's) interest, and to discourage over-use.

Towards a single insurer

Australia already has the framework for a single payer system, with Medicare, the Pharmaceutical Benefits Scheme, and Commonwealth-state hospital agreements. From 1984, when the Hawke Government introduced Medicare (essentially resurrecting the Whitlam Government's Medibank), Australia was heading in that direction. By 1996, before the Keating Government lost office, PHI hospital coverage had fallen to 30 per cent of the population.

Subsidies for PHI introduced by the Howard Government (and reinforced by subsequent governments, Labor and Coalition) rapidly lifted coverage to 45 per cent, and coverage peaked in 2015 at 47 per cent. It's now declining – slowly – but the fall is more marked among younger people, which means it carries disproportionate threats to insurers' viability.

There are several possible explanations for consumers cutting or downgrading their cover. One is a reaction to premium increases which have been running at about 2.7 per cent above inflation over this century so far: that's an accumulated real increase of 60 per cent. In times of rising incomes these rises may have passed largely unnoticed, but for the last three years, since the end of the mining boom, real incomes have been stagnating or falling, and people are reviewing their expenses.

Another explanation is that when people have been paying premiums over a long time they find that PHI does not necessarily represent good value for money. They may realise that what they have spent on ancillary cover is far more than they would have spent if uninsured; they may have made a claim and learned for the first time about out-of-pocket expenses; they may have had an accident or severe illness and have found to their surprise that they got good and free cover in a public hospital.

Under pressure from the PHI industry, governments may try to arrest and reverse this decline.

But subsidies for PHI are already costing public expenditure at least $11 billion a year — $6 billion in direct budgetary outlays and $2 billion in revenue forgone because the rebate is exempt from income tax — both these figures are contained in federal budget papers. As well another $3 billion in revenue is forgone because higher income earners with PHI are exempt from the Medicare Levy Surcharge — that figure is based on a conservative estimate derived from published Tax Office figures.

Governments will be tempted to shift these subsidies away from the exposure of direct budgetary outlays by forcing more people to pay the Medicare Levy Surcharge if they don't hold insurance.

In last year's budget, in a measure buried deep in the budget papers, the government froze the surcharge threshold at $90 000 until 2021, by which time $90 000 will be about the level of average earnings.

Not to be outdone in the election campaign a month later, Labor, for all its rhetoric about saving Medicare, proposed freezing the surcharge threshold at $90 000 until 2026.

Rather than paying ever-increasing public subsidies to this industry – a high-cost financial intermediary – governments would be well-advised to help it make an orderly departure. There are precedents for phasing out high-cost industries – the automobile industry for one.

Contrary to scare campaigns there would still be a thriving private hospital system: it's simply that its funding base would be more in line with the funding base of public hospitals. There may even be some healthy competition between private and public hospitals.

Taxes, probably in the rate of the Medicare levy, would have to rise, but this rise would be more than compensated for by people not having to pay PHI premiums. After all, PHI, particularly when supported by the compulsion of the Medicare Levy Surcharge, is simply a high-cost privatised tax. The ATO does a much better and fairer job at collecting taxes.

Policy downgrades – a closer look

Terence Cheng, Senior Lecturer at the School of Economics at University of Adelaide

Premiums for private health insurance are expected to increase by an industry average of 4.8 per cent in April this year. This comes on the back of sustained increases in premiums, which have grown at a rate of 1.5 to 3 times higher than the rate of inflation since 2010. This is expected to place further strains on household budgets; indeed there is much mentioned in the media, of individuals and families who have downgraded or discontinued their private health cover.

Much of the available evidence pointing to the increasing occurrence of policy downgrades come from data documenting an increase in the number of private health insurance policies that are written with exclusions and/or excesses and co-payments. To shed more light on this issue from a different perspective, let us look at data on households and household expenditure collected in the Household Income and Labour Dynamics in Australia (HILDA) survey.

Figure 1 shows how household spending on private health insurance premiums has changed between 2012 and 2013, using two waves of the HILDA survey (data from the survey is released with a lag of roughly two years). From the survey, out of all individuals and families that have private health insurance in 2012, 60 per cent have maintained or increased their spending on premiums in 2013. In contrast, two in five have either reduced their spending (36 per cent) on premiums, or have dropped insurance cover (4 per cent) entirely.

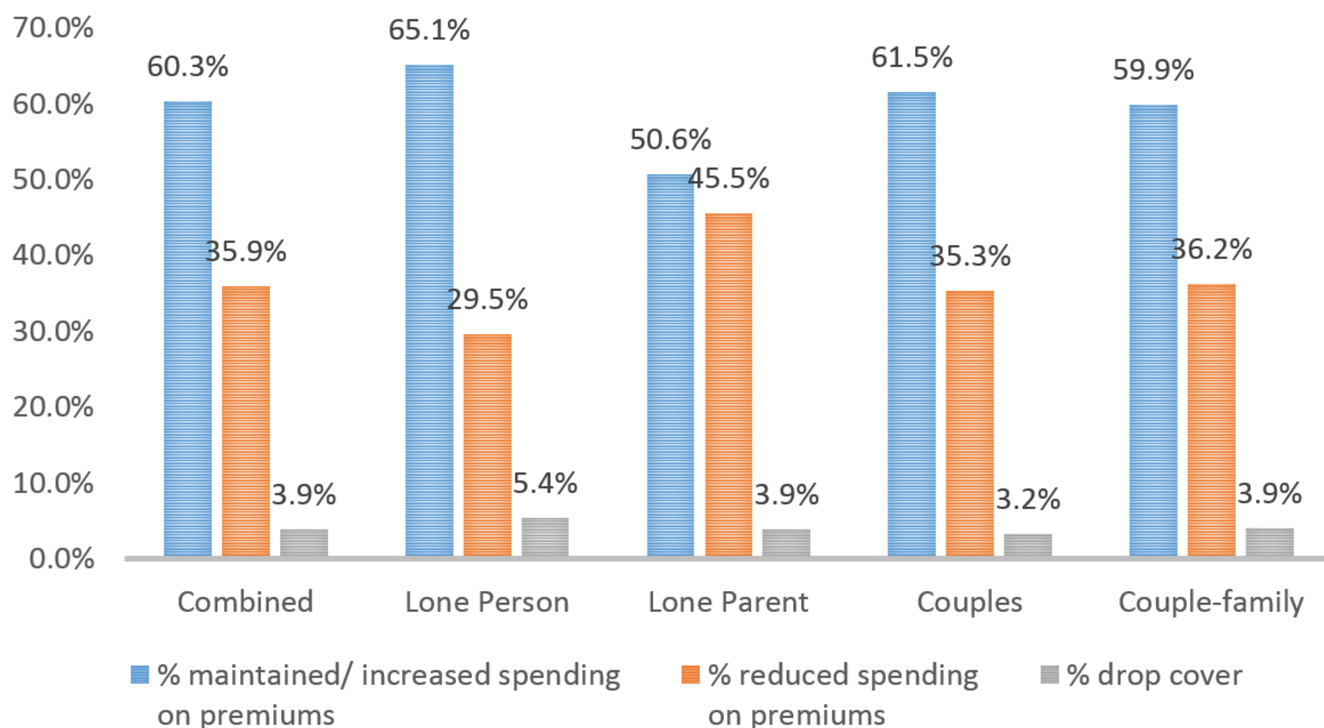


Figure 1: Changes in spending on private health premiums (HILDA 2012-2013)
Notes: N=6,293. Proportions are weighted so that the estimates are representative to the population

There are some differences in how expenditure patterns vary across family types. For instance, lone parents are significantly more likely to reduce the amount they spent on premiums compared with singles (lone person in Figure 1), and couples and couple families. Singles, on the other hand, are more likely to drop cover altogether.

Let us look at Figure 2 to understand how much spending on premiums has changed. In 2012, the average household spent $2,326 on private health insurance premiums. Those who have maintained or increased their outlay on premiums have spent an average of $763 more per year in 2013 compared with 2012. Those who have spent less on premiums have, on average, spent $718 less. This corresponds approximately to a 30 per cent decrease in expenditure on premiums compared to the year before. Across different family types, the reduction in spending on premiums, in percentage terms, varies between 27 per cent and 32 per cent, and is lowest for singles and highest for couples.

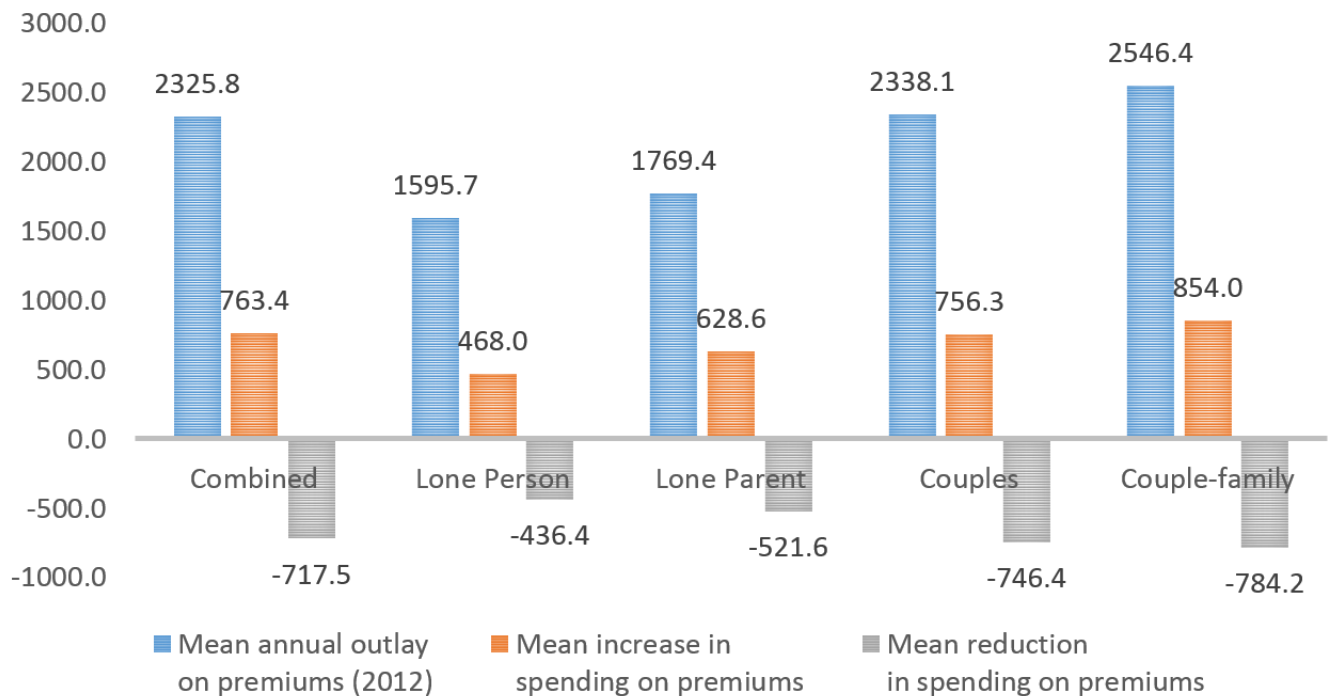


Figure 2: Household spending on private health insurance premiums (HILDA 2012-2013)

Notes: Mean are weighted so that the estimates are representative to the population

To anticipate the impact of policy downgrades it is useful that we understand the factors that are associated with the probability of downgrading. This is shown in Figure 3. Individuals aged 18 to 30 years and 31 to 64 years are more likely to downgrade compared with older individuals over the age of 65 years. Health status does not appear to be a factor as individuals in good and poor health are roughly equally likely to downgrade.

In terms of hospital use, individuals reported to have been hospitalised as a day patient in the 12 months preceding the survey are less likely to downgrade compared with those who were not hospitalised as a day patient. The probability of downgrading does not appear to be associated with whether or not an individual is hospitalised for an overnight episode.

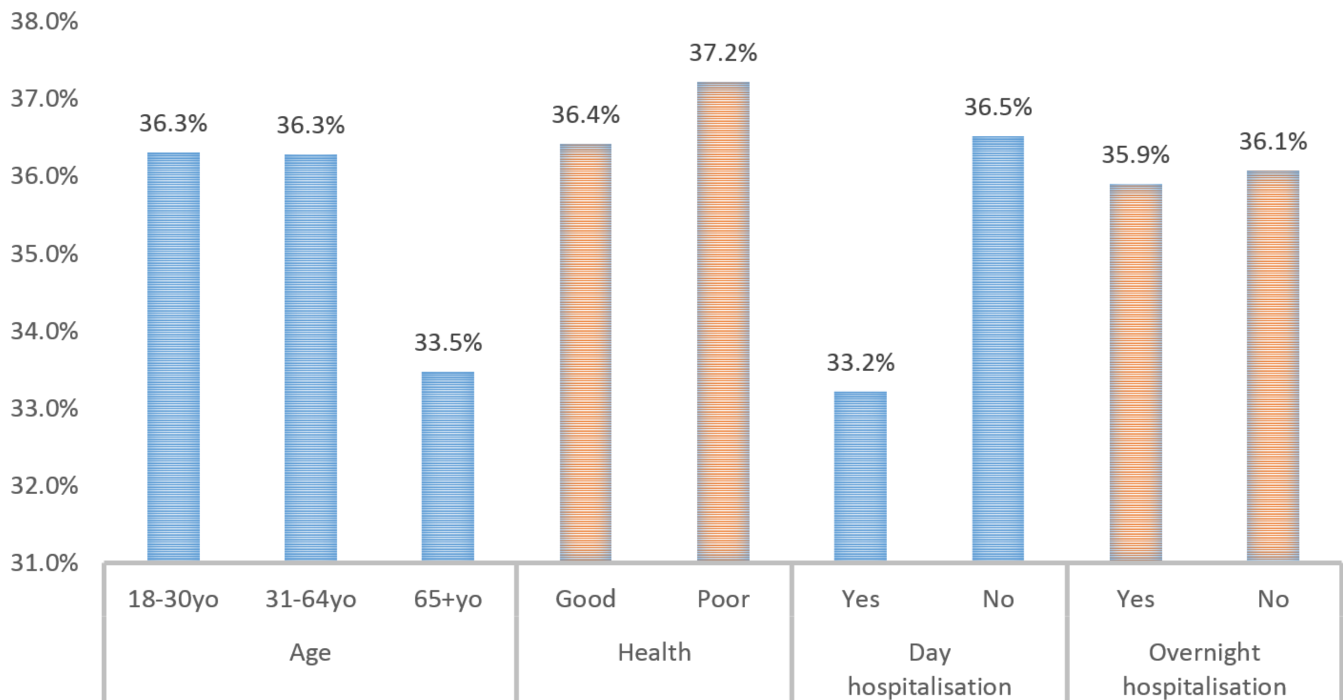


Figure 3: Probability of downgrading by personal characteristics (HILDA 2012-2013)

Notes: Proportions are weighted so that the estimates are representative to the population

What do these cursory evidence tell us about the possible impact of policy downgrades on the private health insurance market? We saw from the data that downgraders are more likely to be younger, and are less likely to have used day hospital services (though not overnight hospital services).

If the trend of downgrading continues, this may potentially worsen the problem of increasing premium costs, as healthier consumers (i.e younger) scale back on private health insurance, resulting in a remaining pool of 'less healthy' consumers with greater health care needs.

Whether or not policy downgrades translate to greater pressures on public hospitals would depend on how changes in insurance coverage affect consumers' decisions on whether to obtain hospital care from the public or private health sectors. There is, to my knowledge, no evidence on how health care decisions of these individuals have changed and hence it is important to evaluate the impact of downgrading. It is also important to identify the factors driving the persistent growth in premiums that we have experienced.

Downgrades however are not necessarily bad. Government incentives, through rebates and the Medicare Levy Surcharge, have distorted consumers' perceptions on the value of private health insurance, and clouded decisions on whether individuals should insure, and how much insurance to buy. There are both efficiency gains overall, and savings on the part of consumers, if downgrades are a result of consumers re-evaluating and 'optimising' their private health cover, by for instance choosing not to be insured for services they do not expect to use. This process necessitates that consumers have the required information, and understand the health insurance plans that are available, to make a fully informed choice.

Acknowledgement: This research uses unit record data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey. The HILDA Project was initiated and is funded by the Australian Government Department of Social Services (DSS) and is managed by the Melbourne Institute of Applied Economic and Social Research (Melbourne Institute). The findings and views reported in this paper, however, are those of the author and should not be attributed to either DSS or the Melbourne Institute.