Chapter 2

Consumers

2.1 This chapter considers the difficulties faced by private health insurance consumers in terms of affordability and out-of-pocket costs. This chapter also examines why there has been an increase in the number of individuals dropping or down-grading their private health insurance.

Number and content of policies

2.2 Throughout the inquiry, submitters raised concerns about the complexity of private health insurance products and the lack of information provided by insurers.[1] Many submitters noted that a greater number of available policies, changes to available benefits, difficult to understand terminology and a rise in non-comprehensive policies added to complexity for consumers.[2]

2.3 In June 2015, the Australian Competition and Consumer Commission (ACCC) noted there were approximately 46 500 private health insurance products on offer.[3] At the same time, research has suggested that up to 60 per cent of Australians have low levels of health literacy.[4]

2.4 The Commonwealth Ombudsman and Choice emphasised that health insurance policies are often unnecessarily complex and difficult for consumers to understand.[5] Both submitters noted that this complexity is compounded by private health insurers using different terminology to explain similar concepts. Choice noted that 'complex jargon makes it challenging for consumers when reading, comparing and understanding their policies'.[6] The Commonwealth Ombudsman further stated that the 'information provided by health insurers causes a number of problems for some consumers who consider the policy they received does not match their expectations.'[7] One consumer noted the difficulty in finding appropriate coverage and comparing it to other private health insurance policies:

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1 Australian Healthcare and Hospitals Association (AHHA), *Submission 3*, pp. 9–10; Breast Cancer Network Australia, *Submission 12*, pp. 6–7; Royal Australasian College of Physicians (RACP), *Submission 11*, pp. 3–5; Commonwealth Ombudsman, *Submission 19*, p. 5; Consumers Health Forum of Australia, *Submission 17*, p. 6.

2 Mr John Biviano, Acting Chief Executive Officer, Royal Australasian College of Surgeons (RACS), *Committee Hansard*, 5 July 2017, p. 9; Choice, *Submission 207*, pp. 13–16; Private Healthcare Australia, *Submission 18*, p. 24.

3 Australian Competition and Consumer Commission (ACCC), *Communicating changes to private health insurance benefits: A report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance: For the period 1 July 2014 to 30 June 2015*, p. 35; RACP, *Submission 11*, p. 3.

4 Consumers Health Forum of Australia, *Submission 17*, p. 6.

5 Commonwealth Ombudsman, *Submission 19*, p. 5; Choice, *Submission 207*, p. 13.

6 Choice, *Submission 207*, p. 13.

7 Commonwealth Ombudsman, *Submission 19*, p. 5.

> My wife is a doctor and we have two children. After having decided recently that we would not be having any more children we thought we would investigate if we could obtain a better rate from another fund as the Doctors fund does not let you separate maternity cover. We spent a few weeks doing so but ended up very confused. Trying to find which [policy] is the best for the consumer is very difficult and the government needs to act.[8]

Exclusions, co-payments and changes

2.5 The number of policies with exclusions or co-payments has increased dramatically in recent years.[9] According to the Australian Private Hospitals Association (APHA) citing Australian Prudential Regulation Authority (APRA) data, the number of people covered by exclusionary policies has increased from seven per cent in June 2007 to 40 per cent in 2017.[10]

2.6 The Department of Health (Department) noted that the most commonly excluded services include: heart investigations and surgery, eye surgery, pregnancy and birth related services and hip and knee replacements.[11]

2.7 These exclusions mean that individuals who use the private healthcare system are left with a lower value policy.[12] Day Hospitals Australia noted that the rise in exclusions can lead to unnecessary stress for policy holders when they require care, particularly if exclusions in a policy are not properly explained:

> The failure by health funds to clearly explain the policy holders [sic] cover and the associated product restrictions and exclusion, at the time of purchase, creates enormous stress for the consumer when they require hospital services.[13]

2.8 The committee heard evidence regarding the influence that co-payments and 'gaps' have on driving up medical costs.[14] While some health funds have 'no gap' arrangements with certain providers, these may not be the providers the patient is referred to. A patient diagnosed with breast cancer experienced the financial impact of this gap:

> I queried the gap with the private health fund and they said to me: 'Well you've got the wrong surgeon' and I said: 'Well when you're told you've got breast cancer, you don't say "hold on a minute, I'll go find another surgeon"'. You're sort of overwhelmed by the diagnosis and you want to get

8 Choice, *Submission 207*, p. 13 (brackets in original).

9 RACP, *Submission 11*, p. 3.

10 Australian Private Hospitals Association (APHA), *Submission 80*, p. 12.

11 Department of Health (Department), *Submission 127*, p. 20.

12 AHHA, *Submission 3*, p. 11.

13 Day Hospitals Australia, *Submission 91*, p. 5.

14 AHHA, *Submission 3*, pp. 3–4; Breast Cancer Network Australia, *Submission 12*, pp. 4–5.

> the treatment. I had confidence in him (the surgeon) but not in his bills. It was a lot of money we weren't expecting to pay.[15]

2.9 Another consumer noted the large and unexpected out-of-pocket payment they faced when their policy changed despite holding top cover:

> 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 [sic].[16]

2.10 COTA Australia noted that older people are also susceptible to unexpected out-of-pocket costs:

> A recurring story…is older people having maintained [private health insurance] for decades, only to find when they need to draw on it in later life they cannot realise the benefits because they cannot afford to meet the co-payments or other out-of-pocket costs associated with a procedure or treatment.[17]

2.11 Dr Michael Gannon, President of the Australian Medical Association (AMA), outlined the case of an elderly woman who was recently told by her insurer that her surgery was covered. However, the insurer decided not to pay after the surgery was performed, leaving the woman out of pocket by $7000.[18] Dr Gannon suggested that the insurer may not have paid because evidence of the clinical necessity of the surgery was not provided to the insurer prior to surgery.[19]

2.12 The AMA suggested to the committee that changes to a policy after purchase had the capacity to shake consumer confidence in private health insurance:

> When policies change haphazardly and reduce choice, consumers lose faith that the product provides value for money. Private health insurance provides choice for the patient and without that choice, its value is diminished.[20]

Affordability and rising out-of-pocket costs

2.13 Some submitters raised concerns about rising out-of-pocket costs and the difficulties faced by consumers in accurately estimating these costs before and after they received treatment.[21]

2.14 A 2015 poll on healthcare and insurance in Australia conducted by Ipsos found that Australians were most concerned about the affordability of private health

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15 Breast Cancer Network Australia, *Submission 12*, p. 4 (brackets in original).

16 Consumers Health Forum of Australia, *Submission 17*, p. 11.

17 COTA Australia, *Submission 88*, p. 6.

18 Dr Michael Gannon, President, Australian Medical Association (AMA), *Committee Hansard*, 31 October 2017, p. 32.

19 Dr Gannon, *Committee Hansard*, 31 October 2017, p. 32.

20 AMA, *Submission 58*, p. 9.

21 Consumers Health Forum of Australia, *Submission 17*, p. 9.

insurance.[22] Of those surveyed, 61 per cent of people identified the cost of premiums as the primary reason for allowing their private health insurance to lapse.[23] A further 71 per cent of people without private health insurance reported that the primary reason was that premiums were too high.[24] Further research commissioned by Private Healthcare Australia shows that if trends of low-wage growth and increasing premiums continue, private health insurance will 'potentially become unaffordable for up to one in five current hospital policyholders within the next 5-6 years'.[25]

2.15 Ms Alison Verhoeven, Chief Executive of the Australian Health and Hospitals Association (AHHA) noted that numerous Australians over the age of 50 held concerns that affordability was a barrier to purchasing private health insurance.[26]

2.16 Ms Verhoeven told the committee that the affordability of private health insurance was affecting uptake among the Aboriginal and Torres Strait Islander (ATSI) community and the elderly.[27] Ms Verhoeven referred the committee to the most recent data available, an Australian Institute of Health and Welfare study from 2012–13, that showed that only 20 per cent of ATSI adults had private health insurance and 72 per cent indicated they could not afford private health insurance, or believed it was too expensive.[28]

2.17 Concerns about affordability have led to an increase in the number of members who have downgraded their private health insurance. As the figure below demonstrates, HBF is one company that has experienced an increase in policy downgrades.

22 Private Healthcare Australia, *Submission 18*, p. 11.

23 *Submission 18*, p. 11.

24 *Submission 18*, p. 12.

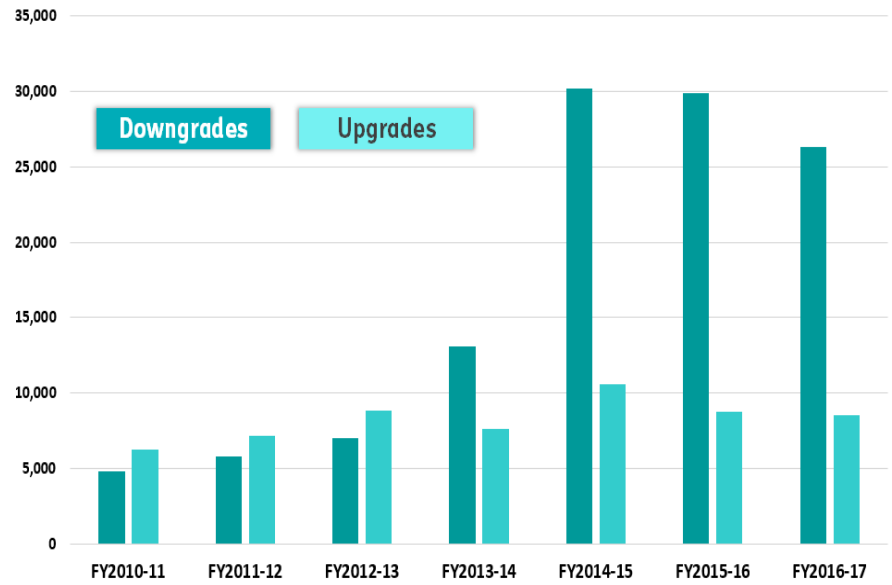
25 *Submission 18*, p. 12.

26 Ms Alison Verhoeven, Chief Executive, AHHA, *Committee Hansard*, 5 July 2017, p. 20.

27 Ms Verhoeven, *Committee Hansard*, 5 July 2017, p. 20.

28 Ms Verhoeven, *Committee Hansard*, 5 July 2017, p. 20.

Graph 2.1—HBF Policy upgrades and downgrades between FY2010–11 and FY2016–17



Source: HBF, *Submission 63*, p. 6.

2.18 HBF also noted a dramatic increase in the number of its members who took out 'less comprehensive products'.[29] In 2009–10, 31 per cent of HBF members chose 'top hospital' coverage.[30] By 2017 the percentage of HBF members who chose 'top hospital' cover had fallen to 14 per cent.[31]

2.19 Submitters expressed concern about rising out-of-pocket costs. In Australia, out-of-pocket costs now account for roughly 20 per cent of healthcare expenditure.[32] According to the AHHA, this figure is higher than other similar countries such as Canada (14 per cent), New Zealand (13 per cent) and the United Kingdom (10 per cent), though similar to the Organisation for Economic Co-operation and Development (OECD) average.[33]

2.20 A similar trend in higher out-of-pocket costs was identified by a number of specialist health organisations. The Australian Federation of AIDS Organisations and the National Association of People with HIV Australia noted concerns about the affordability of HIV medication:

> Each time a medication is dispensed, there is a co-payment – currently $38.80 at the general rate, and $6.30 at the concessional rate. In addition to the costs of HIV medication, many people with HIV pay additional co-payments for treatments associated with other HIV-related medical conditions, for example the control of lipids, diabetes and depression.

29 HBF, *Submission 63*, p. 6.

30 *Submission 63*, p. 6.

31 *Submission 63*, p. 6.

32 Ms Verhoeven, *Committee Hansard*, 5 July 2017, p. 21.

33 Ms Verhoeven, *Committee Hansard*, 5 July 2017, p. 21.

> Research shows that these cumulative costs cause financial stress, and result in some people forgoing treatment, leading to lower medication adherence. The outcomes of this are poorer individual health outcomes and increased onward transmissions, as a result of viral rebound.[34]

2.21 The Australian Dental Prosthetists Association voiced concern that 'dental services generally fall under ancillary or extras cover'.[35] As a result, roughly 10 per cent of insured adults pay all their dental expenses and 76 per cent registered dissatisfaction with the level of rebates received for dental treatment.[36]

2.22 Other issues relating to out-of-pocket costs in dentistry are canvassed in Chapter 4.

2.23 The committee received evidence regarding the scale of fees charged by some specialists.[37] The Royal Australasian College of Surgeons (RACS) drew the committee's attention to the *Surgical Variance Report 2017: General Surgery*.[38] The surgical variance report revealed that there can be significant variations in separation costs, surgeon out-of-pocket costs and out-of-pocket costs for other medical services.[39] Private Healthcare Australia noted that a market exists in specialist fees and it is information that consumers do not have access to.[40]

2.24 RACS acknowledged that some surgeons charged excessive fees and that disclosure of those fees may be one way to address that problem.[41] Dr Stephen Duckett, Director of the Health Program at the Grattan Institute suggested that publishing surgeons' fees would be relatively simple:

> One option, of course, is to say, 'Well, if you want to charge patients you can charge what you like, but there's going to be no rebate if you charge more than 50 per cent above the schedule'—or whatever you like and so force some discipline into the market. The government already collects information about what fees are charged and it would be relatively easy for Medicare to publish the information about fees charged by individual doctors by procedure.[42]

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34 Australian Federation of AIDS Organisations and National Association of People with HIV Australia, *Submission 59*, p. 3.

35 Australian Dental Prosthetists Association, *Submission 77*, [p. 1].

36 *Submission 77*, [p. 1].

37 Mr Biviano, *Committee Hansard*, 5 July 2017, p. 10.

38 Mr Biviano, *Committee Hansard*, 5 July 2017, p. 10; RACS and Medibank Private, *Surgical Variance Report 2017: General Surgery*, p. 2.

39 See for example RACS and Medibank Private, *Surgical Variance Report 2017: General Surgery*, pp. 13–20.

40 Dr Rachel David, Chief Executive Officer, Private Healthcare Australia, *Committee Hansard*, 31 October 2017, p. 48.

41 Mr Biviano, *Committee Hansard*, 5 July 2017, p. 10.

42 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 31 October 2017, p. 18.

2.25 Dr Duckett also suggested that transparency data should not just include fees but a range of outcomes at both the surgeon and hospital level:

> My view is that we should publish the complication rates. We already collect information on that. On every patient discharge from every public and private hospital we collect diagnoses that occurred during the course of admission, whether there was an infection, or a laceration during surgery, and so on. We should publish those rates for hospitals—at the hospital level. Because there is a private contract between the doctor and the patient, we should also publish that information where such a private contract exists. That is, the customer should know in advance what the risk of a complication is with the surgeon from whom they are purchasing their service.[43]

2.26 RACS told the committee that it did not oppose the public disclosure of surgeons fees, but the college did not wish to be the body to publish them:

> We're not opposed; it's just how it's done. We wouldn't be doing it. We're not opposed to an independent agency doing that, as long as they're using the right parameters to judge the fees themselves and how they're presented. Our view is that the best way of managing this is to make sure the consumer has all of the information that they need and also to make sure that they ask the right questions from the very start.[44]

2.27 Submitters commonly raised concerns that increasing out-of-pocket costs are leading to worse health outcomes because individuals are either rejecting or delaying treatment.[45]

2.28 Lynch Syndrome Australia noted that 19 per cent of respondents delayed their surveillance or treatment of Lynch Syndrome due to financials costs. A further eight per cent delayed their cancer treatment for financial reasons.[46]

2.29 The AHHA and the Grattan Institute, among others, highlighted that out-of-pocket costs disproportionately disadvantage those on low incomes.[47]

2.30 On 13 October 2017, The Hon Greg Hunt MP, Minister of Health (Minister) announced that a committee would be established 'to consider best practice models for the transparency of out-of-pocket costs'.[48]

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43 Dr Duckett, *Committee Hansard*, 31 October 2017, p. 15.

44 Mr Biviano, *Committee Hansard*, 5 July 2017, p. 13.

45 AHHA, *Submission 3*, p. 3; Combined Pensioners & Superannuants of NSW, *Submission 15*, p. 9; Haemophilia Foundation Australia, *Submission 50*, p. 7; Cancer Council Australia, *Submission 54*, p. 5.

46 Lynch Syndrome Australia, *Submission 55*, p. 2.

47 Ms Verhoeven, *Committee Hansard*, 5 July 2017, p. 21; AHHA, *Submission 3*, p. 3; Grattan Institute, *Submission 72*, p. 13. See also Combined Pensioners & Superannuants of NSW, *Submission 15*, p. 9.

48 Department, *Submission 127—Attachment 2*, [p. 8].

'Junk' policies

2.31 A number of submitters raised concerns about the use of so-called 'junk' or basic policies. These policies are often cheap and are taken up by people who perceive a lack of value in more expensive private health insurance coverage.[49]

2.32 'Junk' policies include policies which provide coverage for a small number of accidents such as knee reconstructions and investigations but have the majority of services and illnesses excluded or covered in a public hospital. They also often offer private hospital cover for accident and ambulance only.[50]

2.33 Choice identified that often 'junk' or basic policies are taken out by consumers who either:

- want the cheapest policy possible, but do not realise the policy offers limited coverage; or
- who know the policy offers limited coverage, does not intend to use it and take it out solely for tax purposes.[51]

2.34 The Australian Nursing and Midwifery Federation (ANMF) raised concerns about the current tax incentives to encourage consumers to maintain private health insurance and noted a recent ACCC report that found that tax incentives are 'driving consumers to lower-priced policies than they would prefer, with an emphasis on tax rather than health outcomes'.[52]

2.35 Some submitters called for an end to 'junk' policies because they believe that they deliver poor value for consumers.[53] Others called for the withdrawal of the rebate from these 'junk' policies.[54]

2.36 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the National Association of Specialist Obstetricians and Gynaecologists (NASOG) raised concerns about the disproportionate effect these

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49 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), *Submission 51*; Australian Nursing and Midwifery Federation (ANMF), *Submission 70*; Australian Society of Ophthalmologists, *Submission 71*.

50 ANMF, *Submission 70*, [p. 10].

51 Choice, *Submission 207*, p. 33.

52 ANMF, *Submission 70*, [p. 8].

53 Mr Biviano, *Committee Hansard*, 5 July 2017, p. 10; Ms Verhoeven, Committee Hansard, 5 July 2017, p. 22; Mr Michael Roff, Chief Executive Officer, APHA, *Committee Hansard*, 31 October 2017, p. 42; Combined Pensioners and Superannuants Association of NSW, *Submission 15*, pp. 6–7; Consumers Health Forum of Australia, *Submission 17*, pp. 35–36; HBF, *Submission 63*, p. 4; ANMF, *Submission 70*, [pp. 9–10]; Australian Physiotherapy Association, *Submission 74*, p. 3.

54 Choice, *Submission 207*, p. 33; Private Health Insurers Intermediaries Association, *Submission 221*, [pp. 8–9].

junk policies have on women holding private health insurance.[55] RANZCOG argued in their submission:

> These policies may cover small proportions of treatments provided in private hospitals…Because these policies usually do not cover treatments in private hospital for the most important and common needs of women – maternity care, menstrual disorders, gynaecological malignancies, prolapse and incontinence, and private psychiatric facilities in case of a perinatal mental health condition, their value is questionable.[56]

2.37 However, some people do consider that basic policies afford some benefit.[57] The benefit is mostly attributed to contributions made to the risk equalisation pool. This is considered in greater detail in Chapter 3.

Groups who face additional barriers to using private health insurance

2.38 The committee received evidence from groups who considered that they face additional barriers to using their private health insurance. This included people living in rural and regional Australia, people suffering from chronic diseases and those diagnosed with certain illnesses.

Rural and regional consumers

2.39 The committee received substantial evidence from consumers in rural and regional areas. In particular, numerous submitters drew attention to the lack of contracted providers in rural towns.[58] The paucity of private health infrastructure in rural areas can be seen in the figure below.

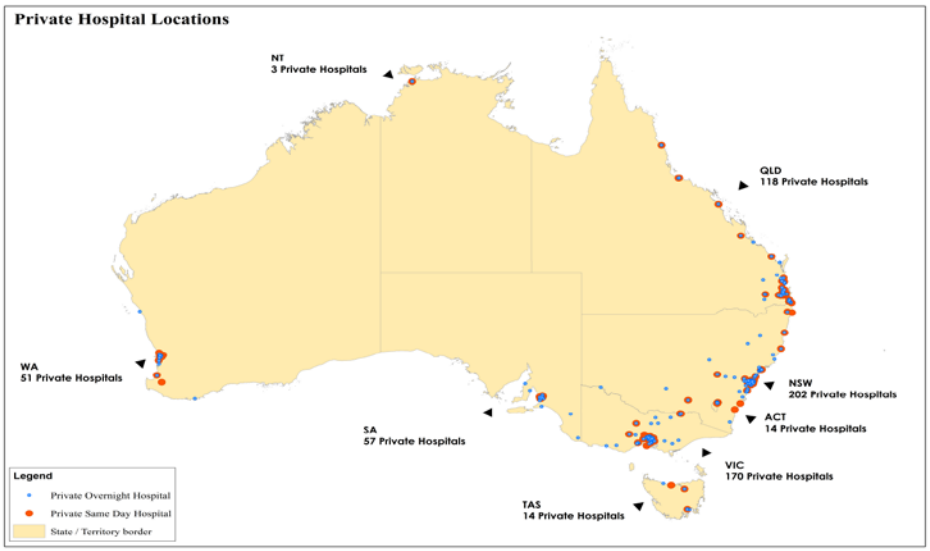
55 RANZCOG, *Submission 51*, p. 5; National Association of Specialist Obstetricians and Gynaecologists (NASOG), *Submission 83*, pp. 3–4.

56 RANZCOG, *Submission 51*, p. 5.

57 Dr David, *Committee Hansard*, 31 October 2017, p. 56; Dr Dwayne Crombie, Managing Director, Private Health Insurance, Bupa Australia, *Committee Hansard*, 31 October 2017, p. 56.

58 ANMF, *Submission 70*, p. 17; National Rural Health Alliance (NRHA), *Submission 48*; Optometry Australia, *Submission 8*; Services for Australian Rural and Remote Allied Health (SARRAH), *Submission 61;* Name withheld, *Submission 128*, p. 3; Australian Physiotherapy Association, *Submission 74.*

Figure 2.1 Locations of private hospitals in Australia



Source: Department, *Submission 127*, p. 6.

2.40 The National Rural Health Alliance (NRHA) noted that 52.3 per cent of individuals living in regional and remote communities do not have private health insurance, compared to 39 per cent in major cities.[59]

2.41 The NRHA argued that private health insurance products need 'to enable better access to services and supports designed specifically to enhance access for rural and remote Australia'.[60] The NRHA's recommendations include an increased range of benefits for non-hospital based services in rural areas, increased access to higher rebates to cover transport and accommodation when forced to travel to receive medical services and progressive reductions based on geographic remoteness to encourage people to take out private health insurance.[61]

2.42 People living in rural areas have also noted their frustration at their inability to access 'preferred providers' and therefore face higher out-of-pocket expenses.[62] In regional areas the scarcity of these providers means that consumers are required to travel long distances if they wish to access one.[63]

2.43 Due to the lack of health facilities in rural areas, patients noted they would often have to travel long distances to receive treatment.[64] As a result of limited access to facilities and lower access to medical specialists compared to urban areas, regional Australians have substantially lower levels of private health membership.[65]

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59 NRHA, *Submission 48*, p. 3.

60 NRHA, *Submission 48*, p. 1.

61 *Submission 48*, p. 1.

62 *Submission 48*, p. 4.

63 *Submission 48*, p. 4.

64 ANMF, *Submission 70*, p. 17.

65 *Submission 70*, p. 17.

2.44 Despite access to fewer medical facilities, individuals who live in rural and remote areas pay the same premium as those living in urban centres. Services for Australian Rural and Remote Allied Health (SARRAH) noted that this is compounded by the additional financial costs faced by those in rural areas who often have to travel greater distances and face additional costs to access adequate healthcare.[66] These issues often lead to rural and regional consumers accessing health services 'less frequently' or relying 'on intermittent outreach services'.[67]

2.45 Numerous submissions have therefore recommended initiatives to improve the value of private health insurance for consumers living in regional and remote locations. The Australian Physiotherapy Association recommended rebates for the non-hospital option to include any transport or accommodation costs to assist rural patients.[68] The ANMF recommended the 'provision of incentives for private practitioners to operate in rural areas' and the 'leveraging of models of care that would enhance access, such as telehealth, remote monitoring and the funding of nurses and allied health professionals to deliver care, closer to people's homes'.[69]

2.46 SARRAH have suggested that private health insurance products 'should be tailored to meet the needs of indigenous and non-indigenous Australians living in rural and remote Australia'.[70] This includes improving access and value through increasing the range of benefits for non-private hospital services and increasing transport and accommodation benefits.

2.47 On 13 October 2017, the Minister announced that insurers would be able to offer accommodation and travel benefits for people in rural and regional areas.[71]

Chronic illnesses

2.48 Other submitters raised concerns about high out-of-pocket expenses for people diagnosed with chronic diseases.[72] Allied Health Professions Australia stated that high costs for this cohort 'reduce the accessibility of services and results in consumers avoiding treatment and increasing their risk of avoidable health issues'.[73]

2.49 Breast Cancer Network Australia told the committee that in 2016 it conducted research into the financial impact of breast cancer. This research showed that women with private health insurance 'typically pay more than twice as much for their breast cancer treatment and care than women without private health insurance'.[74]

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66 SARRAH, *Submission 61*, p. 5.

67 *Submission 61*, p. 5.

68 Australian Physiotherapy Association, *Submission 75*, p. 10.

69 ANMF, *Submission 70*, p. 18.

70 SARRAH, *Submission 61*, p. 5.

71 Department, *Submission 127—Attachment 1*, [p. 1].

72 Allied Health Professions Australia, *Submission 52*.

73 *Submission 52*, p. 4.

74 Breast Cancer Network Australia, *Submission 12*, p. 3.

2.50 The Haemophilia Foundation Australia also undertook an internal survey of individuals diagnosed with the disease. This found that 34 per cent of individuals used the public health care system.[75] The reasons cited for using the public system instead of private healthcare included, management of the bleeding risk and that respondents saw 'limited value in using public health insurance for extras…as the benefits were low and far outweighed by the premium costs'.[76] The majority of respondents said they were debating whether they could afford private health insurance.[77]

2.51 A number of submitters also drew attention to the significant out-of-pocket expenses incurred by individuals diagnosed with particular illnesses. Parkinson's Australia noted that patients can face costs of as much as $50 000 depending on their level of private health insurance coverage.[78]

2.52 Parkinson's Australia told the committee that the high costs associated with treating particular illnesses could be very substantial:

> Parkinson's Australia is aware of people who have had to mortgage their homes or have had to dip into their superannuation to finance their DBS [deep brain stimulation] treatment. There are also many who cannot afford this treatment at all even though it is appropriate for them and is considered cost effective.[79]

2.53 The Royal Australian College of General Practitioners (RACGP) noted that chronic disease management is an area where private health insurance can provide long-term saving to patients.[80] In particular it noted that '[private health insurance] organisations can improve the health of their members and Australians more widely through supporting services not funded through Medicare'.[81] These include chronic disease management, care coordination and general practice modernisation.

2.54 Product design relating to the management of chronic illnesses is considered further in Chapter 4.

Transparency

2.55 Some submitters to the inquiry raised concerns that consumers find it difficult to understand what their health insurance product covers.

2.56 A common recommendation throughout this inquiry has been for the implementation of standardised terminology for health insurance products. The AHHA, for example, recommends a 'mandated simplification and consistency of product information provided across the sector'.[82] It was proposed that this would

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75 Haemophilia Foundation Australia, *Submission 50,* p. 5.

76 *Submission 50,* p. 5.

77 *Submission 50,* p. 6.

78 Parkinson's Australia, *Submission 1,* p. 2.

79 Parkinson's Australia, *Submission 1,* p. 2.

80 Royal Australian College of General Practitioners (RACGP), *Submission 9,* p. 2.

81 *Submission 9,* p. 2.

82 AHHA, *Submission 3,* p. 10.

allow consumers to better compare private health insurance products and increase transparency in the sector.

2.57 The Private Health Insurance Ombudsman (PHIO) provides information for consumers to understand private health insurance policies via the consumer website privatehealth.gov.au.[83] In 2016 this website attracted 1.2 million unique visitors, approximately one-eighth of the roughly 10 million health insurance consumers in Australia.[84] When questioned on these figures, Mr David McGregor, Director of Private Health Insurance for the Commonwealth Ombudsman, said this was not a 'surprising figure'.[85] Mr McGregor also noted that there was currently no allocation in its budget to promote the website.[86]

2.58 A number of submitters suggested that better promotion of the website by both the Commonwealth Government and private health insurers is essential to increase transparency of the industry and to allow consumers to make better informed decisions about the products available to them.[87]

2.59 Promotion of the PHIO-run site is critical because it is one of the only independent comparison websites.[88] Many of the other comparison websites are run by intermediaries, also known as commercial comparison services.[89] 'Intermediary' is a broad term that includes comparators,—such as Compare the Market, iSelect and Choosewell—agents and brokers who provide advice and guidance to consumers about available products.[90] These companies operate on commissions from private health insurers, but are not necessarily transparent about the private health insurers they receive commissions from, which can make it difficult for consumers to know if they are being shown all of their available options.[91]

2.60 On 13 October 2017, the Minister announced a series of reforms including a policy to redevelop the privatehealth.gov.au website to assist consumers in choosing private health insurance products suited to their needs.[92] The website will also see the introduction of a 'minimum data set' to communicate private health insurance product data in an online format.[93]

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83 Ms Doris Gibb, Acting Deputy Commonwealth Ombudsman, *Committee Hansard*, 5 July 2017, p. 1.

84 Mr David McGregor, Director, Private Health Insurance, Commonwealth Ombudsman, *Committee Hansard*, 5 July 2017, p. 1–2.

85 Mr McGregor, *Committee Hansard*, 5 July 2017, p. 2.

86 Mr McGregor, *Committee Hansard*, 5 July 2017, p. 2.

87 AHHA, *Submission 3*, p. 10; Mr Shaun Gath, *Submission 5*, p. 28.

88 Mr McGregor, *Committee Hansard*, 5 July 2017, p. 2. The other independent website is run by the Australian Consumers' Association.

89 Private Health Insurance Intermediaries Association (PHIIA), *Submission 221*, [p. 3].

90 *Submission 221*, [p. 3].

91 National Seniors Australia, *Submission 86*, p. 6.

92 Department, *Submission 127—Attachment 1*, [p. 2].

93 *Submission 127—Attachment 2*, [p. 9].

2.61 The Commonwealth Government has also proposed a new system for categorising private health insurance products. This includes the introduction of categories ('gold', 'silver', 'bronze' and 'basic') which place a minimum standard against each category. This classification is intended to assist consumers to compare and contrast private health insurance products. The Commonwealth Government will seek to introduce a list of standard clinical definitions insurers will be required to apply across all private health insurance documentation.[94]

2.62 Submitters to the inquiry generally welcomed the new classification system, but agreed that consumers needed to be able to clearly understand what they were covered for.[95] Dr Gannon told the committee that:

> With gold, silver, bronze, it is just absolutely important that people understand what they're getting. And if gold means 'everything', silver means 'everything with excesses or co-payments', if you must, and 'bronze' means 'a reduced level of service, but more than just junk', then we can live with that. But what we want is people, your average member of the community, to be able to understand it and to have something in their hands that's actually worth something.[96]

Minimum standard benefits

2.63 Some submitters proposed that a new minimum standard for a complying private health insurance policy be introduced. Currently, the only requirement for a complying health insurance policy is that minimum benefits are provided for psychiatric, rehabilitation and palliative care services.[97]

2.64 The Department explained that these requirements reflect concerns by hospitals and other providers that insurers would not contract for those services.[98]

2.65 NASOG suggested that obstetric services ought to be a mandatory inclusion:

> Australian society has an overriding responsibility to support, and care for, the women of our nation who undertake the great responsibility of our next generation. The inclusion of obstetric cover in the design of all PHI [private health insurance] policies for women of childbearing age is paramount, and should be a standard inclusion.[99]

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94 *Submission 127—Attachment 2*, [p. 5].

95 Mr Ian Burgess, Chief Executive Officer, Medical Technology Association of Australia (MTAA), *Committee Hansard*, 31 October 2017, p. 6; Mr Ian Yates, Chief Executive Officer, COTA Australia, *Committee Hansard*, 31 October 2017, pp. 8, 11; Ms Leanne Wells, Chief Executive Officer, Consumers Health Forum of Australia, *Committee Hansard*, 31 October 2017, p. 12; Dr Gannon, *Committee Hansard*, 31 October 2017, p. 32; Dr David, *Committee Hansard*, 31 October 2017, p. 48.

96 *Committee Hansard*, 31 October 2017, p. 39.

97 AHHA, *Submission 3*, p. 10.

98 Mr Charles Maskell-Knight, Principal Adviser, Department, *Committee Hansard*, 31 October 2017, p. 73.

99 NASOG, *Submission 83*, [p. 3].

2.66 In relation to obstetrics, RANZCOG made the argument that:

> There is evidence that in the Australian community at least half, and probably more, of all pregnancies are unplanned, so couples or women don't have the opportunity to make provision through their cover beforehand. It should not be an issue that they have to wade through thousands of policy types in the hope that they will encounter or be able to select and buy a private health insurance product that covers maternity.[100]

2.67 Other submitters singled out mental health care as a feature to be included in all policies.[101] Dr Duckett advocated for the inclusion of mental health as a minimum requirement on the basis that people are unlikely to anticipate whether they will acquire a mental illness:

> Most people would probably think they're never going to have a mental illness; so they would probably be comfortable about having mental health as an exclusion. But yet we know…that mental illness is something that can affect everybody of every age—mental illness is not something that people like to talk about or people like to think about. But it is a serious illness and we want to make sure that if people have private health insurance they are covered for it because, as I said, it's not like orthopaedics or obstetrics, which have quite different incidents over time. But it's something that can affect everybody.[102]

2.68 However, the Department clarified that the government recently decided not to include comprehensive psychiatric care in basic policies because it would have a dramatic impact on premiums:

> …if you look at the range of basic products that are out there in the market at the moment, and they generally cover those three things that they must cover and then they cover a range of minor surgery…the question then becomes: 'Okay, so what would you want to add to those products to make them more comprehensive?' And this is where the candidate that is often mentioned is one that is providing full cover for psychiatric care rather than restricted cover. As soon as you do that, several things happen. One of them is that all the people who are buying top cover at the moment so that they get access to psychiatric care and who don't want to get anything else much drop out of top cover and move down. As soon as you do that, the extra benefits that have to be paid out of that basic cover go up and that makes premiums go up by 15 per cent. Once that became clear and the advice was provided to the government around this, the government decided that it didn't wish to pursue expanding the scope of those basic things.[103]

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100 Prof Steve Robson, President, RANZCOG, *Committee Hansard*, 31 October 2017, p. 34.

101 Dr Duckett, *Committee Hansard*, 31 October 2017, p. 14; Dr Kym Jenkins, President, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 31 October 2017, p. 34.

102 Dr Duckett, *Committee Hansard*, 31 October 2017, p. 20.

103 Mr Maskell-Knight, *Committee Hansard*, 31 October 2017, p. 71.

Committee view

2.69 The committee recognises that consumers are currently confused by the large number of private health insurance policies that are on offer and that it can be difficult for consumers to understand what they are covered for. The committee also understands that rising premiums, exclusions and out-of-pocket costs are diminishing the value of private health insurance for consumers.

2.70 Whilst a certain onus must be placed on the consumer to understand their level of coverage and the exclusions in their private health insurance policy, the committee is concerned about the rising level of exclusions in private health insurance policies. The committee also considers that consumers who pay for private health coverage should not face unexpected out-of-pocket payments.

2.71 The committee is concerned about reports of individuals using their superannuation savings or mortgaging a house to pay out-of-pocket medical costs. The committee notes the government's announcement relating to accommodation and travel costs for people in rural and regional areas. The committee's conclusion on this announcement is contained in Chapter 5.

2.72 The committee believes that private health insurers should be more transparent about the scope of coverage of their private health insurance policies.

2.73 The committee recognises there are pressures that are placed on private health insurers in setting premiums. Premiums are examined in the next chapter.