Chapter 4

Using private health insurance

4.1 This chapter will consider the use of private health insurance in a range of different settings, including in public hospitals, out-of-hospital care and in dentistry.

Public hospitals

4.2 A number of submitters to the inquiry were concerned that current arrangements allow policy holders to be treated as private patients in a public hospital.[1]

4.3 The National Health Reform Agreement (Reform Agreement) allows a patient to elect to be treated as a private patient in a public hospital.[2]

4.4 The Independent Hospital Pricing Authority (IHPA), one of the bodies created by the Reform Agreement, commissioned professional services firm Ernst and Young (EY) to write a report on the utilisation of private patients in public hospitals.[3] The IHPA provided the committee with a copy of the EY report that noted that more people are choosing to be treated as private patients in public hospitals.[4] The rate of increase has varied across Australia as the below table shows.

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1 National Rural Health Alliance (NRHA), *Submission 48*, p. 6; HBF, *Submission 63*, p. 10; Royal Australasian College of Surgeons, *Submission 69*, [p. 3]; Australian Nursing and Midwifery Federation (ANMF), *Submission 70*, [p. 5]; Day Hospitals Australia, *Submission 91*, p. 3; Ramsay Healthcare, *Submission 190*, [p. 3].

2 Amanda Biggs, *Private Health Insurance: a quick guide*, 4 August 2017, p. 2 http://parlinfo.aph.gov.au/parlInfo/download/library/prspub/5434084/upload_binary/5434084.pdf (accessed 27 November 2017).

3 Independent Hospital Pricing Authority (IHPA), *Submission 2*, p. i.

4 *Submission 2*, pp. 9–10.

Table 4.1 - Proportion of public hospital separations funded by private health insurance by State and Territory 2008-09 to 2014-15

Year	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	National
2008-09	15.8%	8.9%	4.0%	6.9%	8.4%	13.2%	6.5%	0.7%	9.7%
2009-10	17.1%	9.7%	4.5%	6.6%	8.2%	15.0%	6.6%	0.5%	10.4%
2010-11	17.2%	9.8%	5.7%	5.9%	7.4%	15.1%	6.8%	0.6%	10.5%
2011-12	17.2%	10.5%	8.3%	5.6%	7.2%	16.7%	7.4%	0.6%	11.1%
2012-13	19.0%	12.9%	10.6%	6.1%	7.6%	17.7%	9.2%	0.7%	13.0%
2013-14	20.0%	13.3%	11.7%	7.5%	8.2%	18.4%	10.3%	0.8%	13.9%
2014-15	20.7%	13.3%	12.1%	7.7%	8.1%	18.3%	10.8%	1.4%	14.1%
Growth in proportion between 2008-09 and 2014-15	4.9 percentage points	4.4 percentage points	8.1 percentage points	0.8 percentage points	-0.3 percentage points	5.1 percentage points	4.3 percentage points	0.7 percentage points	4.4 percentage points

Source: IHPA, *Submission 2*, p. 10.

4.5 The EY report investigated whether a change in the hospital funding model—from block funding to Activity Based Funding (ABF)—was driving the increase in the number of patients electing to be treated privately.[5] The report concluded that ABF was not a significant driver of the increase, but that intentional policy settings adopted by state governments are attracting larger numbers of private patients.[6]

4.6 IHPA told the committee that the Commonwealth provides ABF to the states in accordance with the Reform Agreement.[7] However, public hospitals may have a financial incentive to attract private patients depending on whether the funding model adopted by the state or territory accounts for the revenue generated by private patients:

> …funding provided to State and Territory governments per National Weighted Activity Unit (NWAU) is discounted for private patients through the implementation of a Private Patient Adjustment to account for additional revenue for private patients from Private Health Insurers… and other Commonwealth sources.
>
> Without making allowances for additional funding for private patients through private patient adjustments, there would be financial incentives for State and Territory governments, LHNs [Local Hospital Networks] and

5 IHPA, *Submission 2*, p. 29.

6 *Submission 2*, p. 29.

7 *Submission 2*, p. 5.

public hospitals to increase the number of patients admitted as private patients to public hospitals to generate additional funding.[8]

4.7 The below table briefly explains that there is a financial incentive in some jurisdictions to treat private patients in public hospitals.

Table 4.2—Incentives to attract private patients

State	Private patient adjustments	Incentive
NSW	Local Health Districts (LHDs) and Specialty Health Networks (SHNs) were set private patient targets.[9] Where private patient targets are exceeded, the LHD / SHN retained the associated own source revenue (OSR) and where targets were not met LHDs / SHNs experienced a decline in funding.[10]	Yes
QLD	Only 36 QLD public hospitals were funded using ABF (87 block-funded). There were no private patient adjustments because the Health and Hospital Service (HHS) contributed some OSR. When the HHS was above its target for private patients, it retained the surplus funds. QLD Health advised the IHPA that these funds were used to mitigate the financial impact of unrecovered revenue.[11]	Yes
TAS	The Tasmanian ABF model provided funding to health organisations on a gross basis with revenue targets.[12] The Tasmanian model made no adjustment for private patient accommodation or service adjustments.[13] Therefore, there was an incentive to recruit more private patients because there was no deduction to account for the additional revenue received from private patients.[14]	Yes
VIC	Victoria used a Weighted Inlier Equivalent Separation (WIES) funding model.[15] The WIES model had a 24 per cent discount for private patients.[16] Across some	May be a residual incentive

8 IHPA, *Submission 2*, p. 8.

9 *Submission 2*, p. 13.

10 *Submission 2*, p. 13.

11 *Submission 2*, p. 16.

12 *Submission 2*, p. 23.

13 *Submission 2*, p. 23.

14 *Submission 2*, p. 23

15 *Submission 2*, p. 14.

16 *Submission 2*, p. 15.

	Diagnosis Related Groups (DRGs) the Victorian model did not adequately adjust and there may have been an incentive to target private patients with particular conditions where additional revenue had not been fully incorporated into the discounted WIES price.[17]	
WA	The WA ABF model did not apply any private patient adjustments and so the same amount was received from the state government for public and private patients.[18] The IHPA model provided a private patient discount to offset the revenue states and territories received from alternate sources.[19] However, there may have been an incentive to target private patients if the provider considered it could obtain additional revenue from the Commonwealth or the private health insurer.[20]	May be a residual incentive
SA	SA adopted the National ABF model for acute care but not sub-acute or non-acute care, including the private patient accommodation and service adjustments.[21] The Local Health Networks that provided sub-acute and non-acute care received the same amount from the state government regardless of whether the patient was a private or a public patient.[22] However, they may have had an incentive to target private patients if the provider considered it could obtain additional revenue from the Commonwealth or the private health insurer.[23]	May be a residual incentive
ACT	Hospitals in the ACT received the same amount regardless of whether the patient was public or private because it implemented the full ABF model including the adjustments.[24]	No
NT	There was insufficient information publicly available to determine whether there were price differences between public and private patients.[25]	Unknown

17 IHPA, *Submission 2*, p. 15.

18 *Submission 2*, p. 19.

19 *Submission 2*, p. 19.

20 *Submission 2*, p. 19.

21 *Submission 2*, p. 20.

22 *Submission 2*, p. 21.

23 *Submission* 2, p. 21.

24 *Submission 2*, p. 24.

25 *Submission 2*, p. 25.

4.8 The committee received evidence that some hospitals or health services have hired specific staff, often known as a Private Patient Officer (or similar), to encourage consumers to be treated as private patients in a public hospital.[26] One way hospitals or health services have promoted the use of private health insurance in a public hospital is to tell patients that using their private health insurance will assist the hospital.[27]

4.9 The Haemotology Federation of Australia conducted an 'online community survey' to assist in preparation of its submission to the inquiry.[28] Based on that survey, Haemotology Federation of Australia advised the committee that:

> Although [respondents] were largely required to attend public hospitals due to their bleeding disorder, some respondents described being asked to be admitted as a private patient. Many were happy to do this as they felt it was a contribution to the public health system, and some also preferred this where it gave them the possibility of a single room and choice of doctor, and covered telephone and newspapers.[29]

4.10 Some submitters raised concerns that some institutions apply pressure to policy holders to get them to use their private health insurance.[30]

4.11 The Consumers' Health Forum of Australia told the committee that some policy holders are being coerced or are being asked to elect whether to use their private health insurance in circumstances of severe stress. The Consumers' Health Forum of Australia provided the following example from a patient who responded to one of its private health insurance surveys:

> 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.[31]

4.12 Bupa Australia also told the committee that it had received anecdotal evidence from policy holders that some public hospitals had pressured patients into using their private health insurance:

> Current behaviour by many public hospitals sees many Bupa members receiving a bedside visit after a procedure or letters two or three months after an event pressuring them to declare their private cover and we believe

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26 IHPA, *Submission 2*, p. 27. The report provides job advertisements for roles in NSW and Tasmania.

27 *Submission 2*, p. 28.

28 Haemotology Federation of Australia, *Submission 50*, p. 1.

29 *Submission 50*, p. 7.

30 Consumers' Health Forum of Australia, *Submission 17*, p. 7; Bupa Australia, *Submission 43*, pp. 11–12.

31 *Submission 17*, p. 8 (capitalisation in original).

> this is unquestionably inappropriate and contrary to the intent of private patient declaration.[32]

4.13 Accordingly, Bupa Australia recommended to the committee that policy holders should only be able to elect to use their private health insurance for pre-booked admissions and only if the patient signs a form that is submitted to the insurer at least 24 hours before admission to hospital.[33]

Waiting times

4.14 The committee received evidence that many people believe they will gain access to surgery more quickly if they are admitted to a public hospital as a private patient.[34]

4.15 Choice conducted a survey of 1027 consumers about their reasons for purchasing private health insurance in April 2017.[35] The respondents to Choice's survey found that 43 per cent of respondents and 56 per cent of respondents over the age of 56 considered 'avoiding public hospital waiting lists' as one of the key reasons for purchasing private health insurance.[36]

4.16 The Consumers' Health Forum of Australia received a similar indication from consumers:

> [Consumers' Health Forum of Australia's] work with consumers has found that one of the main reasons they value having PHI [private health insurance] 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.[37]

4.17 The Department of Health (Department) provided the committee with a copy of Clause 4 of the Reform Agreement which provides:

> States will provide health and emergency services through the public hospital system, based on the following Medicare principles:
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> a. eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided by hospitals;
>
> b. access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and

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32 Bupa Australia, *Submission 43*, pp. 11–12.

33 *Submission 43*, p. 12.

34 Choice, *Submission 207*, p. 10; Consumers' Health Forum of Australia, *Submission 17*, p. 7.

35 *Submission 207*, p. 8.

36 *Submission 207*, pp. 10–11.

37 Consumers' Health Forum of Australia, *Submission 17*, p. 7.

c. arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.[38]

4.18 The Department explained to the committee that this means that:

> …providing that access to services for public patients is on the basis of clinical need and within a clinically appropriate period, the NHRA [National Health Reform Agreement] does not prevent public hospitals from treating private patients before public patients.[39]

4.19 Mr Charles Maskell-Knight, the Department's Principal Adviser, Health Systems Policy Division, was more explicit, suggesting hospitals may positively discriminate in favour of privately insured patients:

> **Mr Maskell-Knight**: There's a misconception that the Medicare principles require access to services within public hospitals to be based on clinical need, and that was the case from 1984 until 1998. In 1998 the then state and healthcare agreements were changed and the relevant principle was that public patients should receive care on the basis of clinical need within clinically appropriate periods.
>
> **Senator DI NATALE**: What does that mean for private patients?
>
> **Mr Maskell-Knight**: That hospitals may differentiate in favour of them.[40]

4.20 Earlier this year the Australian Institute of Health and Welfare (AIHW) released its *Admitted patient care 2015–16: Australian hospital statistics* report.[41] One of the key findings from that report related to the difference in the median waiting times between public and private patients:

> Overall, Public patients had a median waiting time of 42 days, compared with 20 days for hospitalisations with a funding source of Private health insurance.[42]

4.21 Some submitters were very concerned by the prospect that privately insured patients may be receiving preferential treatment on the basis of their insurance status.[43]

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38 Department of Health (Department), *Submission 127*, p. 10.

39 Department, *Submission 127*, p. 10 (emphasis added).

40 Mr Charles Maskell-Knight, Principal Adviser, Department, *Committee Hansard*, 31 October 2017, p. 68.

41 Australian Institute of Health and Welfare (AIHW), *Submission 68*, p. 3.

42 *Submission 68*, p. 4 (capitalisation in original).

43 Council of Procedural Specialists, *Submission 41*, [p. 6]; Australian Salaried Medical Officers' Federation, *Submission 53*, [p. 2]; Grattan Institute, *Submission 72*, p. 24; hirmma, *Submission 75*, p. 22; Australian Private Hospitals Association (APHA), *Submission 80*, p. 7; National Seniors, *Submission 86*, p. 2; COTA Australia, *Submission 88*, pp. 5–6; Catholic Health Australia, *Submission 238*, p. iii.

4.22 The AIHW noted that there may be some legitimate reasons for differences in the timeframes for private and public patients:

> …there may be differences between public patients and patients funded by other sources, in the conditions treated and in the urgency categories assigned, that may account for some variation in waiting times.[44]

4.23 The Australian Health and Hospitals Association (AHHA) noted that the AIHW data did not take account of acuity or case mix, both of which would impact on waiting times.[45] In relation to the AIHW data, the Queensland Government told the committee that:

> It is important to note that published results do not separate the different urgency categories patients are placed into, which consist of different clinically recommended treatment times (treatment within 30, 90 and 365 days for Category 1, 2 and 3, respectively).[46]

4.24 Consumers' Health Forum of Australia agreed that the AIHW data may require further investigation:

> …the data from which these conclusions are drawn are not necessarily robust and there may be clinical reasons for this apparent trend. 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.[47]

4.25 In December 2017, the AIHW released a more comprehensive report—*Private health insurance patients in Australian hospitals, 2006–07 to 2015–16*—to address the issues identified in the *Admitted patient care 2015–16: Australian hospital statistics* report.[48] The AIHW *Private health insurance patients in Australian hospitals, 2006–07 to 2015–16* report identified that:

> Private health insurance patients were more likely to be assigned to clinical urgency category 1 (admission within 30 days) compared with public patients and other patients (39%, 27% and 23%, respectively).
>
> Among surgical specialties, the largest differences in the proportion assigned to clinical urgency category 1 were for Neurosurgery (50% for

44 *Submission 68*, p. 4.

45 Australian Healthcare and Hospitals Association (AHHA), *Submission 3*, p. 8.

46 Queensland Government, *Submission 85*, [p. 5].

47 Consumers' Health Forum of Australia, *Submission 17*, p. 7.

48 AIHW, *Private health insurance patients in Australian hospitals, 2006–07 to 2015–16*, 6 December 2017, https://www.aihw.gov.au/reports/hospitals/private-health-insurance-patients-hospitals/contents/table-of-contents (accessed 6 December 2017).

> private health insurance patients, 30% for public patients, and 32% for other patients).[49]

4.26 As an example, the AIHW examined data for total knee reconstructions. The data revealed that patients with private health insurance had shorter median waiting times than public patients:

> For *Total knee replacement*, 50% of private health insurance patients were admitted within 76 days for their surgery, compared with 203 days for public patients and 54 days for other patients.[50]

4.27 Whilst some submitters called for an end to policies that would allow patients to be treated as a private patient in a public hospital, other submitters warned that ending such policies could have unintended consequences. The Queensland Government told the committee:

> A possible unintentional outcome of restrictions on private patient practices could be that hospitals might have difficulty attracting and retaining medical practitioners, leading to increased difficulty meeting growing health service demand.[51]

Committee view

4.28 The committee is concerned about the trend in the number of people electing to be treated as private patients in a public hospital. The committee has concerns that state and territory governments are implementing policies that encourage hospitals and health networks to attract private patients.

4.29 The committee notes the AIHW findings that confirm that median waiting times for private patients are shorter than for public patients, but longer than for 'other' patients.

4.30 The committee was also concerned by the evidence of consumer groups that some people feel pressured to elect to be treated as a private patient. The committee maintains that the decision on whether to be treated as a private patient ought to be made by the patient with full knowledge of the financial and associated consequences.

Hospitals and out-of-hospital care

4.31 The committee received evidence that current regulation prevents private health insurers from being able to constructively engage with insured consumers to manage their risks.[52]

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49 AIHW, *Private health insurance patients in Australian hospitals, 2006–07 to 2015–16*, 6 December 2017, p. ix. The classification 'other' was assigned to patients whose separation was self-funded or funded other than by private health insurance or public election. Some examples include funding by the Department of Veterans' Affairs or Department of Defence, part of a worker's compensation or third party motor vehicle claim.

50 AIHW, *Private health insurance patients in Australian hospitals, 2006–07 to 2015–16*, 6 December 2017, p. x (italics and capitalisation in original).

51 Queensland Government, *Submission 85*, [p. 4].

52 Private Healthcare Australia, *Submission 18*, p. 26.

4.32 Private Healthcare Australia told the committee that:

> Legislation currently prevents private health insurance from covering medical services that are provided out-of-hospital and covered by Medicare. This may inhibit insurers from funding up-to date models of care for chronic conditions which are based out-of-hospital, and out-of-hospital care which may help to avoid unnecessary hospitalisations. In some cases, out-of-hospital care is preferable to treatment within a hospital for clinical reasons. By preventing insurers from funding out-of-hospital care in these cases (which is often more cost effective than in-hospital treatment), the legislation is putting upwards pressure on premiums.[53]

4.33 Private Healthcare Australia also told the committee that as a result of these legislative restrictions people may be unnecessarily hospitalised:

> It also creates an obvious perverse incentive for doctors to admit patients to hospital, particularly for short-stay admissions when it isn't clinically required. This is because in doing so, the provider can claim gap cover, and additional revenue if they have an additional financial stake in a short-stay hospital facility. This has fuelled huge growth in hospitalisation of patients previously treated in doctors' rooms and in the community, for everything from excision biopsies to cognitive behavioural therapy, and has inevitably put upward pressure on premiums. It would make much more sense to amend the legislation, permitted [sic] health funds to negotiate with providers for appropriate remuneration in an appropriate setting of care.[54]

4.34 As noted in Chapter 2, the Royal Australian College of General Practitioners (RACGP) have also acknowledged that private health insurers may have a role to play in helping to keep Australians healthy:

> PHI [private health insurance] organisations can improve the health of their members and Australians more widely through supporting services not funded through Medicare such as:
>
> - chronic disease management – providing additional services for patients with complex and chronic disease
> - care coordination and team care – supporting patients to access nurse services, additional allied health visits and programs to assist patients transitioning between primary and tertiary healthcare, including preadmission or post-operative care
> - general practice modernisation – supporting patients to access telehealth consultations and services with their regular GP [general practitioner]; supporting the use of newer technologies…[55]

4.35 The private health insurance industry has indicated that this is an area that it would like to move into. Private Healthcare Australia told the committee:

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53 *Submission 18*, p. 26.

54 Private Healthcare Australia, *Submission 18*, p. 26.

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

> Out-of-hospital, we can't contribute. The costs of people treating their cancer out-of-hospital, we can't contribute. Mental health treatment out-of-hospital…the current regulatory system means we cannot easily contribute to patient out-of-hospital costs in the situations where that would avoid hospitalisation. That is something in the modern world we think needs to change. It's also currently acting as a perverse incentive encouraging unnecessary admissions to hospital in some key treatment areas.[56]

4.36 The AHHA suggested that private health insurers ought to be able to contribute to out-of-hospital care in certain circumstances:

> The AHHA recommends that where medical services are provided on referral from the hospital in an outpatient, community or home setting, that these services be eligible for cover through private health insurance.[57]

4.37 NIB also suggested that extending the Broader Health Cover provisions may help to attract more young people and keep premiums low.[58]

4.38 The Department, however, told the committee that private health insurers have been able to provide some of these services since April 2007.[59] The Department indicated that private health insurers could already offer Chronic Disease Management Programs and hospital-substitute treatment, including chemotherapy or a dialysis in a patient's own home or a community clinic.[60]

4.39 The Grattan Institute was supportive of providing private health insurers some greater latitude to determine what products they offer:

> The most recent Australian study I've seen suggests that home-based rehab is just as useful as in-patient rehab. We need to give the private health insurance funds more ability to manage what they are paying for. At the moment they are highly constrained by regulation. If there's going to be more transparency, and more demands made on them, they ought to have a right to more flexibility in what they do.[61]

4.40 However, the RACGP considered that the committee should be cautious in extending the reach of private health insurers into primary care.[62] The RACGP warned that some of the risks may include the duplication and fragmentation of care—

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

57 AHHA, *Submission 3*, p. 13.

58 NIB, *Submission 24*, p. 2.

59 Department, *Submission 127*, p. 27.

60 *Submission 127*, p. 27.

61 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 31 October 2017, p. 15.

62 RACGP, *Submission 9*, p. 2.

potentially involving 'preferred GP [general practitioner] providers'—removal of general practitioners' clinical independence or access on the basis of insured status.[63]

Case study: dentistry

4.41 The committee received a significant number of submissions from dental practitioners, or individuals who work in the dental industry, about the effect that private health insurance has had on private dentistry.[64] The committee received some similar submissions from optometrists and physiotherapists.[65] The committee considers that dentistry provides a useful a case study through which to examine the role of private health insurance in the provision of primary health care.

Contracted dentists

4.42 The committee heard that some dentists have entered into contracts with private health insurers to charge agreed fees to the private health insurer's policy holders.[66] In return, the private health insurer markets the dental practice and provides better rebates to the private health insurer's policy holders when they visit that clinic.[67] Private health insurers often refer to these contracted dentists as 'preferred providers' or 'member's choice' providers.[68]

4.43 The most common concern raised by dental practitioners was that private health insurers provided different rebates to insured consumers based on whether their dentist had a contract with the consumer's private health insurer.[69]

4.44 Dental practitioners submitted that it was unfair to consumers who had paid for extras policies to receive lower rebates because they decided to use their private health insurance to visit a non-contracted dentist.[70] These submitters argued that consumers who purchase the same extras policy from the same insurer ought to receive the same rebate regardless of which dentist the consumer decides to visit.[71]

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63 *Submission 9*, pp. 2–3.

64 See for example Name withheld, *Submission 92*, [pp. 1–4]; Name withheld, *Submission 124*, [pp. 1–2]; Name withheld, *Submission 256*, [p. 1–4].

65 See for example Australian Physiotherapy Association, *Submission 74*, p. 10; Optometry Australia, *Submission 8*, pp. 3–4.

66 See for example Name withheld, *Submission 168*, [p. 2]; Name withheld, *Submission 275*, [p. 2].

67 See for example Name withheld, *Submission 128*, [p. 2]; Name withheld, *Submission 210*, [p. 1].

68 See for example Name withheld, *Submission 100*, [p. 1]; Name withheld, *Submission 241*, [p. 1].

69 See for example Name withheld, *Submission 97*, [p. 2]; Name withheld, *Submission 280*, [p. 1].

70 See for example Name withheld, *Submission 103*, [p. 1]; Name withheld, *Submission 98*, [p. 1]; Name withheld, *Submission 137*, [p. 1].

71 See for example Name withheld, *Submission 254*, [p. 1]; Name withheld, *Submission 229*, [p. 1].

4.45 The Australian Dental Association (ADA) told the committee that in some cases, the rebates private health insurers paid to consumers that visited non-contracted dentists were so low that dentists who charged substantially lower rates struggled to compete against contracted providers:

> You will see from these examples that the issue is not with the fee charged, but rather the rebate paid. In the first two scenarios the fee for the porcelain crown is less at an independent, non-contracted dentist. However, the rebate provided by the fund is significantly higher when the patient is treated by a contracted dentist. This results in a substantial difference in the patient's out-of-pockets cost, which has little or nothing to do with the fee charged by the dentist.[72]

4.46 The ADA and many dental practitioner submitters considered that consumers would be better empowered to make decisions about where to use their private health insurance if insurers were required to pay the same rebate to insured consumers regardless of which dentist they visited.[73] Accordingly, the ADA and the dental practitioners called for an end to the practice of applying differential rebates depending on whether the dentist was contracted or not.[74]

4.47 In response to a question on notice, Bupa Australia disputed the suggestion that a consumer who visited a cheaper dentist could end up with larger out-of-pocket costs because of the rebate provided by the private health insurer.[75] However, the ADA provided the committee with further documents to substantiate its claim.[76]

4.48 Submitters advised the committee that clients who called their private health insurer have often been provided with incorrect information. One concern was that clients were sometimes told that the reason they received a low rebate was because the dentist 'charged too much'.[77]

4.49 Specialist dentists, such as orthodontists and endontists, told the committee that private health insurers were providing advice to insured consumers that, instead of going to see the dental specialists recommended by their dentist, they should visit a 'preferred provider' dentist.[78]

4.50 One endontist told the committee:

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72 Dr Sachs, *Committee Hansard*, 31 October 2017, p. 21; ADA, *Rebate Disparity Case Study*, [p. 1] (tabled 31 October 2017).

73 Dr Sachs, *Committee Hansard*, 31 October 2017, p. 21. See for example Name withheld, *Submission 155*, [pp. 3–4].

74 ADA, *Submission 222*, p. 6. See also for example Name withheld, *Submission 145*, [p. 5]; Name withheld, *Submission 242*, [p. 1]; Name withheld, *Submission 276*, [p. 1].

75 Bupa Australia, answer to questions on notice, 31 October 2017 (received 17 November 2017).

76 ADA, *Information responding to statements made in submissions, submissions responses and answers to questions on notice*, [p. 1], received 28November 2017.

77 See for example Name withheld, *Submission 141*, [p. 1]; Name withheld, *Submission 214*, [p. 1]; Name withheld, *Submission 270*, [p. 1].

78 Name withheld, *Submission 119*, p. 1; Name withheld, *Submission 211*, [p. 1].

> …most of my patients are seeking relief from pain or discomfort caused by either trauma or infection. They are seeking that treatment through a registered specialist because they have been referred by their general dental practitioner to achieve the best possible outcome for their long-term health. Most have complex management needs. However, my patients report at least weekly that they are disappointed and frustrated by the fact that, on inquiry about rebates, health funds actively endeavour to redirect them to health fund preferred providers, or health fund clinics, where no specialist care is available. The justification for this is that the preferred providers or health fund clinics provide better rebates (despite the fact it is not specialist care).[79]

4.51 Many other specialists expressed similar views and considered the advice of the private health insurer's staff to be clinical in nature and therefore inappropriate.[80]

4.52 Another concern that dental practitioners raised with the committee was that new dentists are unable to join the 'preferred provider' schemes.[81] The inability to become a preferred provider meant that they were unable to ensure that their clients received higher rebates. In some cases, this meant that independent dentists lost clients who were under financial pressure.[82]

Anti-competitive practices

4.53 The dental practitioner submitters to the inquiry considered that the 'preferred provider' schemes, and a number of other practices engaged in by the private health insurers, are anti-competitive.[83]

4.54 One of the concerns that the dental practitioners raised was that private health insurers have started a process of vertical integration where private health insurers now own some contracted dental clinics.[84]

4.55 Many dental practitioners considered that owning clinics was a conflict of interest because the private health insurer, with whom they were now in competition, was able to unilaterally determine the rebate that insured consumers would get if they visited a non-contracted dentist.[85]

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79 Name withheld, *Submission 211*, [p. 1].

80 See for example Name withheld, *Submission 253*, [p. 1]; Name withheld, *Submission 259*, [p. 1].

81 See for example Name withheld, *Submission 102*, [p. 1]; Name withheld, *Submission 200*, [p. 2].

82 See for example Name withheld, *Submission 130*, [p. 1]; Name withheld, *Submission 149*, [p. 1].

83 See for example Name withheld, *Submission 179*, [p. 1]; Name withheld, *Submission 186*, [p. 2]; Name withheld, *Submission 227*, [p. 1].

84 See for example Name withheld, *Submission 111*, [p. 2]; Name withheld, *Submission 223*, [p. 1]; Name withheld, *Submission 246*, [p. 2].

85 See for example Name withheld, *Submission 275*, [p. 2]; Name withheld, *Submission 194*, [p. 2].

4.56 In addition, submitters told the committee that private health insurers were actively steering or redirecting policy holders toward contracted dentists where they could obtain a better rebate.[86] This steering could take the form of a letter or phone call to a client after a visit to an independent dentist advising them that they should visit a 'preferred provider'.[87]

4.57 Bupa Australia rejected the suggestion that it redirected insured consumers from independent dentists to contracted dentists:

> There are a lot of things said about us 'directing' people—we don't. We promote that there is a range of benefits people can access via their products. Every consumer has the same choice in their product.[88]

4.58 Dental industry submitters were also concerned that the private health insurers could compete against them with full knowledge of what practitioners' fees are and what rebates patients are receiving. Private health insurers obtain this information through a billing system called the Health Industry Claims and Payment Service (HICAPS).[89]

4.59 Dental practitioners told the committee that through HICAPS:

> The PHI's [sic] have access to all of the information processed by the HICAPS machine in every dental surgery. This means that they can monitor a dentists [sic] fees, the type of work, client base size and composition, and obviously if any of their own customers are patients to that dentist. This puts the dentist at an extreme disadvantage.[90]

4.60 Since 1999 the Australian Competition and Consumer Commission (ACCC) has produced 18 reports for the Senate about the anti-competitive practices of private

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86 See for example Name withheld, *Submission 143*, [p. 2]; Name withheld, *Submission 264,* [p. 1]; Name withheld, *Submission 166*, [p. 2].

87 See for example Name withheld, *Submission 131*, [p. 3]; Name withheld, *Submission 152*, [p. 3].

88 Mr Adam Longshaw, Director, Health and Benefits, Bupa Australia, *Committee Hansard*, 31 October 2017, p. 54.

89 See for example Name withheld, *Submission 112*, [p. 2]; Name withheld, *Submission 143*, p. 3; Name withheld, *Submission 165*, [p. 2].

90 Name withheld, *Submission 111*, [p. 3].

health insurers.[91] The ACCC has been asked to consider if 'preferred provider' schemes are anti-competitive on a number of occasions.[92]

Management of services

4.61 Both 'preferred provider' dental practitioners and independent practitioners raised concerns in relation to attempts by private health insurers to influence the treatment of patients by refusing to pay for particular item combinations to be charged together or by imposing restrictions on benefits.[93]

4.62 One submitter explained to the committee:

> For example, you are not allowed to have a comprehensive dental examination and a dental crown on the same day…I once had a patient present with a broken tooth so I undertook a comprehensive examination and performed a crown for the tooth on the same day to fix the problem. But the patient received no rebate for the crown. The patient obviously was very upset. The patient left to discuss it with the PHI [private health insurer's] office, and so I received a call by the PHI representative. I was told that to do a crown on the same day as the comprehensive exam was not a reasonable treatment and violated their rules... So I was told that perhaps I should not charge the patient for the dental examination. That way the patient can receive the full rebate for the crown. They were asking me to remove a legitimate code and were trying to manipulate my clinical operations by suggesting that my treatment was not reasonable! That is not their decision to make as the insurer.[94]

4.63 Another submitter explained that they had a similar experience with private health insurers placing restrictions on performing clinically necessary dental work:

> Some health funds restrict or do not pay on item numbers related to crowns (611, 613, 615 or 618) when an item of removing a crown has been performed on the same day (655). It is common practice that if a crown needs replacement due to decay or breakages, then the crown is removed, the tooth repaired and a crown commenced for a new crown on the same day to avoid further harm and exposure of the tooth. Patients I have treated

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91 See for example Australian Competition and Consumer Commission (ACCC), *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 2015 to 30 June 2016*, 17 July 2017, https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2015-16 (accessed 4 December 2017) (Report to the Senate 2015–16). See also *Journals of the Senate*, No. 27, 25 March 1999, p. 626.

92 See for example ACCC, Report to the Senate 2015-16, pp. 28–29; ACCC, *Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance for the period 1 July 2010 to 30 June 2011*, 6 June 2012, pp. 30–33, https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2010-11 (accessed 4 December 2017).

93 See for example Name withheld, *Submission 96*, [p. 2]; Name withheld, *Submission 99*, [p. 1]; Name withheld, *Submission 234*, [p. 2].

94 Name withheld, *Submission 205*, [p. 5].

> have been left paying higher out of pocket costs and financially worse off than expected because the health fund has not been clear in their rebates on these items when associated with other items.[95]

4.64 The dental practitioners explained that they used to be able to accurately predict patients out-of-pocket costs because private health insurers used to publish guides to their rebates:

> Many years ago, the Health Funds used to publish their rebates in a booklet. This was of benefit to their customers and to their Dentists because we were able to let our patients know how much they might receive as a rebate from their Health Fund and what the gap payment may be. The Health Funds stopped publishing these rebate booklets because we were able to show our patients (ie their customers) that the rebates had not increased, or increased only slightly, over the years and also we were able to show comparisons of rebate amounts between various Health Funds. The Health Funds claimed that they stopped publishing their rebates because they were "commercial in confidence". The current situation is that when we present a treatment plan to our patients, we give them our fees as well as the item numbers involved so that they can contact their PHI [private health insurer] to see how much they may get back as a rebate. In some cases, when the patient has contacted their PHI to make this enquiry, they have been told that our fees are high, or in some cases, that the patient would receive more rebate if they went to one of the PHI's "preferred providers".[96]

Hospital contracting in paediatric dentistry

4.65 The committee heard evidence that some forms of surgery are financially unviable for private hospitals because private health insurers provide them with very low rebates.[97]

4.66 The committee heard evidence from paediatric dentists that they have been excluded from private hospitals and day surgeries because the hospitals receive low rebates from private health insurers:

> The rebate provided by private health insurers to private hospitals for in-hospital paediatric dental surgery is so low it is not financially viable for private hospitals to accommodate paediatric dentistry in their facilities. As a result, patient access to care is becoming increasingly restricted due to hospitals and other facilities excluding paediatric dentistry.[98]

4.67 The Australian Association of Paediatric Dentists (AAPD) noted that the unwillingness of the private health insurers to negotiate contracts meant that facilities that accommodate paediatric dentists are forced to rely on second tier default benefits.[99] Second tier default benefits are a safety net for small hospitals that do not

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95 Name withheld, *Submission 154*, [p. 2].

96 Name withheld, *Submission 219*, [pp. 1–2] (capitalisation in original).

97 Australian Association of Paediatric Dentists (AAPD), *Submission 25*, p. 3.

98 Dr Daniel Ford, Treasurer, AAPD, *Committee Hansard*, 31 October 2017, p. 22.

99 AAPD, *Submission 25*, p. 3.

have agreements with private health insurers, which is approximately 85 per cent of the average rate for a particular service.[100]

4.68 The AAPD told the committee that the second tier default benefits were inadequate:

> Given that the full rebate is inadequate, the amount paid under 2nd Tier benefits is grossly inadequate to cover the cost of providing the services and the patient must be charged a fee over and above the 2nd Tier rate. This results in reduced access to care and financial hardship.[101]

4.69 That financial hardship is compounded because the Child Dental Benefits Schedule prevents children from being eligible to receive benefits if they received treatment under general anaesthetic.[102]

4.70 The AAPD noted that a survey of its members indicated that fewer facilities were accommodating paediatric dentists:

> …our members have reported; the closure of facilities due to unsustainability financially, a reduced number of operating sessions, unreliable ad hoc time only, changes in sessions to accommodate a more profitable surgeon, time restraints on cases and denial of access despite being accredited for many years at a facility.[103]

4.71 The Australian and New Zealand Society of Paediatric Dentistry also reported that its members have had operating rights restricted in favour of surgeons performing more profitable surgeries.[104]

Committee view

4.72 The committee acknowledges that private health insurers may be able to play a greater role in the management of chronic conditions and out-of-hospital care. The committee accepts that it is desirable, where possible, to avoid unnecessary hospitalisation and that providing private health insurers with some greater latitude to offer these services may be beneficial. However, the committee is mindful of the concerns raised by the RACGP about duplication and fragmentation of care.

4.73 The committee acknowledges the concerns of dental practitioners and, in particular, the financial pressure that can be applied to their businesses by private health insurers. The committee is concerned by some of the practices raised above, such as the active redirection of patients and the restriction on the payment of certain item numbers.

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100 *Submission 25*, p. 3.

101 *Submission 25*, p. 3 (capitalisation in original).

102 *Submission 25*, p. 4.

103 AAPD, *Submission 25*, p. 3.

104 Australian and New Zealand Society of Paediatric Dentistry, *Submission 42*, [p. 5].

4.74 The committee is also concerned about the exclusion of paediatric dentists from operating theatres in private hospitals and day surgeries and its effect on children who are in need of specialist dental services.

4.75 Until the issues raised in this chapter are resolved the committee would be concerned about the further extension of private health insurance to out-of-hospital care.