Chapter 5
Conclusions

5.1 Private health insurance is complicated and the committee acknowledges that it is difficult to achieve a balance between offering more comprehensive products and maintaining affordable premiums for consumers.

5.2 In this inquiry, the committee received evidence from consumers who are finding private health insurance increasingly unaffordable. Meanwhile, private health insurers told the committee that they had little ability to control the costs in their supply chains.

5.3 Submitters—consumers, private health insurers, device manufacturers and dental practitioners—called on the committee to increase transparency, both in private health insurance and across the health industry more generally. As discussed in greater detail below, transparency may assist consumers to be better informed about purchasing and using their private health insurance.

Government's 2017 reforms

5.4 On 13 October 2017 the Minister for Health, the Hon. Greg Hunt MP (Minister), announced a series of reforms to private health insurance including:

- a new 'gold', 'silver', 'bronze' and 'basic' system of categorising policies;
- improving access to mental health services;
- permitting travel and accommodation benefits for Australians living in rural and regional areas to be offered under a hospital policy;
- increasing the powers of the Private Health Insurance Ombudsman (PHIO) to allow for inspections and audits;
- establishing a committee to consider out-of-pocket costs;
- allowing private health insurers to offer a 'reverse' lifetime health cover discount;
- further Prostheses List benefit reductions;
- an agreement with the Medical Technology Association of Australia (MTAA) to reduce the costs of prostheses;
- increasing maximum excess levels;
- removing coverage for some natural therapies;
- streamlining second tier administrative reforms; and
- discussing options relating to private patients in public hospitals as part of the next National Health Agreement.[1]

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1 Department of Health, *Submission 127—Attachment 2*.

5.5 The committee commends some of the proposed changes. For example, as discussed in Chapter 2, the committee received evidence that it was very difficult for consumers in rural and regional areas to access private healthcare services. The committee notes, in particular, evidence from the National Rural Health Alliance who called for reform in this area. The committee considers that including travel and accommodation benefits in hospital policies, and thereby allowing the costs to be shared through the risk equalisation pool, is beneficial for consumers.

5.6 The committee approaches some of the other announced changes with caution. In Chapter 2, the committee noted the difficulty faced by consumers in understanding what their private health insurance policy covers them for and the challenges faced by consumers when their coverage is different than what they thought it was. Increasing the maximum excess that consumers must pay before receiving coverage may compound this problem. The committee notes the Government's stated commitment to consult on implementation in the first half of 2018.

5.7 In Chapter 2 the committee noted that many submitters were broadly supportive of a categorisation system that would assist consumers. The committee considers that the classification of 'gold', 'silver', 'bronze' and 'basic' may assist consumers depending upon what is included in each category and how well the categories are able to be understood.

5.8 The committee also noted that hirmaa, Private Healthcare Australia and private health insurers outlined that lower cost policies were used by many Australians who valued the more limited coverage where they met members' personal circumstances and that lower cost products played a role in rural and regional Australia.

5.9 However, the committee notes the concerns raised by submitters, such as the Australian Nursing and Midwifery Federation, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the National Association of Specialist Obstetricians and Gynaecologists about 'junk' or 'basic' policies, which they considered should be discontinued because they provide low value to consumers. The committee also notes that this was the Government's view before the last election, when the then Minister for Health, the Hon. Sussan Ley MP, committed to 'weed out junk policies by ensuring consumers have access to a product with a mandated minimum level of cover'.[2]

5.10 In Chapter 3, the committee considered evidence from the Department of Health (Department), and others, that 'junk' or 'basic' policies make a substantial contribution to risk equalisation and decrease pressure on premiums.

2 The Hon. Sussan Ley MP, former Minister for Health, 'Coalition's plan to ensure private health insurance delivers value for money', http://sussanley.com/coalitions-plan-to-ensure-plan-to-ensure-private-health-insurance-delivers-value-for-money/ (accessed 15 December 2017).

Recommendation 1

5.11 The committee recommends that the Commonwealth Government undertake an evaluation of the value provided by 'basic' policies as a fourth product category (Gold/Silver/Bronze/Basic). Following that evaluation, the Commonwealth should determine whether consumers are best served by a three-tier or a four-tier product categorisation system.

5.12 In Chapter 2, the committee noted that submitters raised concerns about access to mental health services and whether comprehensive psychiatric services should be made a mandatory inclusion in private health insurance policies. However, the committee also noted the Department's advice that making comprehensive psychiatric services a requirement for a complying health insurance product would have the effect of increasing premiums by 15 per cent.

5.13 The Minister has announced that patients with limited mental health cover will be able to upgrade once without serving a waiting period. The committee considers that the Minister's announcement is a good first step, though the committee notes that significant further detail is required from the Minister.

5.14 The committee received evidence that private health insurance is becoming increasingly unaffordable for many Australians. The committee notes Private Healthcare Australia's evidence that private health insurance may become unaffordable for one in five Australians in the next six years and the evidence of the Australian Healthcare and Hospitals Association that Australians pay 20 per cent of their healthcare costs out-of-pocket, more than any comparable Organisation for Economic Co-operation and Development (OECD) country.[3]

5.15 The committee notes that the Minister has announced that he will convene a committee to consider how to achieve transparency in out-of-pocket costs. However, this committee has already heard some evidence regarding transparency measures that can be taken immediately to assist consumers.

5.16 Evidence received by this committee suggests that dentistry is one area that requires attention. Dentists and practice managers informed the committee that they were unable to advise clients what their out-of-pocket costs would be because they did not know what rebate the private health insurer would provide. Instead, consumers are required to phone private health insurers to attempt to seek advice on what they might be covered for.

5.17 Dentists advised the committee that private health insurers have previously published guides to their rebates. The committee considers that requiring private health insurers to publish comprehensible guides to their rebates would be of assistance to consumers and other health practitioners.

3 Private Healthcare Australia, *Submission 18*, p. 12; Ms Alison Verhoeven, Chief Executive, Australian Healthcare and Hospitals Association, *Committee Hansard*, 5 July 2017, p. 20.

Recommendation 2

5.18 The committee recommends that the Minister for Health require private health insurers to publish all rebates by policy and item number.

5.19 Another area that the committee considers warrants examination is the fees charged by medical specialists. The committee received evidence that some surgeons, and other specialists, charge excessive fees. The committee also heard evidence that the Royal Australasian College of Surgeons would accept the public disclosure of surgeons' fees, and that it would be a relatively simple task to publish fees in order to enable consumers to better understand their out-of-pocket costs and make an informed decision.

5.20 Public disclosure of fees would introduce more discipline to the market, and would empower consumers to request a referral from their general practitioner to a preferred specialist that they can afford.

5.21 Ideally, fees would be published in a searchable database which would also include the type and volume of procedures performed, and risk-adjusted complication and error rates, to enable consumers to also weigh the relative skill of their surgeon/medical practitioner.

5.22 Some submitters recommended the implementation of an online searchable tool that patients and private health insurers could use to obtain an estimate of professional fees. The committee believes that such a scheme is worthy of further consideration.

Recommendation 3

5.23 The committee recommends that the Minister for Health instruct the Department of Health to publish the fees of individual medical practitioners in a searchable database.

5.24 The committee notes the Prostheses List reforms announced by the Minister and the agreement with the MTAA to constrain the cost of implantable devices. As discussed in Chapter 3, Prostheses List costs have been contributing to rising premiums and the committee commends efforts to reduce the benefits paid in this area.

5.25 The committee notes the MTAA's recommendation that the accounts of each private health insurer be audited by the Australian National Audit Office to ensure that savings from the Prostheses List reforms are passed on to consumers. Private health insurers did not oppose the recommendation for an audit. The committee considers that it is important to ensure that savings from these reforms are applied to making premiums more affordable for consumers.

Recommendation 4

5.26 The committee recommends that the Commonwealth Government ask the appropriate body (such as the Australian National Audit Office, Department of Health, Australian Prudential Regulation Authority, Australian Competition and Consumer Commission or the Private Health Insurance Ombudsman) to

report in 12 months on whether the benefits from the Prostheses List reforms are being passed on to consumers.

5.27 As part of the private health insurance reforms announced on 13 October, the Government announced that the PHIO's website would be upgraded to make it easier for consumers to compare insurance products.

5.28 The independent website privatehealth.gov.au provides consumers with objective comparator information on private health insurance policies. However, the PHIO has currently has no budget to promote the website with the result that awareness appears limited, with only about one in eight consumers using the service in 2016.

Recommendation 5

5.29 The committee recommends that the Commonwealth Government provide additional funding to the Private Health Insurance Ombudsman to enable it to widely promote its upgraded website and comparison service to consumers.

5.30 Submitters raised concerns with the committee about privately funded patients being treated in public hospitals. The committee notes the increase in the number of patients electing to be treated privately in public hospitals, though also notes that this has always been a feature of Australia's mixed public-private system. The committee was also concerned that some state governments appear to have adopted policies with the intention of attracting private patients, though notes that states feel this is necessary in the context of Commonwealth hospital cuts.

5.31 The committee received anecdotal evidence that some consumers were being asked to make an election about whether to use their private health insurance under some stress. The committee considers that all consumers should be able to make an election with full knowledge of the financial and other consequences and free of pressure or duress.

5.32 The committee notes the Department's perspective that public hospitals may treat private patients ahead of public patients, provided public patients are treated within a clinically appropriate period.

5.33 The latest Australian Institute of Health and Welfare report concludes that patients with private health insurance were more likely to be assigned a higher clinical urgency rating for a similar procedure than a public patient. The committee is concerned by this practice and notes that the Minister intends to raise the matter as part of the next National Health Agreement. The committee agrees that this matter ought to be given high priority by the Minister, the Department and by state and territory governments.

Recommendation 6

5.34 The committee recommends that all state and territory governments review policies and practices regarding private patient election to ensure that all patients can provide informed financial consent.

Recommendation 7

5.35 The committee recommends that the Commonwealth Government and state governments ensure that public hospitals provide equality of access for public and private patients based only on clinical need and not on insurance status.

5.36 In Chapter 4, the committee considered whether state and territory activity based funding models sufficiently adjust to account for privately funded hospital separations. The committee received evidence indicating that some state and territory policies do have such an incentive, particularly where states and territories retain revenue resulting from exceeding private patient targets. The committee was concerned that such financial incentives appear to be leading to an increase in privately funded public hospital separations.

Recommendation 8

5.37 The committee recommends that the issue of private patient adjustments be considered in the context of negotiations on the next National Health Agreement, consistent with the Minister's broader approach.

Other concerns raised with the committee

5.38 The committee received evidence that private health insurers may be able to make a greater contribution to out-of-hospital care. The committee notes that private health insurers are already able to contribute under the Broader Health Cover provisions of the *Private Health Insurance Act 2007*, but recognises that private health insurers would like to cover a wider range of out-of-hospital procedures.

5.39 The committee understands that unnecessary hospitalisation should be avoided where possible and that there is limited clinical evidence that hospital based rehabilitation is superior to rehabilitation provided in a patient's home. Equally, the committee understands that introducing another payer into out-of-hospital care risks undermining the universality of Medicare and inflating costs for both consumers and the Commonwealth.

5.40 The committee is concerned that private health insurers will place limitations on benefits in an attempt to keep costs down. As noted in Chapter 4, private health insurers have placed restrictions on benefits that may be claimed and that this delivers poor outcomes for patients who either incur greater out-of-pocket costs or are forced to delay treatment.

Recommendation 9

5.41 The committee recommends that the Commonwealth Government consider extending the Broader Health Cover provisions of the *Private Health Insurance Act 2007* on the basis that such services, if offered, do not undermine the universality of Medicare by creating a two-tiered primary health care system, do not inflate costs for the Commonwealth by introducing another payer, are provided on a comprehensive basis and do not delay treatment or lead to greater out-of-pocket costs.

Recommendation 10

5.42 The committee recommends that the Commonwealth Government review current regulations to allow private health insurers to rebate out-of-hospital medical treatment where it is delivered, on referral, in an out-patient, community or home setting.

5.43 The committee was very concerned to learn that many children are unable to have serious dental issues addressed because private health insurers will not provide adequate rebates to private hospitals and day surgeries. The committee received evidence that private hospitals are revoking the admitting rights of paediatric dentists and adding children requiring serious dental work to public waiting lists. The committee urges all parties to work together to resolve these issues in the interests of paediatric dental patients.

Recommendation 11

5.44 The committee recommends that private health insurers engage in negotiations with private hospitals and paediatric dentists to urgently resolve the issues surrounding paediatric dentistry.

5.45 The committee also received significant evidence from dental practitioners about the effect 'preferred provider' schemes were having on independent dentistry. In particular, dental practitioners raised concerns that consumers are disadvantaged and received lower rebates because they visited a non-preferred dental practitioner.

5.46 The committee is concerned by evidence received from dental practitioners regarding the impact of 'preferred provider' schemes. Dental practitioners raised concerns that they believed that some practices of the private health insurers were anti-competitive. The committee considers that reforms should be implemented that specify that, where two consumers in the same jurisdiction pay the same private health insurance premium, they should be entitled to the same rebate for the same clinical service.

Recommendation 12

5.47 The committee recommends that the Commonwealth Government amend relevant legislation to prohibit the current practice of differential rebates for the same treatments provided under the same product in the same jurisdiction.

5.48 The committee received evidence from the Australian Competition and Consumer Commission (ACCC) that it had previously considered 'preferred provider' schemes and found that they were not anti-competitive. However, the committee understands that those findings were made on the basis that dentists were able to join those schemes. The committee has questions as to whether private health insurers' use of data obtained from Health Industry Claims and Payments Service (HICAPS) terminals could be used inappropriately when offering competing dental services. The committee asks the ACCC to consider the issue, especially in light of the Productivity Commission report on *Data Availability and Use*, where it was noted that the use and sharing of membership data exemplify 'the advantage that access to vast quantities of data could offer by way of market power'.[4]

Recommendation 13

5.49 The committee recommends that the Australian Competition and Consumer Commission reconsider whether private health insurers' use of data obtained from the Health Industry Claims and Processing Service is anti-competitive.

5.50 The committee also recommends the Commonwealth Government amend relevant legislation to ensure there is a clear delineation between data obtained from the Health Industry Claims and Processing Service and data used by health insurers competing for services against other non-preferred providers. This should extend to a requirement that such data be maintained strictly and separately and that private health insurers should be prohibited from using data gained through claims processes for commercial gain.

5.51 In Chapter 3, the committee considered the role of intermediaries in policy selection and switching between private health insurers. The committee received evidence that consumers are unaware of the commissions paid to intermediaries. The committee considers that consumers should be made aware of commissions paid to intermediaries by private health insurers.

Recommendation 14

5.52 The committee recommends that the Commonwealth Government require intermediaries to disclose any commissions received from private health insurers for the service.

Recommendation 15

5.53 The committee recommends that the Commonwealth Government amend relevant legislation to require all private health insurers disclose executive remuneration and other administrative costs.

5.54 Many private health insurance products have waiting eligibility periods of up to 12 months. Ideally, notice to consumers about changes to their insurance product should align with relevant waiting periods for any treatment affected by the change, so that consumers are not disadvantaged should they choose to change their cover as a result.

Recommendation 16

5.55 The committee recommends that the Minister for Health amend the legislation to require private health insurers to provide adequate written notice of changes to policies and eligibility to allow consumers to consider alternatives, and that this notice clearly communicates changes to the policy that may affect the insured person's coverage, especially where such changes may be

4 See Australian Dental Association (ADA), *Submission 222*, pp. 42–43.

detrimental. Where relevant, the notice period should correspond to the eligibility period for any service or treatment affected by the changes.

5.56 The Private Health Insurance Code of Conduct (Code) is designed to promote 'informed relationships between private health insurers, consumers and intermediaries'.[5] It covers four main areas of conduct in private health insurance, including that consumers receive the correct information from appropriately trained staff, ensuring that consumers are aware of dispute resolution procedures, and ensuring policy documentation contains all the information consumers require to make a fully informed decision.

5.57 It is important to note the Code is voluntary and, as such, does not have the force of legislation. A breach of the Code does not give rise to any legal right or liability. Further, the quality of information that is provided in the Code is not necessarily user-friendly or helpful to consumers.

5.58 As highlighted by the Australian Dental Association (ADA), whilst it is a legislative requirement that new policy holders are given a Standard Information Statement and details about what their policy covers and how benefits provided under it are worked out, this does not always occur in practice. The end result is a lack of informed financial consent for consumers and little scope for redress.[6]

5.59 Evidence provided to the committee also highlighted that there is very little regulation and oversight of the interactions between private health insurers and providers. In its submission, the ADA recommended that the ACCC, in consultation with the PHIO, encourage private health insurers to work with healthcare providers to develop a code of conduct to promote ethical co-operative relationships between funds and health providers.[7]

Recommendation 17

5.60 The committee recommends that the Private Health Insurance Ombudsman advise the Minister for Health in 2019 on additional measures that could be introduced to make private health insurance easier to understand that are in addition to significant reforms being introduced in 2018 and 2019.

Recommendation 18

5.61 The committee recommends that the Australian Competition and Consumer Commission, in consultation with the Private Health Insurance Ombudsman, commence work to establish a new code of conduct that will provide the framework for engagement between private health insurers and healthcare providers.

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5 ADA, *Submission 222*, p. 49.

6 *Submission 222*, pp. 28–30.

7 *Submission 222*, p. 49.

Recommendation 19

5.62 The committee recommends that the Minister for Health write to the Private Health Insurance Ombudsman to request advice on the disclosure of limitations to treatment type or frequency which may arise from contract arrangements with individual hospitals or providers that impact on members' access to services and out-of-pocket costs.

Senator Rachel Siewert

Chair