Consumers Health Forum of Australia

SUBMISSION

Options to reduce pressure on private health insurance premiums by addressing the growth of private patients in public hospitals discussion paper

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CONTENTS

Contents

Introduction

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers and those with an interest in health consumer affairs. CHF works to achieve safe, quality, timely and affordable healthcare for all Australians, supported by accessible health information and systems. We support the principles of consumer centred care and chief among these is the principle of universal health care[1]. Private Health Insurance (PHI) and concerns about medical costs are two of the areas most frequently raised with CHF by the community. Because of this, PHI is one of our key areas of interest. We have been active participants in all waves of reform about PHI, including through representing the needs of consumers on the current Private Health Ministerial Advisory Committee (PHMAC). Through our role on PHMAC we have continually advocated for greater simplicity, transparency and greater value for both consumers who use PHI and the broader taxpaying community. We welcome the discussion paper presented by the Department of Health and are pleased to provide a submission to it. In writing this submission we have drawn on our previous commentary on the issue and have consulted widely with our members – both health consumer organisations and individual consumers with an interest and expertise in the area. We are happy for our submission to be made public and would value hearing back from you as to when this will be possible.

First and foremost, we would like to remind the government and policy makers that consumers, the people who use the health system and for whom it was created, should be at the centre of all of decisions. As advocates for consumers, who do not have a financial stake in this, we offer suggestions which are based on the reality of consumers' use of their PHI and how the health system can best serve them. Our key principles in this area are:

- That consumers' ability to choose to be private patients in public hospitals be maintained
- That PHI policies that are public hospital only should still attract government incentives particularly given their importance for rural consumers
- That patients should be treated according to clinical need, not ability to pay. This needs to be strengthened by improved monitoring and data collection on this issue.

As our submission highlights, most of the options presented in this paper and the broader discussion around PHI do not currently have consumers at the centre and may be seen to penalise consumers, instead of supporting them. While we acknowledge the importance of equitable sharing of funding between the commonwealth and states and territories, changes should not be made which would limit patient choice and potentially increase confusion or costs for individual consumers. We suggest that while this issue is not unimportant, that changes in this area are unlikely to have substantial or wide-ranging affects in the areas of value or affordability for consumers.

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

The discussion paper has many assumptions and conclusions that we suggest are not clearly substantiated with the evidence offered. For example, the paper argues that "(i)f the number of private patients in the public sector had grown at the same rate as private patients in private hospitals since 2010-11, premiums in 2015-16 would have been about 2.5% lower than they actually were" (page 4). It is unclear how these figures were derived.

Systemic issues with Private Health Insurance

Australian consumers find that PHI is increasingly unaffordable, confusing and are unsure about the value that it provides. Despite considerable government investment in the PHI industry, there is yet to be conclusive evidence that this investment is providing sufficient returns with regard to the original policy intent which included taking the pressure off public hospitals, including elective surgery wait times. We are concerned about the quantum of government outlays in this area.

We note that these tensions are not acknowledged in the discussion paper. While the growth in numbers of private patients in public hospitals is clearly outlined, the factors leading consumers to make this choice are not. We have outlined what we perceive to be the most important of these issues below. We suggest that they should be taken into consideration and further investigation conducted into the reasons that consumers are using their PHI in public hospitals prior to any substantive change being made.

Current reforms are occurring in an increasingly challenging economic environment for Australian consumers. Wage growth is low relative to increases to the cost of living and specifically healthcare costs. In this context, PHI premium increases at greater than CPI become particularly challenging for consumers to absorb. When compared to housing, electricity and basic healthcare costs PHI is increasingly a luxury or discretionary product, which consumers are increasingly unable to justify. CHOICE's consumer pulse survey illustrates this – results from May 2017[2] revealed the lowest level of households living comfortably since June 2014. One of the main cost pressures for households is healthcare affordability which tied with household electricity prices for top spot.

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

[2] CHOICE. Australians worry most about electricity bills, health care: https://www.choice.com.au/money/budget/cost-of-living/articles/australian-households-worry-most-about-electricity-prices-healthcare-030417, accessed 21 July 2017. 2017

Because of this, reforms to PHI must centre around two key questions – how can PHI provide better value for the taxpayer, and how can it provide better value to consumers?

The use of Private Health Insurance in public hospitals

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

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

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

When the treatment takes place in a private hospital they are not, in reality, jumping the queue but rather joining another separate queue. This is a totally rationale choice for consumers who can afford it to make.

However – if consumers are indeed jumping the queue to get faster treatment in a public hospital, even as a private patient, we are concerned about this. If consumers are able to access care in public hospital systems faster on the basis of their ability to pay, rather than clinical need this is a significant issue. If it is occurring, it is undermining the universality of our public health system through the prioritising of consumers who can pay over consumers who need healthcare. Evidence for this concern has emerged from a recent report from the Australian Institute of Health and Welfare[3] which has suggested there may be a negative impact on elective surgery waiting lists which may be attributable to private patients being in public hospitals. However, we do acknowledge that there have been some doubts raised about the data from which these conclusions are drawn, related to whether or not this priority is being granted on the basis of clinical need or ability to pay. This ambiguity needs to be resolved and 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 ensure this principle is not compromised.

[3] Australian Institute of Health and Welfare. Admitted patient care 2015–16: Australian hospital statistics. Health Series no.75. Cat. no. HSE 185. Canberra; 2017.

Consumers should not be coerced or given information which they may perceive to be misleading about using their PHI in public hospitals. While we do not oppose State and Territory health departments asking consumers if they would like to use their PHI in public hospitals, the way they are asked is crucially important. Under the National Hospital Reform Agreement[4] (the NHRA page 59) there is a directive for public hospitals to have dedicated support for helping people elect to use their private health insurance. Our work to date has found that this directive is applied inconsistently, with practices varying from state to state. Given that consumers are often asked to make these decisions at a time of extreme stress (e.g. when admitting themselves to a hospital emergency department), public hospitals need to ensure that their practices are considerate and appropriate and include appropriate provisions for informed financial consent. Examples of these experiences include:

> *I had a minor operation at a Private Hospital. Pneumonia from op... Ended up in casualty at a major hospital for 14 hours on a trolley as there was no bed. Serious pain, no relief. A bed became available and I was asked am I "Private or Public"? No explanation. I said private and I just got bills as a result. Nearly died from all of this. Private insurance? What use? Too complicated and disappears when you really need despite having paid*[5]

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

The final area of concern for CHF is how insurers factor in public hospital-only policies to their premium calculations and projections. The peak body for for-profit private health insurers, Private Healthcare Australia (PHA), has suggested that public hospital 'cost shifting' or transferring the cost of public services to health funds in Australia is putting upward pressure on premium costs, in their estimation this accounts for 6% of PHI premium costs per year and that this amounts to 2.1% of all hospital funding[6]. Whilst this may increase the number of services claimed for it needs to be remembered that people could opt for all their services in private hospitals, if their policy allowed it. This has the potential for higher costs for insurers if people with PHI always opted for treatment in private hospitals and services.

Response to options presented in the discussion paper

Our responses to the options presented in the discussion paper are below. Broadly, we believe that this situation is to be expected in Australia's mixed public/private system structured the way it is. We believe that the best option from a consumer's view point is Option 5.

[4] Council of Australian Governments. National Health Reform Agreement. 2011.
[5] Consumers Health Forum of Australia. Consumer comment from CHF Private Health Insurance Survey report. 2015
[6] Private Healthcare Australia. Ideas for improving the value and affordability of private health insurance: 2017-2018. 2017

Options 1 through 4 move to reduce the practice of consumers using their private health insurance in public hospitals inherently reduce choice and reduce competition, which may contribute to increased premiums. These options may also reduce consumer's ability to choose their doctor restricting one of the key reasons that consumers have private health insurance and could lead to people abandoning private health insurance completely.

Option 1: Limit PHI benefits to the medical costs of private treatment in public hospitals with no benefits paid to the hospital

CHF does not support this option.

While Option 1 may reduce costs to the insurers, it is likely to lead to higher out of pocket costs for consumers through hospitals remaining able to choose to raise charges against private patients, with insurers not being able to pay a benefit. This would not disadvantage consumers with coverage for private hospitals who live in in major cities and for health conditions for which treatment is equally available in both the private and public systems, as they would be able to fully utilise their cover in private hospitals. It is not clear what the insurers would gain from this as they would still be meeting the costs, which may in fact be higher.

However, consumers who live in rural and regional areas or who are better served in the public system would be disadvantaged by this. It would undermine the value of their private health insurance and may discourage them from staying insured.

If this option was to be implemented then a major public awareness campaign, including in hospitals, would need to be conducted to explain the change. A barrier to this campaign would be the probable unwillingness of public hospitals to promote this change.

Option 2: Prevent public hospitals from waiving any excess payable under the patient's policy

CHF does not support this option.

We believe that Option 2, if implemented, would have substantial negative consequences for consumers. In addition to our concerns regarding Option 1 around consumers from rural and regional areas and those who are better treated in the public system, we believe that consumers are unlikely to understand this practice. This option hinges substantially on the practice of providing informed financial consent conduct. Specifically, it relies on state and territory governments, and individual hospitals, to make the financial implications of their choice clear. CHF has heard of examples, and has expressed concerns that informed financial consent procedures are currently poorly implemented. If this option were to be implemented regulations to improve these practices would also need to be designed and implemented. As noted in the paper, this would need to be done by states and territories, who are unlikely to be willing to strengthen this through regulation which would impede their own practices.

Whilst it might reduce the numbers using their private health insurance in public hospitals it would further erode the value that consumers are able to gain from their insurance. Again, this could lead to more people discontinuing their insurance.

Option 3: Remove the requirement for health insurers to pay benefits for treatment in public hospitals for emergency admissions

CHF does not support this option.

As outlined above, CHF are strong supporters of the ability of consumers to choose their doctor. Because of this, we believe that the ability of consumers to choose to use their insurance in public hospitals, including through the emergency department, should continue. Stopping people admitted through the emergency department from opting to use their private health insurance or at least allowing PHI funds to not pay benefits takes away the right to choose a doctor, when this is possible. If PHI funds are unable to pay then potentially consumers could be up for increased out of pocket expenses.

However, we acknowledge that currently major deficiencies exist with regard to informed financial consent procedures. We are concerned by reports from consumers feeling pressured into using their PHI in the emergency department. We acknowledge that this option would address these concerns, but believe that there are other options through which this could be achieved which do not restrict the choice entirely. Good practice for informed financial consent procedures exist, but currently hospitals aren't using these procedures consistently across the board. Regulatory changes to enforce the use of these procedures would improve the experience of all consumers and continue to allow consumers this choice.

One of the key issues for both this and the following option is the challenge of definitions of episodes of service, and where the admission starts and stops. If a consumer is admitted through the emergency department, but then transferred to another ward and provided with ongoing treatment in the same hospital, there might be difficulties in separating the episodes and deciding when the person could opt to use their PHI and whether they could claim benefits.

Finally, one of the objectives of the current round of reforms to private health insurance is to reduce complexities and make it easier for consumers to understand what they can and cannot claim for. This option fails to meet that objective. We are concerned that this option would lead to increased complexity, uncertainty and confusion on the part of all stakeholders, with the impacts being most felt by consumers.

Option 4: Remove the requirement on health insurers to pay benefits for episodes where there is no meaningful choice of doctor or doctor involvement

CHF does not support this option.

We think that option 4 is fraught with difficulties due to the myriad challenges associated with defining the concept of 'meaningful'. As noted in the discussion paper, a key challenge that would result from this option is that an assessment would need to be made of the type of services which could be categorised as having no (or limited) choice of doctor and that these services would need to be defined in regulation. Given that many of the key challenges within PHI arise from consumers' lack of understanding about their product and insurers failures to clearly define and articulate these we have little confidence that this option could be implemented successfully.

We also believe this option would act as a disincentive for some people to continue with their private health insurance, especially those in areas with fewer choices. Some people in rural and remote areas maintain private health insurance to be able to have choice of doctor when they go to larger hospitals in urban or regional centres. They might not think the expense is worthwhile if they cannot use it in their local hospital.

Option 5: Make changes to the NHRA NEP determination and funding model

Of the options presented, this is the only one that CHF considers to be acceptable to consumers.

These negotiations would set the ground rules and have a way of ensuring states and territories are not double dipping, and where they are using these practices to obtain additional funding that this funding is allocated toward health system improvement. These negotiations should also be enhanced by examining options for improvements in the way that public hospitals are funded. We encourage the Commonwealth government to work more collaboratively with the states and territory governments to change the policy settings which are causing the problems of perceived insufficient funding. This may be complemented by the broader sector working more collaboratively together.