Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Senate Inquiry into the value and affordability of private health insurance and out-of-pocket medical costs

Dear Senators,

My name is Kang Kim, I am a Western Australian private practice dentist, I have been an office holder at the Australian Dental Association (WA Branch) and was a clinical tutor at the UWA School of Dentistry. I was also an MBA student at UWA, until I discontinued my studies due to increased work duties. Thank you for this opportunity to contribute to the Senate Committee's discussions. I have tried my best to use my experience and knowledge to add some valuable points to the Terms of Reference with regards to Extras health policies.

Terms of Reference:

The value and affordability of private health insurance and out-of-pocket medical costs, with particular reference to:

(c) private health insurance product design including product exclusions and benefit levels, including rebate consistency and public disclosure requirements;

Benefit Levels

Benefit levels in the "Extras" policies of private health insurance has evaded scrutiny and needs to be examined objectively.

Fundamentally, insurance is designed to protect policy holders against an adverse event, from which it may be difficult or impossible to recover. When purchasing insurance, the vast majority of consumers assume a net loss and undertake an expense to protect against risk. This expense is only justifiable when the risk is real and the cover is adequate.

Extras insurance covers against a number of allied health categories predominantly dental, physiotherapy and optical. Compared to examples such as car insurance, adverse events in these categories are minor and far more manageable without insurance cover.

It is true that in extreme circumstances, dental treatment costs are comparable to a car insurance claim. However, in the case of a true insurance product the size of the claim overshadows the deductible, effectively rescuing the policyholder from the adverse event. With Extras cover, the deductibles (gap payments) are so significant that even in catastrophic circumstances, the patient is often liable for most of the cost.

Hence, it can be said that Extras policies charge their patients to be improperly insured against a manageable risk.

Furthermore, these policies do not only cover adverse events but regular, periodic expenditures outside of the true definition of insurance. Such regular expenses would be far better managed under a Medical Savings Account (MSA) model. Under the high maintenance and complex administration of a health insurance model, the current Extras policies are inefficient in delivering support for private patients. A model such as the MSA, would provide a higher yield towards health treatment without subjecting the funds to high administrative expenses with only a small remaining percentage left for the provision of healthcare.

The value of Extras health insurance needs to be examined carefully. An improved model, such as the Medical Savings Account model, needs to be considered to provide more efficient management of the Australians' private health expenditure.

Rebate Inconsistency

In the private dental sector, the contracted provider (preferred provider) arrangements have had a significant influence on the manner in which treatment has been delivered to patients. It has also introduced a significant rebate inconsistency throughout the sector which has had knock on effects to the value of private health insurance for the healthcare patient/consumer.

In essence, the aim of contracted provider arrangements is to ensure a predictable out-of-pocket cost for the consumer. However, in order to achieve this, it requires control over health practitioners' fees. For many years, private health insurers (PHIs) have attracted health practitioners to contracted provider arrangements by promising higher rebates. In return, the practitioner must sacrifice control of his/her fees. By controlling practitioners' fees, the PHI can promise predictable out-of-pocket costs for their policyholders.

Unfortunately, these arrangements were quickly affected by commercial factors which brought a negative influence to patient care. Perhaps understandably, PHIs began utilising contracted provider schemes for marketing purposes. By advertising a significant percentage cover in dental treatment, they were able to attract a greater market share. Furthermore, the initial infiltration of these arrangements allowed PHIs to financially coerce other health providers to join their contracted provider schemes. PHIs informed their policyholders that if they see contracted dentists then they would receive a financial benefit, they were able to steer patients away from non-contracted practices.

However, the PHIs began to realise that as more patients seek out contracted providers to take advantage of higher rebates, it negatively affects their bottom line. One health fund has recently ceased any new uptake of contracted providers. Most health funds have reduced or limited provider fees despite regular increases in health insurance premiums and health CPI. This has inevitably put the strain on quality of care as contracted providers have had to find ways to maintain their business viability with diminishing fees and increasing costs of operation.

The retort from PHIs is that contracted providers have a choice to exit their contracts at any time and patients can still choose to see non-contracted providers. Although this is technically correct, in an increasingly competitive environment, contracted providers cannot exit their contracts for fear of losing their patient base to other contracted providers. Furthermore, many patients cannot choose to see the dentist of their choice due to their own financial constraints.

PHIs are using rebate inconsistency to influence the healthcare market. To ensure their own bottom line, they are potentially inducing compromises in quality of care to a segment of the allied health sector, then compelling patients to take that option. In private practice, I continue to see that patients with poorer finances are often influenced by rebate inconsistency to make health decisions that they would not have otherwise made. This includes rebate inconsistency between different modalities of treatment which is imposed by PHIs based on financial objectives rather than clinical factors.

As health practitioners, we need to understand that we cannot immunise healthcare from financial drivers. However, as a health practitioner, I have also come to understand that health is not disposable or interchangeable. Hence, a compromised decision in healthcare tends to lead to far greater costs in the future. Rebate inconsistency significantly affects patient choice and must be recognised as a short-term and long-term detriment to the value of private health insurance.

To maintain the high standard of our Australian healthcare system, there must be greater control or a prohibition against inconsistent rebates.

I have attempted to keep this submission brief. However, I would be more than happy to provide further commentary and elaborate on the above points. If I can be of any further value to the Senate Committee, please do not hesitate to contact me

Yours faithfully,

Kang Kim
BDSc (UWA)